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Curtailing Reproductive Freedom through Choice: The Informed Consent Doctrine and "Abortion Regret" in U.S. Abortion Regulation

Author

Staschus, Sophie

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Curtailing Reproductive Freedom through Choice: The Informed Consent Doctrine and "Abortion Regret" in U.S. Abortion Regulation

A Dissertation submitted in partial satisfaction of the requirements
for the degree Doctor of Philosophy

in

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by

Sophie Staschus

Committee in charge:

Professor Valerie Hartouni, Co-Chair
Professor Robert Horwitz, Co-Chair
Professor Claire Edington
Professor Kelly Gates
Professor Catherina Gere

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The Dissertation of Sophie Staschus is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

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DEDICATION

À ma sœur préférée,

"Tu n'es plus là où tu étais, mais tu es partout où je suis"

Victor Hugo

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VITA

2014 Bachelor of Arts in Communication, University of California San Diego

2017 Master of Arts in Communication, University of California San Diego

2023 Doctor of Philosophy in Communication (Science Studies), University of California San Diego

TEACHING

2016-2018 Teaching Assistant, Department of Communication

2018-2022 Teaching Assistant, Muir College Writing Program

2019-2020 Senior Teaching Assistant, Muir College Writing Program

2020-2023 Instructor of Record, Department of Communication

2021-2022 Senior Teaching Assistant, Department of Communication

ABSTRACT OF THE DISSERTATION

Curtailing Reproductive Freedom through Choice: The Informed Consent Doctrine and "Abortion Regret" in U.S. Abortion Regulation

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Professor Robert Horwitz, Co-Chair

Before the *Dobbs v. Jackson* (2022) decision overturned the constitutional right to abortion, the 21st century anti-choice movement was focused on establishing informed consent statutes as a means to discourage or prevent abortions. Often titled "A Woman's Right to Know," these laws require that patients are warned of alleged risks of breast cancer, infertility, and psychological trauma following abortions. In some states, patients must

undergo an ultrasound and wait at least 24-hours before receiving an abortion. These statutes have been shown to delay or hinder care.

This dissertation is a genealogy of these informational requirements. I analyze how *Roe v. Wade* (1973) and ensuing abortion jurisprudence in the 1970s enshrined the abortion right in a medicalized framework of abortion access. This framing eschewed feminists' requests that women be solely responsible for deciding when and why to undergo an abortion. Instead, the Court articulated a qualified first-trimester privacy right in which pregnant women were tasked with making a responsible abortion decision in consultation with their physician.

Through historical and legislative analysis, this dissertation traces how the medicalized right to abortion enabled the later development of informed consent statutes. The informed consent doctrine ideally seeks to protect patient autonomy from medical paternalism. But the noun "patient" acts as a qualifier that configures someone's autonomy and available choices according to their status as a patient. The doctrine was thus an ideal vehicle for anti-choice efforts to implement restrictions meant to protect abortion patients. It enabled statutes that nominally promoted pregnant women's autonomy, while infusing informational requirements with religious views of well-being that confused motherhood with health. I contend that the discourse of "abortion regret", which produced motherhood as the rational, retroactive, even if foregone choice, legitimized these informational requirements. From *Roe* onwards, pregnant people were tasked with making responsible abortion decisions in light of their health. Throughout the decades, however, 1) how "women's health" was conceptualized and 2) whether physicians or the State were the rightful shepherds of the abortion decision became battlegrounds for pro- and anti-choice organizing.

INTRODUCTION

On June 24th, 2022, the United States Supreme Court overturned *Roe v.* Wade, which instituted the constitutional right to abortion in 1973, under *Dobbs v. Jackson Women's Health Organization* on the basis that the Constitution did not confer a right to abortion. Thirteen states had preemptively instituted so-called trigger laws that would ban abortions almost immediately if the *Roe* decision was overturned. That same morning, abortion patients, seated in consultation rooms awaiting their scheduled procedure, were turned away (Kitchener, 2022).

The decision has already had devastating implications on women who find themselves in states that have already criminalized nontherapeutic abortions. These implications will become all the more concerning and widespread as anti-choice activists, invigorated by this recent victory, fight for a country in which abortions are not only federally banned but rendered "unthinkable" (Shapiro, 2022).[1] In the months since the decision, anti-choice activists and legislators have attacked some of the loopholes created by the existing patchwork of state legislation. For instance, pro-abortion activists and physicians have sought to overcome state bans by referring pregnant women to international organizations that can mail safe, prescribed abortion pills; efforts that were aided by the Federal Drug Administration's (FDA) 2021 decision to permanently allow abortion pills to be mailed rather than exclusively dispensed in-person by a certified health provider (Belluck, 2021).[2] The Alliance Defending Freedom, a conservative legal

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[1] The *Dobbs* decision engendered almost immediate plans to institute a federal ban on abortions. A common sentiment expressed by anti-choice activists and lobbyists is that the *Dobbs* decision is just the beginning of their quest to (re)criminalize abortion (Grabenstein, 2023). Some anti-choice activists go so far as desiring a country in which abortion is not only illegal and inaccessible but rendered morally "unthinkable" (Shapiro, 2022).

[2] Aid Access, an Austrian organization, was founded in 2018 in an attempt to provide telemedicine abortions to pregnant women in all U.S. states. The organization has seen requests for self-managed abortions rise by 33% since the *Dobbs* decision (Baker, 2022). Since the FDA's decision to lift the ban on telemedicine abortions, the organization has been an important resource for pregnant women in states with abortion bans or restrictive regulation. It offers to mail abortion pills to pregnant women on a sliding-scale fee of up to $150.

group, filed a federal lawsuit in November 2022 asking a Texas court to ban the U.S. postal service from delivering abortion pills. The Alliance cited the 1873 anti-obscenity Comstock Law, which proscribed sending sexual content, contraceptives, and abortifacients through U.S. mail (Baker, 2023). Even as the Department of Justice (DOJ) issued an opinion stating that the Comstock Law did not prohibit the delivery of abortion pills, it does not protect individuals from being charged by state prosecutors. The Alliance, joined by the Alliance for Hippocratic Medicine and the American Association for Pro-Life Obstetricians and Gynecologists, filed another suit in November requesting that Trump-appointed Judge Matthew Kacsmaryak compel the FDA to reverse its approval of mifepristone, the first abortion pill, on the basis that the FDA had "exceeded its regulatory authority" when approving the drug in 2000 (Tuma, 2023). The suit further argued that the FDA "ignored" evidence of alleged harm and thereby failed in its duty to "protect the health, safety, and welfare" of pregnant women (Tuma, 2023).

My dissertation examines an iteration of what legal scholar Reva Siegel (2008) termed the "Woman Protective Anti-Abortion Argument" (WPAA). Siegel defines this strategy as the attempt to popularize claims that abortions harm women in hopes of legitimizing abortion restrictions. Within this larger blueprint, anti-choice legislators have instituted atypically stringent and medically dubious informed consent requirements meant to warn abortion patients of alleged physical and emotional risks. My project examines how, and to what effect, the anti-choice movement mobilized pro-abortion discourses of choice and medicine to implement informed consent statutes that *restricted* abortion access. I seek to understand, for example, how compulsory waiting-periods, which force pregnant women to wait at least 24-hours between a consultation and their scheduled abortion, are framed as helping and protecting pregnant women even as waiting-periods have proven to delay or hinder care.

The *Dobbs* decision may render this strategy increasingly obsolete. The opinion was largely the result of the Court's composition, which is a product of symbiotic anti-choice and the Republican party's efforts to stack courts with conservative judges (Ziegler, 2015). "Packing" the courts with conservative judges may render strategies such as the one I explore increasingly unnecessary as anti-choice activists, lobbyists, and legislators are no longer forced to rely so strongly on public sentiment and approval.[3]

My project's focus can nevertheless tell us something important about this moment. As I argue throughout the dissertation, abortion's medicalization has obscured the moral and religious framings that inform much of abortion politics. Medicalization has not only erased the procedure's emancipatory potential that enables women to live their lives unencumbered by the perpetual threat of an unwanted pregnancy, it simultaneously seeks to efface moral and religious arguments about the sanctity of life. And yet, these arguments about women's autonomy and fetal personhood have nonetheless made their way into the medical framing under the lens of "women's health". This project demonstrates the versatile and protean nature of the notion of "health" and how it lends itself to shifting and even conflicting understandings of pregnancy, fetal life, and motherhood. It thus reveals how paternalistic concerns for "women's health" can continue to be a vehicle through which women's (reproductive) freedom is curtailed. The dissertation can therefore help us make sense of current battles over abortion pills, for example. It can problematize and complicate blanket statements about pregnant women's "health, safety, and welfare" that are currently mobilized in the quest to render abortion pills inaccessible. Alternatively, the project can serve as a warning to pro-abortion activists and lobbyists who may

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[3] I say this with reservation since I think we will continue to see secularized and medicalized discourses as the anti-choice movement will work to a) normalize, naturalize, and legitimize the harm inflicted on pregnant people by the *Dobbs* decision, b) institute a federal abortion ban, and/or c) pursue incremental restrictions in states currently allowing or expanding abortion access.

find themselves resorting to this medicalized framing in hopes of demonstrating the procedure's necessity.

I.1 Project Overview

This project starts from the basic premise that the abortion procedure can be understood in two, often confused and related but nonetheless distinct, ways. It is a necessary, occasionally lifesaving, medical *treatment.* According to the American College of Obstetricians and Gynecologists (ACOG, n.d.), without access to abortions, patients with an ectopic pregnancy, "placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, illness during pregnancy, and exposure to teratogenic medications" can die. As ACOG (n.d) states, "the fact is, abortion is an essential component of women's health care". But it is also so much more. It is a technology that allows women to live their lives freed from their reproductive capacities. It enables women to pursue their educational, professional, social, political, and relational lives as they desire in accordance with their motivations, values, and beliefs. It gives women the opportunity to be freed from potentially unwanted pregnancies and the ways in which those can compound oppressive living conditions.

These two conceptualizations of abortion are based on conflicting presumptions about women's autonomy and decisional capacity. Under the medicalized framing, the procedure is a treatment over which the physician ought to have at least some decisional authority. Questions regarding the appropriate scope of physicians' authority and the extent to which this authority is shared with the patient and/or the State arise. On the one hand then, pregnant women's choices and self-determination are demarcated by physicians' technical expertise and by perceptions of what benefits women's well-being. The *Roe* Court, for example, presumed that compulsory motherhood harmed women by forcing them to endure the physical, psychological, relational, and economic consequences of an unwanted pregnancy. To the contrary, ensuing abortion jurisprudence and anti-choice activists assumed that abortion was deleterious to women's physical and psychological health. The ambiguous and versatile nature of the notion of "health" partially explains the politicization of the abortion procedure and how the term was used as the basis upon which to either expand or restrict abortion access. In all these moments, women's right to abortion and broader self-determination was circumscribed by external stakeholders' interest in paternalistically protecting their health.

On the other hand, abortions exist as emancipatory technologies. Feminists have argued that women bear the consequences of an (unwanted) pregnancy and ought to therefore be the only ones to decide why, how, and when to undergo a pregnancy termination. Under this framing, physicians are merely technicians who effectuate the procedure at the patient's request. This thus centers pregnant women's right to make their (reproductive) decisions free from external oversight or guidance. Women's decisional capacity is assumed and respected.

My dissertation argues that abortion jurisprudence in the 1970s largely enshrined the abortion right in the medicalized framing of the procedure, thereby producing the procedure as medical *treatment* and the pregnant woman as a patient. Ensuing anti-choice practices that instituted atypically stringent informational requirements were the culmination and manifestation of this deference to medical authority. *Roe v. Wade's* (1973) qualified first-trimester privacy right, to be shared between physician and patient, was quickly complemented by an informed consent requirement, under *Planned Parenthood v. Danforth* (1976). Both the privacy right and the informed consent requirement encouraged, urged, pregnant women to make well-informed, weighted, and ultimately good decisions in light of their health and well-being. Women's self-determination was seen as best served by an abstract notion of patient autonomy that prized information and transparency in the pursuit of quality and weighted decisional processes. Self-determination was reconfigured as patient autonomy.

The informed consent doctrine was instituted in the early 1970s in an attempt to curb rampant and largely unbridled medical paternalism. It sought to redistribute decisional power to patients and give them the opportunity to make their own medical decisions and to refuse a recommended treatment, even if doing so was contraindicated. But the form of autonomy lauded and instituted under the doctrine is one that is always qualified, and hence demarcated, by the noun "patient". Patients acquired the right to make medical decisions, but within the confines of the profession's commitment to health and well-being. I contend that the doctrine could thus never be expected to institute a broader, more robust notion of self-determination for abortion patients. To whatever extent their autonomy could be materialized, it would be within the confines of a medical and beneficent commitment to their health**.** The doctrine was thus an ideal vehicle for anti-choice efforts at the beginning of the 21st century, which legitimized abortion restrictions on the paradoxical basis that these expanded women's rights and protected their health.

Indeed, since the early 2010s, we have witnessed a series of abortion legislation, often titled "Women's Right to Know", that structure and detail the informed consent process for abortion procedures (Daniels et al., 2016). These laws compel women to either 1) undergo counseling; 2) wait at least 24-hours between a consultation and the actual procedure; 3) view the ultrasound; and/or 4) be informed of fetal gestational age, fetal developmental stages, fetal pain, and/or the unsubstantiated link between abortion and breast cancer, future infertility, and possible psychological trauma (Guttmacher Institute, 2019a; Vanderwalker, 2012).

The complementary “abortion regret” discourse threatened potential abortion patients with the possibility that they may be making the wrong decision. When I mention the “abortion regret” discourse I am gesturing to a series of practices and statements that (re)produce motherhood as women’s innate and preferred choice, despite their previous abortion. In turn, this casts the alternative, abortion, as unnatural, deviant, and ultimately harmful. I define “abortion regret” as a woman’s retroactive evaluation of her previous abortion decision, whereby she comes to yearn for the foregone choice: motherhood. The discourse was popularized in 2007 under *Gonzalez v. Carhart*, when the Supreme Court proscribed a type of later-term abortion, deemed necessary and safer in some circumstances, on the basis that “some women come to regret their choice to abort the infant life they once created and sustained”. Informational requirements were the perfect mechanism through which to warn abortion patients of this potentiality. Abortion patients needed not only consider the nature of the procedure and its alleged risks, as typically disclosed for medical procedures. They were further tasked with considering their future emotions. The “abortion regret” discourse thus forewarns of the consequences of foregoing motherhood, while the informed consent statutes seek to formalize a particular decisional process that encourages women to choose motherhood. This strategy was deeply contingent on a context in which women’s reproductive choices were presumed and pursued.

I argue that this strategy was the culmination and materialization of early abortion jurisprudence that had tasked pregnant women with making the “right” medical decision. This project is thus a tale of “continuity and discontinuity” (Koopman, 2013, p. 39). In all these moments, from *Roe v. Wade* through anti-choice informed consent statutes in the 2010s, the judiciary, legislators, and physicians were concerned with the quality of women’s reproductive decisions. Even if women were given the right to choose between an abortion, adoption, or motherhood, they were never quite envisioned as capable of making the decision on their own, in accordance with their own values and priorities. The abortion choice was protected but the decisional process to reach that decision was never imagined as entirely free from external institutions of oversight. What changed throughout the decades, as the anti-choice movement gained traction and the ideological composition of the Supreme Court shifted, was 1) whether physicians or the State were identified as the rightful shepherds of women's abortion decision and 2) whether compulsory motherhood or abortions were identified as the locus of harm against which pregnant women needed protection.

I.2 Methodological Framing and Ethical Commitments

This project is a Foucauldian genealogy, or "history of the present", of current informed consent requirements. According to sociologist David Garland (2014), one of genealogy's important methodological contributions is to identify "a present-day practice that is both taken for granted and yet, in certain respects, problematic or somewhat unintelligible (…) and then seeks to trace the power struggles that produced them" (p. 373). Genealogies are thus not so concerned with understanding the past, as understanding "traces of the past (…) and their continuing operation today" (Garland, 2014, p. 375). This entails confronting "the reality of a history that undergoes transformations such that history can be studied as a process in which both continuity and discontinuity are essential to their temporalities" (Koopman, 2013, p. 39). Paying attention to these continuities and discontinuities helps explain how something in the present came to be, what were its "conditions of possibility" or emergence. Michel Foucault sought to render the present situation "comprehensible", which, in turn, enables "a possible redirection toward another future" (Koopman, 2013, p. 26). I thus take as my starting point informed consent requirements and the “abortion regret” discourse in abortion regulation. I use historical methods and jurisprudential analysis to unpack the “conditions of possibility” and I use textual and legislative analysis to render the “present situation comprehensible” and examine what work it does.

Since 1973, many scholars have traced the various, evolving ways in which the anti-choice movement has appropriated pro-abortion, feminist, and scientific discourses in its quest to curtail and ultimately proscribe the abortion right. It is almost a platitude to state that the movement, like any other social movement, mobilized its adversary’s strategies for paradoxical purposes. On a broad level, my project is similarly concerned with examining the anti-choice movement’s appropriation of the pro-abortion movement’s discursive, political, and legal strategies. More specifically, the “present day practice that is both taken for granted and yet (…) problematic and somewhat unintelligible” (Garland, 2014, p. 373) is the application of informed consent statutes and of the “abortion regret” discourse. It is unintelligible because both the statutes and the “abortion regret” discourse presume a rational, liberal subject who has the freedom to make reproductive choices. This strategy operates in a larger context in which pregnant women are assumed to have access to reproductive technologies that give them control over their reproductive processes. The informed consent doctrine, in particular, seeks to protect and expand patient autonomy. It is thus counter-intuitive, paradoxical, that the anti-choice movement ultimately mobilized a strategy that both presumed and nominally pursued women’s reproductive autonomy in its quest to restrict access to a technology recognized, by some, as enabling and materializing women’s reproductive freedom.

I thus wanted to understand *how* the anti-choice movement had successfully done so. How could a doctrine meant to promote patient autonomy be used to effectively restrict patient autonomy? And how was this implementation done with seemingly so little resistance or concern, even by people who consider themselves pro-abortion? Could the informed consent doctrine, conceptualized and instituted as a liberal artifact, ever fulfill its promise of promoting abortion patients' autonomy? As Carole Pateman (1988) asks more generally: "does contract immediately become attractive to feminists and socialists if entry is truly voluntary, without coercion?" (p. 8). In other words, if current informed consent statutes were freed of biased, ideologically driven information requirements, could the doctrine reach its promise of promoting abortion patients' autonomy? My analysis of early abortion jurisprudence that upheld unbiased informed consent requirements indicates it could not. I ultimately argue that the doctrine could only ever enact a particular iteration of self-determination, patient autonomy, which is distinctly different from a broader, more expansive and robust form of freedom.

Three analytical frameworks inform the project. First, like feminist legal theorists, I presume neither the neutrality nor objectivity of the law and recognize that the law acquires and retains much of its authority and power because it is presented as such (Scales, 1992). The project then necessitates exploring how the law deviates from this ideal and how it institutes and reifies, in practice, systems and relations oppression. Part of this task entails feminist legal theorists' commitment to unpacking "limitations (…) in efforts to realize liberalism's full potential" (Rhode, 1991, p. 338). I thus explore how the terms of liberalism shift from its theoretical aspirations. While this assumes that liberal notions of choice, self-determination, privacy, and correlated concepts of coercion and refusal are historically contingent and flexible, it simultaneously assumes that a certain understanding of liberalism is perpetually lauded and pursued. Wendy Brown (2003) defines political liberalism as "an order in which the state exists to secure the freedom of individuals on a formally egalitarian basis". An important ancillary presumption is that the:

> Liberal state is composed of autonomous, rational individuals. Their expressed choices reflect a stable and coherent understanding of their independent interests. Yet, while capable of full knowledge of their own preferences, these liberal selves lack similar knowledge about others. Accordingly, the good society remains as neutral as possible about the meaning of the good life (Rhode, 1991, p. 338).

This definition of the liberal subject as autonomous, rational, with "stable and coherent understanding of their independent interests" is one of the grounding assumptions of the patient under the informed consent doctrine. In this framing, "decisions are constructed as a product of objective calculation on the basis of near perfect information" (Sherwin, 1998, p. 24). The liberal subject is an important character throughout this project. Additionally, this definition of liberalism and its presumed liberal subject explain the importance of privacy as a liberal concept since a society and government that "remain neutral (…) about the meaning of the good life" necessitate and legitimize the privacy right. I thus seek to understand how abortion jurisprudence, informed consent statutes, and the "abortion regret" discourse both presume and pursue these definitions of the liberal subject, privacy, and self-determination while instituting different conceptualizations thereof tailored to particular ideological commitments.

Second, and very similarly, the informed consent doctrine is not a stagnant, inflexible process with "doctrinal, cognitive, and communicative certainties" (O'Regan, 2020, p. 5). Instead, I treat informed consent as a living artifact, which is unavoidably negotiated, reconceptualized, and ultimately reconfigured to meet cultural, historical, and politically contingent views. Since the doctrine's inception, it has emerged under specific historical circumstances that circumscribe how it is imagined and implemented, both in the law and in medical practice. The doctrine's foundational notions of consent, choice, refusal, and coercion have repeatedly been reconceptualized to accommodate shifting views on the patient-physician relationship, on abortion patients' decisional capacity, and on pregnancy and motherhood.

Third, much of the project is concerned with the processes and repercussions of abortion's medicalization. While I trace two moments of medicalization in the history of abortion politics, my larger commitment is to explore how medicalization is "better characterized as a protean, dialetically shifting, social and politically dynamic" which is "both responsive and powerfully supple when faced with challenges, resistance, and appropriations" (Pauly Morgan, 1998, p. 86). The notion was framed by Irving Zola (1972) to theorize the ways in which previously legal, cultural, nonmedical issues, such as alcoholism, addiction, or abortion, were placed under medical jurisdiction and "treated as medical problems" (Conrad, 1992, p. 209), making it the "new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health" (Zola, 1972, p. 487). An important consequence of medicalization, for this project, is that it can remove a topic from public debate and relegate it to physicians' authority with the purview to determine the terms of the issue (Kohler Riessman, 2003). I seek to consider how abortion's early medicalization under jurisprudence in the 1970s was later appropriated, reconceptualized, and reconfigured by the anti-choice movement.

Finally, I want to address a notable silence in this project. Abortion patients' voices and experiences are all but absent; a striking erasure in a dissertation concerned with their decisional processes. This is because abortion patients have been interviewed and studied since the early

1990s. As I trace in Chapter 4, ever since the development of Post-Abortion Syndrome (PAS) as an alleged variation of Post-Traumatic Stress Disorder (PTSD), scholars from a variety of fields and activists with different political commitments have attempted to explore why pregnant women choose abortions, to what psychological effect, and whether it was the “right” decision. Even the most current, rigorous research that is concerned with expanding abortion access focuses on patient’s “decision rightness” (Rocca et al., 2013; Rocca et al., 2015; Rocca et al., 2020). In this framing, abortion ought to remain legalized because patients are making the “right” decision. Gauging pregnant women’s “decision rightness” is thus another iteration of a paternalistic concern with the content and quality of women’s (reproductive) decisions, even if done with the best political and scholarly intentions. And that always leaves the question open of what ought to happen if we conclusively determine that abortion patients are making the “wrong” decision? If research finds that most patients regret their termination, should we criminalize all nontherapeutic abortions? Part of my project’s argument is that abortion patients have, since 1973, been tasked with making the “right” decision in light of their well-being and health, which has worked to efface abortion’s emancipatory potential and confuses self-determination with patient autonomy. I thus stay away from abortion patients’ lived experiences because I deem those to be their own, private experiences that need not be intruded upon once again. An important ethical commitment that informs my methodological framework is to leave pregnant people alone and work to expand abortion access, irrespective of the rationales, content, quality, and consequences of patients’ abortion decision.

I.3 Chapters Overview

Chapter 1 traces shifting anti-choice strategies since 1973 as a way to familiarize my reader with these, to demonstrate their relatively ephemeral and culturally contingent commitments, and to locate the focus of my project within the movement's historical developments. I identify three dominant tactics:

1) 1973 – 1980s: Rights-based claims about fetal personhood that sought to obscure the movement's Catholic leadership and constituency's religious commitments by espousing the discourses of science and liberalism and by framing the movement as the rightful descendent of the civil rights movement.
2) Late 1980s-1990s: Direct, often illegal, and occasionally violent action that was legitimized on the basis that "rescuing" imminently threatened fetal life from unjust and blasphemous laws and from murderous providers and women necessitated proportional strategies.
3) 1990s-2010s: What legal scholar Reva Siegel (2008) termed the "Woman Protective Anti-abortion argument" (WPAA), which popularized the previously fringe commitment to protecting pregnant women from the alleged harms of abortion. The mobilization of the informed consent doctrine and the concomitant "abortion regret" discourses were iterations of the WPAA, which are the focus of this project.

While these three dominant tactics all are complementary, I associate them with particular historical moments because they did emerge in reaction to specific cultural and historical conditions. This chapter seeks to demonstrate the ways in which the anti-choice movement has perpetually been in conversation with its opposition and with larger cultural trends. By extension, this chapter, even if implicitly, illustrates the WPAA's strategic, transactional, and ultimately temporary focus on women's well-being.

Since the project is a genealogy of current informed consent statutes that are the focal point of Chapter 5, Chapters 2 through 4 explore some of their "conditions of possibility" or emergence. Chapter 2 contextualizes the third chapter's jurisprudential analysis and identifies the conflicting interests at stake in the decriminalization of abortion. I thus trace the history of abortion, from the mid-19th century onward, and the history of the informed consent doctrine in the early 1970s. These histories are juxtaposed because they both grapple with competing claims about the appropriate scope of medical authority. They both address moments during which medical authority was threatened as lawyers, judges, bioethicists, and the women's movement tried to pry away some of physicians' authority and combat medical paternalism. I conclude by arguing that the doctrine, even in its most ambitious theoretical aspirations, only ever promoted a limited, confined form of self-determination that was always subsumed by the medical profession's commitment to beneficence.

Chapter 3 is an analysis of abortion jurisprudence in the 1970s and 1980s. While I also examine anti-choice victories that proscribed state and federal funding for abortion, I focus on *Roe v. Wade* (1973), *Doe v. Bolton* (1973), and *Planned Parenthood v. Casey* (1976), cases that instituted or protected the abortion right. I argue that the *Roe* Court espoused professional organizations' framing of the medical procedure as a medical *treatment.* The abortion decision was, accordingly, one to be shared between physician and his patient. The *Roe* Court always posited a relatively restricted first-trimester privacy right, in which the physician shepherded the patient in accordance to some predetermined, overwhelmingly medical, criteria. In the decision, the informed consent doctrine, in conjunction with sound medical judgment, protected physicians from having to merely acquiesce to patients' abortion demands while protecting patients from themselves. Much like patients' autonomy under the informed consent doctrine, patients' privacy right and decisional freedom was circumscribed by a commitment to the patient's wellbeing and not to her larger right to self-determination. This had slightly shifted by

Danforth. The Court recognized the doctrine's potential to, even if marginally, remedy the inherent patient-physician power asymmetry. It internalized an anti-choice *amicus* brief's concerns that the physician's consultative role, as imagined by the *Roe* decision, had not materialized. Instead of deferring to physicians, the Court thus articulated a new State interest in assuring and formalizing the woman's decisional process. Even before the *Planned Parenthood v. Casey* (1992) decision, often decried as a watershed decision that instituted the State's interest in childbirth at any gestational stage, the Court had interjected itself into the patient-physician relationship in its quest to ensure a particular decisional process. Medical paternalism was replaced with State oversight.

I argue in Chapter 4 that anti-choice efforts, starting in the late 1990s, were a new iteration, but an iteration nonetheless, of these previous paternalistic inclinations instituted under early abortion jurisprudence. The "abortion regret" discourse produced motherhood as abortion patients' retrospective, rational choice. It thus produced abortion patients as (imaginary, longing, and mournful) mothers despite their previous abortion decisions. The abortion decision was thus framed as an irrational decision, which women came to regret as their rationality and cognitive abilities returned. The threat of "abortion regret" circumscribed and pervaded the use of the informed consent doctrine in abortion restriction. Much like early abortion jurisprudence that instituted and protected the abortion right, both strategies were effectively concerned with ensuring that pregnant patients were making the "right" decisions.

My fifth and final chapter traces how current informed consent statutes, once again, compel abortion patients to make the "right" decision in line with their well-being and health. Yet these statutes fuse a neoliberalized iteration of the informed consent doctrine with, paradoxically, a conditional view of positive freedom that acknowledges how "genuine" (reproductive) choice can only exist when individuals have the material resources with which to effectuate different choices. I argue that Crisis Pregnancy Centers' mission to eradicate abortion by helping pregnant women made its way into legislation. Clinics were not just compelled to disclose the various "risks" of the procedure, but to refer patients to public and private agencies willing and capable of materially and emotionally supporting women through pregnancy, childbirth, and childrearing. Anti-choice activists thus decried the pro-abortion's notion of "choice" as superficial and deeply curtailed by economic coercion. To the contrary, anti-choice activists and legislators provided pregnant women with the resources with which to enact a true choice, free from economic and material constraints. In this framing, abortion patients would choose motherhood both as a preventative medical measure and upon realizing that they were not abandoned to their own devices. And yet, these resource referrals acknowledge, decry, yet simultaneously benefit from and reify the oppressive circumstances that circumscribe pregnant women's reproductive decisions. All listed resources rendered pregnant women dependent upon sometimes explicitly religious organizations or upon a potentially unwilling "father". Pregnant women's choices were materialized and supported if they chose motherhood and resorted to traditional gender norms.

I.4 Terms and Concepts

I want to take a moment to explain the terms I use and why I came to adopt those. Debate over terminology manifests across cultural, political, and legal arenas. The terms someone uses as it relates to abortion is often taken as emblematic of their political, scientific, and cultural affiliations and commitments.[4] Whether someone refers to a fetus as such or as an unborn baby

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[4] In an effort to overcome this politicization, news agencies, such as NPR, have used terms such as "abortion rights supporters/proponents" (Jensen, 2019). The organization argues that this terminology focuses the issue on how either movement is grappling with actual abortion rights, thereby eschewing the moral and political motivations behind each movement.

likely aligns them with a particular political party and how they make sense of abortion procedures, pregnancy, and gender roles.[5] And these controversies also exist within the movements as different factions attempt to delineate the scope of their missions.

I.4.1 Pregnant People or Women

One of the latest debates surrounding terminology is occurring within the pro-abortion movement. In the quest to ensure everyone's access to abortions, pro-abortion and LGBTQ+ activists have emphasized that it is not only women who can get pregnant, even as a majority of abortion patients are women. Transgender men and some non-binary people can also get pregnant. In light of this, most pro-abortion organizations have adopted inclusive language that acknowledges this reality and draws attention to people's reproductive capacities and resulting healthcare needs irrespective of traditional gender roles. These organizations encourage inclusive language such as "abortion patients" or "pregnant people", thereby recognizing that it is not just ciswomen who can get pregnant.[6]

At the same time, some decry this language for erasing the feminist movement's victories throughout the decades and ignoring the ways in which the fight over abortion access has partially, if not overwhelmingly, been a fight about traditional gender norms. As abortion and feminist scholars Carrie N. Baker and Carly Thomsen (2022) argue: "while inclusive language is important because gender diverse people experience pregnancy and need abortion, using sex-

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[5] One of the recent debates over terminology arose as states sought to institute "heartbeat" bills that proscribed abortions after the detection of fetal "heartbeat" (Harmon, 2019). ACOG was quick to denounce the term as ideologically and politically driven, since sounds of cardiac activity in an early pregnancy are an "electrical pulse in a group of cells the size of a pencil tip". The fetus has not yet developed the necessary organs for it be recognized as a "heartbeat".

[6] Even the ACLU, sometimes recognized as a moderate organization, has espoused inclusive terminology (Facci, 2022). NARAL recently issue a revised guide for abortion activists emphasizing the need for "gender-neutral language" (Powell, 2022). Dr. Kyle Bukowski (2021), associate medical director at Planned Parenthood, expressed the organization's commitment "to transgender and non-binary folks" and recognized the "intersecting stigma" these patients already face. Using inclusive language is a "minor discomfort that nowhere nears exceeds the benefits" (Bukowski, 2021).

neutral language risks obscuring the sexism underlying anti-abortion laws and policies". To thus erase the focus on women obscures how the anti-choice movement has repeatedly worked to render womanhood and motherhood synonymous. And, there are concerns that this language will drive away moderate constituencies (Lewis, 2022; Powell, 2022). While I align myself primarily with pro-abortion organizations that embrace inclusive language, I also identify this project as a historical one. Most of the history of abortion politics has been an explicit attack on women's bodies and self-determination and to ignore this in the quest of inclusivity confuses the movement's future missions with its historical lineage. In light of this, I primarily use the term "pregnant woman" in an attempt to recognize the historical lineage between abortion politics and feminism, while also seeking to avoid transposing current terminology upon historical phenomenon. It is in the project's conclusion that I primarily use the term "pregnant people" since the last section is a personal reflection in which I advance recommendations for the future.

I.4.2 The Different Movements

At the beginning of my graduate career, I exclusively used the term anti-choice movement to designate the pro-life movement. A central assumption that guided this decision was that the movement, unlike its opposition, deeply curtailed women's reproductive choices. I have continued to use the term accordingly, even if I occasionally use the terms pro-life or anti-abortion synonymously to avoid repetition. What has primarily changed is my perception around the pro-abortion movement, otherwise known as the pro-choice movement. I echo reproductive justice scholars who denounce the moderate, liberal pro-choice movement for erasing the reproductive abuses that Black and Brown women face by focusing exclusively on the abortion right (Davis, 1990; Goodwin, 2020; Roberts, 1997; Ross, 2017; Solinger, 2001). Under the discourse of choice, which deeply individualizes reproductive decisions without considering the oppressive circumstances under which marginalized women make their choices, the abortion movement has paid little attention to issues such as compulsory sterilization in the 1960s and 1970s, the disproportionate rate of Black maternal mortality rates, environmental racism, lack of adequate childcare and healthcare coverage that deeply curtail poor women's ability to raise children under safe and healthy conditions. As such, I use the term pro-abortion to refer to efforts focused on expanding abortion access and I use the term reproductive justice when discussing more intersectional and inclusive strategies to expand everyone's reproductive freedom. The organization SisterSong first termed the notion "reproductive justice" in 1994 by juxtaposing a human rights and social justice framework. SisterSong (n.d.) defined reproductive justice as: "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities".

CHAPTER I

The Anti-Choice Movement, 1973-2010s

> This movement, born just days after *Roe v. Wade* was decided in 1973, can now be spoken of in the same breath as abolition, suffrage and civil rights. Put plainly, is it now among the most significant and successful social and political movements in the history of the United States of America (Marcus, 2022)

This is how *Fox News* columnist, David Marcus (2022), described the pro-life movement in the days after *Roe v. Wade* (1973) was overturned under *Dobbs v. Jackson* (2022). Even as many anti-choice leaders and activists celebrated *Roe*'s demise, they seemed to immediately look to the future. What would the pro-life movement look like in the years to come? What strategy would be most effective as they work towards passing a federal ban on abortion? How will they grapple with out-of-state abortion travel? Resoundingly, the movement appears determined to cast this moment as "the beginning" of genuine and true change, as they pursue a world in which abortion is not just illegal and unavailable but "unthinkable". Part of making abortion "unthinkable" entails, for Kristan Hawkins, president of Students for Life America, addressing the material and relational circumstances that compel some pregnant women to consider terminating an otherwise desired pregnancy (Shapiro, 2022). Indeed, a new wave of Generation Z anti-choice activists appears to have internalized much of the language and concerns of the reproductive justice movement and consider themselves "whole life", not just "pro-life", in their support "from womb to tomb" (Croxford & Bailey, 2022). In their view, the fight to render abortion "unthinkable" is the ultimate social justice cause. Jess Meeth, national communication director for Democrats for Life of America, got involved in abortion politics during the Black Lives Matter protests in the summer of 2020. As Meeth came to see it, if fetal life could finally be valued and protected, all other issues, such as climate change, systemic racism, or economic inequality, could be resolved because "if we're not respecting life before birth, we can't be surprised that we're not respecting it after birth" (Tavernise et al., 2022).

But even if "the work is just beginning", according to Meeth, this moment is the result of decades of concerted, well-funded, and unrelenting anti-choice efforts. And, in this moment, much of the emerging pro-life rhetoric is an amalgamation of previous anti-choice rhetoric and efforts, all collapsed into soundbites and renewed legislative efforts. Since its inception, the movement has conceptualized of itself as the rightful heir of the "abolition, suffrage and civil rights" movements. During the 1990s, anti-choice activists perceived abortion as the ultimate societal sin, superseding all other cultural issues, because it indicated a deep disdain for life. Much like Meeth, anti-choice protestors believed that saving fetal life would rectify all other social shortcomings. In the early 2000s, anti-choice leaders denounced abortion as women's last, desperate measure in the face of a larger system that prioritized, materially and culturally, careerism over motherhood. This moment is one in which we can observe the collision of decades of various anti-choice strategies, discourses, and efforts.

The purpose of this chapter is to contextualize the moment this project is concerned with. The dissertation unpacks how the anti-choice movement mobilized the informed consent doctrine and the concomitant "abortion regret" discourse in the late 1990s, early 2000s. To do so, I trace how anti-choice activists and legislators reconceptualized notions of autonomy, choice, consent, and coercion in ways that imbued religious understandings of fetal life, pregnancy, and motherhood into a medicolegal process. But this strategy was just one amongst many and it was the result of decades of (then) unsuccessful anti-choice efforts to overturn *Roe* and to federally (re)criminalize abortion.

An extensive body of scholarly work examines specific anti-choice strategies in the decades after the legalization of abortion under *Roe v. Wade* (1973). This chapter is a synthesis of this literature in an attempt to provide a narrative arc of the movement's evolving strategies from 1973 through the 2010s. As such, this chapter is not meant to provide a detailed account of any particular moment in anti-abortion political strategy. Instead, I identify three discursive strategies that gained cultural attention and traction during certain decades: 1) the movement focused on producing the fetus as a rights-bearing entity in the 1970s and 1980s; 2) which was complemented by direct-action, often illegal, and sometimes violent attempts to "rescue" imminently aborted fetuses by the end of the 1980s and throughout the 1990s; 3) and when this proved ineffective, anti-choice leaders mobilized what legal scholar Reva Siegel (2008) termed the "Woman Protective Anti-Abortion Argument" that sought to protect patients from the alleged harms of abortions (see Table 1). Importantly, these strategies have always coexisted and complemented each other. The movement has never been a monolithic entity with clearly defined and circumscribed strategies; instead, different factions occasionally contested, decried, but often espoused, lauded, and benefited from alternative anti-choice efforts. For example, legislative efforts appeared moderate and reasonable compared to coercive clinic blockades, while the latter seemed necessary considering the sluggish and delayed nature of legislative victories. And yet, each strategy did first emerge under specific cultural and political conditions and can therefore not be entirely divorced from the historically contingent circumstances that engendered its advent.

More specifically, I will first argue that the anti-choice movement in the years immediately after *Roe* was a largely Catholic one, which attempted to obscure its religious underpinnings by mobilizing the secularizing discourses of science and liberalism. Amidst a larger cultural moment in which marginalized communities were requesting to be recognized as rights-bearing citizens, early anti-choice activists worked to portray the fetus as an autonomous, legal entity who similarly deserved the rights and protections afforded by the Constitution. Visual culture, feticide laws, and historical comparisons of the "abortion genocide" to slavery and to the Holocaust produced the fetus as a distinct patient and victim who needed to be protected from the pregnant woman upon which it relied for survival. Overwhelmingly, these early efforts attempted to institute change within the confines of liberal institutions; something that started to change in the late 1980s.

Indeed, I will then argue that an increasingly evangelical Christian, radicalized faction of the movement decried legislative change as sluggish and incapable of saving imminently threatened aborted fetuses. For much of the late 1980s and 1990s, this direct-action contingent sought to "rescue" unborn children through clinic sit-ins, blockades, and/or "sidewalk counseling"; all tactics meant to stop abortion patients from accessing their scheduled abortion. Illegal action was not only necessary but morally justified given the inherently blasphemous nature of abortion rights. This reasoning reached its logical conclusion in the early 1990s when some anti-choice extremists turned to murder.

Given the public relations crisis that ensued in the late 1990s-early 2000s, the movement attempted to shed its exclusive fetal-centric focus that had hitherto dictated much of its efforts. Instead, mainstream leaders looked to popularize the women-centric tactics that Crisis Pregnancy Centers had espoused since the early 1970s. Pregnant women needed to be protected from greedy physicians and from their own shortsighted and irrational abortion decision. The informed consent doctrine was a perfect mechanism to do so.

Table 1

Three Dominant Anti-Choice Strategies in the Years after Roe v. Wade

	1973-1980s	1980s-1990s	1990s-2010s
Dominant strategies and their discursive underpinnings	Rights-based claims Mobilized discourses of science and liberalism	Direct (non)violent action that disrupted abortion services Religious discourses about the sanctity of life that legitimized illegal action	"Woman-Protective Anti-Abortion Argument" Mobilized discourses of psychiatry and feminism
Associated Tactics	Attempts to pass the Human Life Amendment (HLA) + to overturn *Roe v. Wade* Personifying the fetus through visual culture and medicine Manufacturing maternal-fetal conflicts	Harassment of abortion clinic staff and patients, through "rescues", counseling, clinic sit-ins, destruction of clinic property. Extreme violence, including murder	Crisis Pregnancy Centers Post-Abortion Syndrome (PAS) Targeted Regulation of Abortion Providers (TRAP) laws "Abortion regret" discourse Informed Consent statutes
Notable figures and organizations	Dr. John Willke, an obstetrician-gynecologist who authored *The Handbook on Abortion* National Right to Life Committee (1968)	Randall Terry, founder of Operation Rescue (1988) Paul Jennings Hill, who received the death penalty for murdering Dr. Tiller	Dr. Vincent Rue, who originated PAS Dr. David Reardon, author of *Making Abortion Rare* and prominent anti-choice researcher Americans United for Life (1971)

1.1 The Fetus as a Rights-Bearing Victim, 1973-1980s

The days after the *Roe v. Wade* (1973) decision were defined by deep anguish and despair for anti-choice activists, who had hitherto only had to grapple with efforts to expand the scope of therapeutic abortions.[7] Quickly, pro-lifers from different backgrounds, beliefs, and occupations convened to strategize. Two major legislative and judicial tactics came from these early meetings. The National Right to Life Committee (NRLC), founded in 1968 at the behest of the

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[7] By 1967, 13 states had adopted the Model Penal Code of the American Law Institute (ALI), which expanded the rationale for therapeutic abortions to encompass those deemed necessary to protect the pregnant woman's physical *and* mental health, or in situation of rape or fetal anomaly (Karrer, 2011b; Luker, 1984; Schwartz, 1972)

National Conference of Catholic Bishops (NCCB), discussed the possibility of passing a Human Life Amendment (HLA) that would punish abortion as murder (Doan, 2007; Dubow, 2011; Karrer, 2011b; Mason, 2002; Wilder, 1998). The HLA was first introduced on January 30th, 1973 by Congressman Lawrence Hogan (R-MD) (Karrer, 2011a). This would be the first of multiple attempts to constitutionally recognize the fetus as a legal person who warranted the rights and protections afforded by the Constitution (Ehrlich & Doan, 2019). For those who supported the HLA, reversing *Roe* would relegate abortion rights to state legislatures and courts, thereby rendering fetal life vulnerable to a patchwork of legislation dictated by the proclivities, whims, and idiosyncrasies of citizens, politicians, and judges (Ziegler, 2015). The HLA could provide more comprehensive, federal protection of fetal life.

Even so, simultaneous efforts sought to overturn *Roe.* And Justice Blackmun's development of the trimester framework provided the very basis for its reversal (Ehrlich, 2014; Ginsburg, 1985; Roth, 2000). Throughout the first trimester, when abortions were deemed safer than childbirth, women's right to privacy, as guaranteed within the penumbra of the Bill of Rights, encompassed the right to unencumbered abortion access. Thereafter, given the state's interest in protecting women's health, states could regulate the procedure, its providers, and clinics in "ways that are reasonably related to maternal health" (*Roe v. Wade*, 1973). Finally, ensuing fetal viability around the 24th gestational week, states could regulate, and even proscribe, abortions to promote "its interest in the potentiality of life", unless medically necessary to preserve the woman's life (*Roe v. Wade*, 1973). Yet, the trimester system rested upon the Court's unwillingness to assert when life began. Considering the lack of medical, theological, and philosophical consensus concerning the genesis of life, the Court oscillated between uncertainty and following legal precedent that did not treat the fetus as a person. However, and very importantly, if fetal personhood were ever scientifically established, the fetus would immediately acquire the rights and protection to life as guaranteed under the 14th Amendment: “If this suggestion of personhood is established, the appellant’s case, of course, collapses, for the fetus’ right to life would then be guaranteed specifically by the Amendment” (*Roe v. Wade*, 1973. The newly invigorated anti-choice movement ardently pursued this apparent legal opening.

Importantly, the *Roe* decision came against a historical background in which previously disenfranchised and marginalized communities sought equal recognition as rights-bearing citizens within the polity. The promise of the social contract, in which naturally free and equal individuals voluntarily enjoin society, had fallen short for many. “Undifferentiated universalism” erased the very systems of domination that rendered the social contract a reality for only a select few (Mills, 2008). The civil rights movement, in its quest to have Black people integrated into “all that American society had to offer” (Taylor, 2016, p. 193), engendered the push to recognize all, including those most marginalized and oppressed, as rights-bearing, autonomous, and rational agents (Horwitz, 2018). It was within this larger sociopolitical context that the women’s movement then advocated for abortion, not just as medical necessity, but as a technology of emancipation that would give women access to educational and professional opportunities akin to those available to men (Condit, 1990; Greenhouse & Siegel, 2012; Luker, 1984). Abortion, in this framing, was a fundamental right that could give way to genuine equality and autonomy by freeing women from the perpetual threat of compulsory motherhood. In other words, this was a moment during which marginalized communities were asking to be integrated into U.S. political society as rights-bearing agents.

According to historian Jennifer L. Holland (2020), focusing exclusively on the fetus’s right-to-life enabled anti-choice activists to align their mission with the civil rights movement while simultaneously sidestepping “the fraught issue of women’s rights in an era when feminist values were infused in popular culture and politics” (p. 5). Doing so would enable the anti-choice movement to (temporarily and ineffectively) ignore accusations that compulsory motherhood infringed upon women’s fundamental rights and autonomy. Instead, the movement was vested in producing the fetus as the latest victim of modernity who deserved the same recognition, protection, and rights as Black enslaved people and the victims of the Holocaust.

The National Right to Life Committee (NRLC), founded in 1968, was the very embodiment of this early right-to-life strategy (Lewis, 2017; Mason, 2002). Its very name speaks to its moral and political commitments. Upon its inception, it drew on the Declaration of Independence, the U.S. Constitution, and the United Nations’ Universal Declaration of Human Rights to argue that “everyone is entitled to all the rights and freedom set forth in this Declaration, without any distinctions of any kind (…) including birth or other status” (as cited in Lewis, 2017, p. 23). Despite its Catholic leadership and constituency, it attempted to efface its religious underpinnings and funding by mobilizing rights-based claims grounded in human or natural law (Condit, 1990; Doan, 2007; Holland, 2020). Disavowing religious discourse, even as it always circumscribed and influenced anti-choice strategy, enabled the movement to appeal to notions of liberal universalism and fundamental rights (Condit, 1990; Ehrlich & Doan, 2019). Indeed, claiming that the fetus deserved the rights and protection afforded by the Constitution echoed earlier central presumptions from the civil rights movement: certain rights should unequivocally and equally be granted to all citizens, which assumes, in turn, that all individuals be recognized as separate, autonomous citizens worthy of protection (Mason, 2022; Roth, 2011). The NRLC illustrated these sentiments and commitments in an article, “When Does Life Begin? Abortion and Human Rights”:

> Since 1776 we have striven as a nation to expand basic human rights for all. There is much yet to be done to fully implement the principle, but even as we do so, we must also defend it against those who mistakenly believe that they can expand their own rights by trampling the human rights of others. Many Americans also believe that every human being is a precious child of God, a brother or sister, of every other human being, regardless of such differences as maturity, race, sex or dependency. In this human family, the strong have a greater obligation to protect and defend the lives and rights of vulnerable persons who cannot defend themselves (as cited in Mason, 2002, p. 18).

This statement encapsulated much of the ensuing right-to-life discourse. In this framing, the pro-life movement was just the latest iteration of efforts "since 1776 (…) to expand basic human rights for all". Defending fetal life was not just a moral imperative, but a patriotic mission that mimicked the nation's very composition and nature of fighting for "basic human rights for all". And "vulnerable" fetuses "who cannot defend themselves" needed protection from women "who mistakenly believe that they can expand their own rights by trampling the human rights of others". The fetus was not just another human being, but a particularly vulnerable one in its inability to defend itself from women's attempts to expand their own rights. Pregnant women and fetuses were not enjoined and aligned in their interests; women's interests were inherently at odds with the fetus'. The anti-choice movement thus embarked on a decades-long quest to produce the fetus as the already human precursor to the future child who deserved the rights and protection afforded by the Constitution. It did so by mobilizing visual culture, medicine, and the law to cast the fetus as the rightful and latest descendant in a long lineage of victims of modernity, liberalism, and science.

1.1.1 How the Fetus Became a Person 1: The Politics of Representation

Visual culture and medicine were, and continue to be, instrumental in portraying the fetus' humanity in ways that erase the very body upon which it depends for survival.

Representations of the fetus were not new (Holland, 2020; Newman, 1996; Sanger 2008).[8] What was novel in the years after *Roe* was: 1) the extent to which these visual representations were imbued with scientific meaning in ways that obscured their cultural contingency, which 2) legitimized inscribing their culturally mitigated meaning into law (Roth, 2020). Swedish photographer Lennart Nilsson's classic series depicting fetal development, first published in *Life* magazine in 1965, became iconic anti-choice imagery of "fetal life", even as Nilsson perfected photographic techniques by capturing fetuses acquired from surgical or spontaneous abortions (Newman, 1996).

These enlarged photographs show a seemingly sleeping, free-floating fetus with recognizable legs, feet, hands, fingers, toes, and head (Condit, 1990; Daniels, 1993; Petchesky, 1987). Early fetal imagery was often of intact, second or third trimester fetuses that conjured familiar images of napping infants, thereby collapsing what is a complex developmental process, often unrecognizable to an untrained eye, into a stagnant image of a mature and likely viable fetus (Condit, 1990). Paraphernalia, such as the "Precious feet" pins, and images of fetal feet were additional anti-choice artifacts that similarly relied on the recognizability of certain body parts (Condit, 1990; Holland, 2020). Intact images of (early) fetuses risk showing unidentifiable fetal features. Focusing instead on recognizable extremities that are present in fetuses as young as ten-weeks, distinguishable in scale only, further enabled the fetus' personification as an already human precursor to the future child. These images were overwhelmingly free of any visual reference to the pregnant body and the fetus' reliance upon it, thereby using women's

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[8] Karen Newman (1996) argues that, from the second until the 17th century, illustrations of the fetus were remarkably similar in showing an atomized, "seemingly autonomous fetal figure" (p. 27). Preserved fetuses had been displayed in classrooms and "freak shows" since the early 20th century (Holland, 2020). However, these very exhibitions promoted entirely different viewing practices, whereby the preserved, often deformed, fetus was meant to conjure morbid curiosity and fascination (Sanger, 2008).

bodies to render the otherwise invisible and private fetus into a publicly available image of a seemingly free-floating, independent, and hence autonomous entity (Petchesky, 1987).

While the development of medical technologies, such as ultrasound imaging, sonograms, electronic fetal monitoring (EFM), or fetal surgery and treatments, cannot alone explain the rise in fetal rights, these did contribute to the production of the fetus as a separate patient entitled to its own physician (Dubow, 2011; Hartouni, 1997). In 1973, the American College of Obstetricians and Gynecologists (ACOG) released a statement recognizing fetology as an independent field (Dubow, 2011). Medical technologies had rendered what had been perceived as the otherwise inaccessible and opaque fetus into a “surprisingly active little creature” (as cited in Hartouni, 1997, p. 37). This newly accessible, interactive, almost agentive and conscientious fetus became the unborn precursor to the future child, with few distinguishable features other than its size and habitat. Birth was just one developmental process amongst others, in this lens, and not the defining moment that distinguished a fetus from the child. Prenatal diagnostics and fetal surgery made it possible to preemptively treat otherwise (fatally) sick fetuses by operating on them outside the womb, while still attached to the umbilical cord. Increasingly, these medical technologies decentered women’s embodied knowledge and deferred their childbearing role and responsibility to physicians and to the State (Daniels, 1993). Some scholars have argued that, even if unintentionally, fetologists were contesting the women’s movement’s emphasis on embodied knowledge. While women were decrying medical paternalism and attempting to regain some control over their reproductive healthcare, physicians developed a field of expertise beyond women’s purview that compelled women to rely on medical expertise and technologies to make sense of their reproductive experiences. The fetus thus emerged as a distinct patient who required its own physician who only catered to its interests, health, and survival.

1.1.2 How the Fetus Became a Person 2: The Legal Politics of Prenatal Injuries

Simultaneously, anti-abortion activists spearheaded efforts to expand fetal rights in instances where pregnant women lost desired pregnancies because of domestic violence, reckless and drunken driving, medical malpractice, or corporate negligence and greed (Daniels, 1993). What initially promised expanded protection and justice for pregnant women against third party perpetrators morphed into precedent that protected the fetus against the pregnant woman and engendered the criminalization of pregnancy (Goodwin, 2020). Legal remedies from the 1960s only existed in cases of fetal injuries that threatened the future child's health; the law offered no redress in the event of prenatal death. The fetus only got protection insofar as it was eventually presumed to be born alive. Case law, while instituting protections against prenatal injuries, never constituted a fetal entity *separate* from the pregnant woman. The fetus was an extension of the pregnant woman, who could not have separate and conflicting interests. These protections sought to acknowledge the pregnant woman's ambiguous legal status, which cannot be neatly encompassed under liberalism's atomized subject, without pitting the woman's interests against the fetus'.

This shifted dramatically in the 1980s when states started to enact laws that recognized "intentional" feticide as murder or that expanded existing murder statutes to include the fetus as a victim. (Daniels, 1993; Paltrow & Flavin, 2013). These laws have overwhelmingly become the basis upon which pregnant women, and Black and Brown women in particular, have faced increased surveillance and criminalization. Between 1973 and 2005, there have been 413 cases (a likely underreported number) in which pregnant women were arrested, detained, or compelled to undergo medical treatments. In a fifth of these cases, the pregnant women were arrested, detained, or compelled to undergo medical intervention because of their unwillingness to follow medical prescriptions meant to protect or save fetal life.[9] To date, there are no drug delivery or distribution laws that redefine distribution as the transfer of drugs through the umbilical cord. No statutes explicitly criminalize pregnant women for using illicit drugs while pregnant. This has not prohibited the surveillance, policing, and criminalization of pregnant women since the late 1980s. In 86% of cases, women's criminalization occurred through the weaponization of existing criminal statutes originally meant to protect pregnant women from third party perpetrators. In virtually all studied cases, "the legal authority for their actions came directly or indirectly from feticide statutes that treat the unborn as legally separate from pregnant women, state abortion laws that include language similar to personhood measures, and *Roe v. Wade*, misrepresented as holding that fetuses, after viability, may be treated as separate person" (Paltrow & Flavin, 2013, p. 322). In other words, anti-abortion efforts to advance fetal personhood and feticide laws have co-constitutively produced a context in which the fetus is increasingly recognized, and treated, as a separate, legal entity who needs to be protected against the pregnant woman it relies upon. In turn, this legitimizes increased state encroachment upon pregnant women's bodily integrity and autonomy.

1.1.3 How the Fetus Became a Person 3: Comparisons to Slavery and the Holocaust

In addition to producing the fetus as a distinct legal victim who needed protection from the pregnant woman, the fetus was further portrayed as a sort of metaphorical victim. During the early 1970s, anti-choice activists started drawing comparisons between abortion rates and the Holocaust, thereby casting the aborted fetus as the ultimate, and latest, victim of modern atrocities (Condit, 1990; Holland, 2020; Mason, 2002). This allowed them to evoke the graphic

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[9] Most cases are prosecuted without medical testimony to substantiate the link between the pregnant woman's actions, or lack thereof, and fetal harm or stillbirth. In fact, longitudinal research has generally failed to conclusively determine that drug use throughout pregnancy can cause long-term fetal harm (Goodwin, 2020).

and gruesome imagery of concentration camps, while simultaneously emphasizing the scale of abortion numbers (Condit, 1990; Holland, 2020). Dr. John C. Willke, an obstetrician who later became president of the NRLC, spearheaded this rhetorical strategy (Rosen, 2015; Siegel, 2008). Along with his wife, Barbara, he wrote the *Handbook on abortion* (1979), which sold 1.5 million copies and was introduced as "the most widely read book in the world presenting the scientific case for the unborn" (Willke & Willke, 1979, p. iv). The *Handbook*, with some pictures resembling Nilsson's classic series and others showing dismembered and botched fetuses, popularized the use of fetal imagery for pro-life purposes (Holland, 2020; Siegel, 2008). The book generally reads like a conversational, informational pamphlet meant to refute the "cornerstone of their argument [that] has been the denial of the humanity of the being who is killed by abortion" (Willke & Willke, 1979, p. iv). Part I instructs pro-life activists how to "scientifically" refute pro-abortion claims. Part II addresses social and moral implications of abortion.

In this section, the Willkes argue that the "abortion genocide", as coined by anti-abortion activists, is comparable, if not worse, to Nazi Germany's Final Solution. More specifically, they contend that abortion practices are always haunted by the technology's eugenic potential and physicians cannot be entrusted with this fraught procedure. They argue that under Hitler:

> a few pediatricians in 1939 in Germany began to 'terminate' a few idiot children. They were pure blood Aryans but defective. By 1945, these same doctors, in university hospitals had so lowered the price tag that they were killing bed wetters, children with misshapen ears and those with learning disabilities (Willke & Willke, 1979, p. 114).

The ease with which Nazi physicians were willing to use abortion, as a genocidal technology, forewarned of the ways in which disability and the value of human life can get renegotiated and reconceptualized in accordance with the dominant group's perception thereof. The Willkes further warned that abortion providers willing to terminate a late-term pregnancy with a diagnosed anomaly may, eventually, find no moral qualms in the infanticide of a disabled child. Abortion was, in this view, a slippery slope. Americans, however, were in a better place to combat the "abortion genocide": "Today we have an open society and full access to information. If today a nation condones killing for defect (unborn or born) its guilt is immensely greater" (Willke & Willke, 1979, p. 115). Americans thus had a duty to protect fetal life from indiscriminate, potentially genocidal, abortions.

Other activists compared *Roe* to the *Dred Scott v. Sandford* (1857) decision, a landmark case in which the Court ruled that enslaved and free Black people were not United States citizens (Holland, 2020; Karrer, 2011; Mason, 2002; Ziegler, 2015). In much the same way that Black people had been excluded from the rights and protections afforded by citizenship, fetuses were not being recognized as legal persons (Lewis, 2017).

Comparing the "abortion genocide" to the Holocaust and slavery allowed pro-life activists to acknowledge these historical atrocities, tap into their rhetorical calls for constitutional protection, while paradoxically retaining libertarian discourses of individual responsibility and accountability (Holland, 2020). Aborted fetuses were the ultimate victims who, unlike Black people and Jews, had not yet been corrupted by modernity, liberalism, and science. They could not possibly protect themselves from the unrelenting, murderous acts by the very women upon which they depended. In this refrain, marginalized communities had the agency to fight corrupting and oppressive systems. These comparisons further allowed pro-life activists to portray themselves as justice fighters, tantamount to Dr. Martin Luther King and "heroic abolitionists and Nazi opposition" (Holland, 2020, p. 65). Much like their supposed predecessors, anti-choice activists were combating an inherently unjust system that did not recognize marginalized communities. In a world fractured by feminist and Black claims of disenfranchisement and inequality, portraying the fetus as *the* ultimate and universal victim, vulnerable irrespective of race, sex, or ability, was viewed as a potential tool of reconciliation and unity.

Despite repeated efforts throughout the 1970s and 1980s, efforts to pass the HLA had proven futile. Reversing *Roe* was similarly proving to be a high task. While this would create a schism within the movement for decades to come, the NRLC and Americans United for Life (AUL), two of the most prominent anti-choice organizations, advocated for incremental restrictions that operated within the parameters delineated in *Roe*'s trimester framework (Ziegler, 2015). Incrementalists believed that this strategy would protect restrictions from constitutional scrutiny, would create momentum and thus attract new activists, and would institute barriers to access while attempting to sway public opinion. In this lens, the overly ambitious goal of passing the HLA and the resulting, perpetual disappointment, would cause the movement to fizzle out. Incrementalists successfully enacted restrictions through informed, spousal, and parental consent requirements, mandatory waiting periods, and funding cuts (Doan, 2007; Karrer, 2011; Roth, 2000; Saurette & Gordon, 2015; Ziegler, 2015).[10] Unlike reversal and constitutional amendment efforts that decried *Roe*'s legitimacy, restrictions worked within *Roe*'s trimester framework.

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[10] Notoriously, Congress passed the Hyde Amendment in 1976, which banned the use of federal funds to cover abortion procedures. While the Senate initially blocked the Amendment, the conference committee compromised by prohibiting federal abortion funding unless necessary to preserve the woman's life. Congressman Hyde argued that *Roe*'s abortion right did not guarantee abortion access. The State, and by extension taxpayers, were not responsible for remedying impoverished women's impulsive sexual choices (Condit, 1994; Dubow, 2011; Ehrlich & Doan, 2019; Saurette & Gordon, 2015; Solinger 2001). To compel taxpayers to fund the consequences of these sexual choices was to rob them of their economic choices and freedom (Railsback, 1984; Saurette & Gordon, 2015).

Ultimately, in the years after the *Roe* decision, the anti-choice movement overwhelmingly focused on pursuing either judicial or legislative change. Some factions focused on passing the HLA, others sought to mobilize *Roe*'s trimester framework in attempts to either reverse the decision or to implement restrictions in accordance with the State's interest in women's health. In all these iterations and strategies, there were two distinct characteristics of the anti-choice movement in the immediate post-*Roe* years. All these efforts were deeply contingent on producing the fetus as a distinct, autonomous, yet vulnerable in its dependency, rights-bearing legal entity. The movement thus espoused secularizing discourses of science and liberalism. And all these efforts, despite their different manifestations, all attempted to work within existing systems of government; something that would change in the following decades. The issue, for early anti-choice activists, was not to operate outside of the law but to expand its conceptualization of human life so that the fetus could access the rights and protections guaranteed under the Constitution. With this goal in mind, different factions turned to ultrasound imagery, as an allegedly objective and unmediated insight into the fetus' habitat, to legal mechanisms that recognized the fetus as distinct victim, and to historical comparisons that produced the fetus as the latest metaphorical victim of modern atrocities. This all worked to manufacture maternal-fetal conflicts, in which the fetus needed protection from pregnant women and potentially eugenic physicians.

Despite incremental restrictions that banned federal funding or mandated parental consent, the failure to overturn *Roe* and to pass the HLA left many discouraged and frustrated. The Catholic leadership and constituency of the 1970s and early 1980s was increasingly replaced by a fundamentalist evangelical Christian base. The movement's dominant strategy shifted accordingly. Early, overwhelmingly Catholic anti-abortion leaders had focused on disassociating their cause from Catholicism in hopes of portraying their mission as a universal one, which was vested in the idea of innate and natural human rights. By the late 1980s, explicitly Christian rhetoric that denounced abortion rights as unjust laws that defied God's law circumscribed and rationalized the movement's novel tactics. A radicalized, fundamentalist faction of the movement turned to direct, often coercive, violent, and illegal action.

1.2 Defensive Action: Rescuing the Fetus by Any Means Necessary, 1980s-1990s

Even as some factions of the movement continued to pursue legislative change, a radical, young, evangelical Christian faction grew increasingly dissatisfied. Ronald Reagan had failed to uphold his repeated campaign promises to overturn *Roe* (Blanchard, 1994; Condit, 1990; Doan, 2007; Ginsburg, 1998; Mason, 2002; Rose, 2011; Saurette and Gordon, 2015; Ziegler, 2015). And years of sluggish and ineffective legislative efforts had failed to protect thousands, if not millions, of unborn children.

While scholars disagree about the composition of anti-choice constituency throughout the 1980s and 1990s (Doan, 2007; Luker, 1984; Ginsburg, 1998; Mason, 2002; Maxwell, 2002; Munson, 2008), they overwhelmingly agree that pro-life activists, especially the most radical and violent ones, thought of themselves as ostracized from wider American culture because their religious values marked them as a "targeted, disenfranchised minority vulnerable to the havoc wrought by a dominant 'liberal', 'humanist' majority" (Maxwell, 2002, p. 9). Importantly, traditional notions of the family, and associated gender roles, were most at risk. Since the family was emblematic of the nation, a threat to the nuclear family was tantamount to a threat to America (Horwitz, 2013). Abortion, emblematic of the world's corruption, was thus the centerpiece around which evangelical Christians organized, in attempts to eradicate this pluralistic, liberal encroachment upon their way of life (Ehrlich & Doan, 2019).

This move towards religious fundamentalism very much mimicked larger cultural trends that saw a resurgence of conservative evangelical involvement in politics. While fundamentalist and conservative evangelical Christians never entirely removed themselves from political involvement, as often presumed, they did remobilize in energized and concerted ways during the mid-to late 1970s (Horwitz, 2013). They perceived federal courts' decisions to proscribe prayer in schools, to relax laws against pornography, and to legalize abortion access as the encroachment of secular humanism on their way of life. Secular humanism was so concerning to evangelical Christians because it "made man, rather than God, the measure of all things" (Horwitz, 2013, p. 87).

For close to two decades, this fundamental, radicalized evangelical Christian faction received media and public attention for its illegal, and occasionally deadly, tactics. What defined this moment were the ways in which protestors saw their tactics as the latest iteration of 1960s civil disobedience. In much the same way that civil rights activists denounced the inherent immorality and injustice of Jim Crow laws, anti-choice protestors decried the legalization of abortion. Given the blasphemous nature of abortions, illegal and coercive action was not only permissible but necessary. What first started as "rescues" to protect imminently aborted fetuses reached its logical conclusion in the early 1990s when "lone wolf" terrorists engaged in extreme, seemingly sporadic, violence and ultimately murders in the name of "killing for life" (Doan, 2007).

1.2.1 "Rescuing" Fetal Life from Imminent Death

In the late 1980s, the direct-action branch of the anti-choice movement sought to "rescue" imminently aborted fetuses by discouraging, and often physically stopping, pregnant women from accessing scheduled abortion services (Condit, 1990; Doan, 2007; Maxwell, 2002; Saurette

& Gordon, 2015). Some activists offered “sidewalk counseling” to patients as they entered the clinic, in hopes that learning about fetal development would deter patients from undergoing their abortion (Maxwell, 2002). Protestors would, at times, turn to pushing and shoving to physically bar patients from accessing the clinic (Condit, 1990). Alternatively, they would chain the clinic’s doors and/or vandalize the property and medical equipment. All these tactics were meant to physically and immediately stop abortions from occurring. However, some activists pursued more sustained approaches than these otherwise temporary, even if immediate, strategies. Some protestors contacted landlords to convince them to increase the rent, thereby burdening clinics with increased operational costs and forcing some to permanently close (Condit, 1990; Maxwell, 2002).

The first “rescue” dated back to 1975, but Terry Randall, who founded Operation Rescue in 1988, popularized the practice in May of that year (Ehrlich & Doan, 2019; Ginsburg, 1998). Thousands of anti-choice activists descended upon New York City to protest at various clinics and pro-choice organizations, such as Planned Parenthood and NOW’s headquarters (Ginsburg, 1998). Approximately 1,600 protestors were arrested, many of them clergymen, for squatting in front of clinic doors. Just a few months later, Randall organized massive protests in Atlanta during the Democratic National Convention, which drew a large media presence. Thousands joined “The Siege of Atlanta”. Protestors identified themselves as “Baby Doe” upon arrest, complicating the booking process and further overwhelming the police force (Nathanson, 1989; Wilkinson, 1989). Indeed, Operation Rescue generally announced its targeted city but would rarely disclose what clinics protestors would host sit-ins at. This forced clinic staff, pro-abortion activists, and the police force to distribute resources across potential locations, which minimized the effectiveness of safety measures and counterprotests (Ginsburg, 1998).

Operation Rescue quickly distinguished itself from mainstream pro-life organizations, such as the incrementalist NRLC, because of its coercive and often illegal rescue techniques and its inflammatory rhetoric. Its unofficial slogan "If you believe abortion is murder, you have to act like it's murder" legitimized its reliance upon unlawful strategies, such as sit-ins, property destruction, bomb threats, and stalking. While most activists sought to avoid police confrontations, they also understood and accepted the risk of arrest (Maxwell, 2002). In their view, sit-ins juxtaposed "Christian fervor with 1960s-style civil disobedience to blockade and temporarily shut down abortion clinics" (Wilkinson, 1989). Sit-ins were thus the necessary and proportional, even if illegal, reaction to inherently discriminatory, murderous, and unjust abortion rights. In fact, unlawful behavior was necessitated in the face of these murderous laws. Protestors did not act despite these laws, but because of them. This reasoning more broadly reflected the belief that "when any government does not fall in line with God's instructions, we are released from robot-life adherence to the law" (Healy, 1988).

1.2.2 "Killing for Life"

Indeed, some radical anti-choice groups encouraged extreme violence on the basis of the doctrine of justifiable homicide, otherwise known as defensive action. Justifiable homicide rationalizes murder as a necessary act to counter greater evil, thereby absolving those who "kill for life" (Mason, 2002). The very formulation "killing for life" indicates the inherently hypocritical and paradoxical nature of murdering in the name of life. For proponents of this belief, however, it was entirely logical and necessary. Given the ineffectiveness of legislative, political action and even of sit-ins, protests, and "sidewalk counseling", murder became the only proportional and effective method to protect hundreds, if not thousands, of fetuses.

For over ten years, the Army of God, an organization in name only, claimed responsibility for vandalism, bombings, anthrax attacks, and shootings targeting abortion clinics and providers (Doan, 2007; Mason, 2002). Between 1990 and 2002, there were a reported 150 incidents of arson, over 100 cases of assault and battery, and 39 clinic bombings (Mason, 2002). Following 9/11, Clayton Lee Waagner, who claimed allegiance to the Army of God, was convicted of 51 counts of federal terrorism in 2003 for mailing dozens of letters containing fake anthrax (Doan, 2007). Even though experts estimate that the Army of God has approximately 100-200 supporters and ever fewer members, it is associated with some of the most infamous anti-choice extremists.

Notably, on March 10th, 1993, Terry's increasingly immoderate and violent pleas to "physically intervene on behalf of the victim" (as cited in Wilder, 1998, p. 81) were answered when forty-seven-year-old abortion provider, David Gunn, was shot during a demonstration at his clinic in Pensacola, Florida. That same year, Dr. George Tiller, a third-trimester abortion provider, survived being shot five times, only to be murdered in 2009 while ushering at his church (Saurette and Gordon, 2015). In 1994, Reverend Paul Jennings Hill (1954 - 2003) murdered Dr. John B. Britton, killed clinic escort James H. Barrett, and shot Barrett's wife in the hip (Doan, 2007; Goodnough, 2003; Saurette and Gordon, 2015). Hill was arrested at the scene and charged with two counts of first-degree premeditated murder, one count of attempted first-degree murder, and one count of shooting into an occupied vehicle. He was found guilty and sentenced to death. Governor Jeb Bush signed his execution warrant and he died by lethal injection on September, 3rd, 2003. In the month leading to his execution, State Attorney General Charlie Crist and prison officials received death threats containing bullets. Prison officials stated that "it was the tightest security at a Florida execution since Ted Bundy was put to death here in

1989" (Goodnough, 2003). There were approximately 50 supporters in attendance that day, some carrying signs reading "Killing Baby Killers is Justifiable Homicide" or "Extremism in Defense of Life Is Not Extreme". *The New York Times* reported that Hill's last words were: "If you believe abortion is an evil force, you should oppose the force and do what you have to, to stop it" (Goodnough, 2003).

That same year, Hill's followers published his manuscript manifesto, *Mix my Blood with the Blood of the Unborn* and a letter, *Defending the Defenseless*, in which he justified his actions. The government was complicit in the murder of thousands and was therefore the very embodiment of evil, according to Hill. And moderate anti-choice activists who viewed abortion as murder but were nonetheless unwilling to commit the necessary and proportionate measure of murdering "abortionists" were similarly complicit. Abortion was, for Hill, the ultimate sin that would forever overshadow all other cultural issues. Religious speech, for example, was irrelevant and secondary if Christians could not be moved by the "abortion genocide". Fighting abortion was thus the ultimate showdown between good and evil, between God and Satan. And it necessitated the "supreme sacrifice" of "laying down their lives in defense of others, including the newborn" (Hill, 2003, p. 5). Extreme violence was not a deviation from God's law but its very materialization.

This violence created a public relations crisis for the mainstream anti-abortion movement, which had hitherto largely benefited from its counterpart's coercive, illegal, and unrelenting harassment of abortion clinics, providers, and patients. In fact, before direct action escalated into the spree of murders throughout the 1990s, the various factions of the movement had a largely mutually constitutive and beneficial relationship (Doan, 2007; Wilder, 1998). The radical faction could legitimize its illegal and violent tactics by pointing to what seemed like ineffective and sluggish legislative and judicial efforts. Protestors who offered nonviolent “sidewalk counseling” or communal prayers operated in a larger context that was replete with the latent threat of potential coercion and violence (Doan, 2007). A simple prayer could quickly escalate into violence. Without having to enact physical violence, nonviolent protestors deeply relied on the ubiquitous menace of escalation as a coercive measure to intimidate abortion staff and patients. In turn, this created a larger culture of fear and paranoia for abortion providers, staff, and patients. And, importantly, fundamentalist rhetoric and associated violence helped portray the remainder of the movement as moderate, open to compromise, and reasonable (Roberti, 2021; Wilder, 1998).

Dr. Bernard Nathanson, who infamously narrated the anti-choice propaganda film *The Silent Scream* released in 1984, published an article in *The Hastings Center Report* titled “Operation Rescue: Domestic Terrorism or Legitimate Civil Rights Protest?”.[11] While Nathanson never explicitly answered this question, his article effectively justified Operation Rescue’s mission and tactics, which he identified as “peaceful, nonviolent protest” (p. 28). Nathanson (1989) introduced the article by extensively quoting Dr. Martin Luther King Jr.'s work on civil disobedience and unjust laws. This had two important rhetorical effects: first, much like previous efforts to compare the fetus to the victims of the Holocaust and slavery, this aligned

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[11] Dr. Bernard. N. Nathanson (1926-2011) was an obstetrician-gynecologist who helped found the National Association for the Repeal of Abortion Laws (now known as NARAL Pro-Choice America) and became the director for the Center for Reproductive and Sexual Health after abortion was legalized in New York in 1970 (Grimes, 2011; Nathanson, 1974). He attributed his growing anti-abortion sentiments to the development of medical technologies, such as electrocardiographic evidence and electroencephalographic recordings (Nathanson, 1974). *The Silent Scream* is an anti-choice propaganda movie depicting a real-time ultrasound imaging of an early-term abortion. Rosalind P. Petchesky (1987) argues that Nathanson’s narration is pivotal in helping the audience make sense of the fetus’ “escape” in the face of “aggression in its sanctuary”, while it simultaneously obscures the cultural contingency of these images under the guise of visual and medical objectivity. Medical authority is merged with myth to persuade the audience of abortion’s atrocity. *The Silent Scream* was a pivotal shift in the use anti-abortion fetal imagery. Whereas previous representations had exclusively been stagnant and decreasingly effective images of a floating fetus, this supposedly educational video showed the living, seemingly conscious, agentive, and reactive fetus.

anti-choice efforts with the civil rights movement's use of civil disobedience as a mechanism of change. Second, it compared abortion rights with segregationist laws, thereby denouncing abortion rights as inherently unjust laws that are "out of harmony with the moral law" (Nathanson, 1989, p. 28). Nathanson (1989) then quickly couched his argument as objective and unbiased by appealing to those who may want to protect fetal life, not out of religious compliance, but out of moral inclination:

> For those who are not bound by biblical edict but perceive the human fetus (even in its zygote stage) as an entity of considerable moral density, Operation Rescue is the latest incarnation of civil disobedience as an expression of moral outrage and nonviolent resistance in the cause of civil rights for the disenfranchised uterine tenants (p. 28).

The article juxtaposed the movement's mainstream mobilization of scientific discourses with Operation Rescue's "civil disobedience" to legitimize the latter. Referring to the fetus as "the disenfranchised uterine tenants", gestured to anti-abortion language that more generally referred to pregnant women as inanimate objects or property (Roth, 2000) while simultaneously constructing the fetus as an agentive, interactive, yet "disenfranchised tenant". Operation Rescue's "moral outrage and nonviolent resistance in the cause of civil rights" was the latest necessary and rightful enactment of civil disobedience.

Operation Rescue's direct and coercive action deeply benefited the mainstream movement. Sit-ins created immediate physical barriers that increased operating costs for clinics (Doan, 2007). And the perpetual harassment of clinics, staff, providers, and patients, coupled with seemingly random and unpredictable murders, have ensured that there is a constant reminder of the possibility, albeit low, of being gravely harmed when entering an abortion clinic.

These methods have proven largely effective. Even before *Dobbs v. Jackson* (2022), clinics had increasing difficulties finding willing providers. Some physicians resorted to working out of multiple clinics, sometimes travelling out of state, because of the dearth of providers in particularly contentious states. These providers face inescapable stalking, harassment, and/or threats that force them to adopt extreme protective measures, such as hiding in car trunks to travel undetected or wear costumes to disguise themselves (Wicklund, 2007).[12] Their families and loved ones are often targeted as well, and they may have limited legal recourses depending on the state in which they practice (Cohen & Connon, 2015). Some existing abortion providers stopped offering services altogether and retired providers are not replaced by incoming physicians (Doan, 2007; Ginsburg, 1998).[13] Medical students can encounter difficulties accessing abortion training, partially because of decreasing physicians with the knowledge and willingness to train them.[14]

Additionally, anti-choice protests and coercive tactics have tangible, material effects on clinics' ability to provide services. Many landlords and insurance providers are unwilling to rent their buildings and provide coverage for abortion providers (Ginsburg, 1998). It was estimated that the violent activities against clinics resulted, on average, in $141,000 worth of repairs (Doan, 2007; Grimes et al., 1991). Between 1977 and 1988, it is estimated that the costs of anti-abortion

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[12] This has become particularly problematic for patients seeking late-term procedures. To date, there are only four providers in the country offering third-trimester procedures after the murder of Dr. Tiller in 2009. These physicians speak openly about the ongoing, isolating disruptions they and their families face on a quotidian basis (Wilson, et al., 2013).

[13] There was an 8% decrease in abortion providers between 1985-1988, an 18% decrease between 1988 and 1992, and another 14% decrease between 1992 and 1996 (Doan, 2007; Henshaw, 1998).

[14] Abortion procedures were not covered in 17% of medical schools, 19% provided "a lecture specifically about abortion in the preclinical years" without offering clinical experience, and almost a quarter of clerkship directors were unaware if any abortion education was available throughout preclinical years (Espey et al., 2005). This is partially explained by a post-*Roe* switch away from abortion services being primarily accessible in hospital centers to nonhospital clinics. While this has rendered abortion procedures more available, it has simultaneously worked to (1) take the procedure outside the realm of hospital-based medical education most easily accessible to medical residents, while (2) rendering abortion providers easily identifiable and thus vulnerable to anti-choice harassment and violence (Aksel et al., 2013).

violence, such as arson, bombing, or firebombing, resulted in $7.6 million worth of damages; a number that does not reflect the cost of rebuilding completely destroyed clinics and the costs incurred from lawyers, increased security measures, ballooning insurance costs, novel licensing requirements, and staff recruitment (Grimes et al., 1991).

This is further exacerbated by what Carol Mason (2002), Professor of Gender and Women's Studies at the University of Kentucky, has termed "guerilla legislation", which are ongoing efforts to legally pursue physicians and/or clinics who lack the resources to fight costly medical malpractice suits. In much the same way that protests and extreme violence co-create an environment of fear and uncertainty, the threat of malpractice suits produces a similar context in which clinics and physicians have to perpetually fear being sued, which makes them less inclined to tackle more risky and contentious procedures.

These immediate, physical, psychological, and material consequences on abortion clinics and providers were lauded by anti-abortion moderates who appreciated the immediate "rescue" of fetal life. However, with the influx of murdered abortion providers in the early 1990s, the moderate faction finally disavowed and condemned anti-abortion violence (Ehrlich & Doan, 2019; Siegel, 2008; Wilder, 1998). Dr. John C. Willke, who penned *The Handbook on abortion* (1979) previously discussed, adamantly denounced the direct-action faction's violent strategies:

> The kind of publicity [Operation Rescue] receives when they demonstrate is bad for the movement. In the sixties, the media were behind the civil rights movement. They are not behind the prolife movement. They portray those demonstrators as a bunch of kooks, religious fanatics. [A sit-in may stop a few abortions] but if it postpones the reversal of *Roe v. Wade* for just one day by turning people off the cause. That's 4,000 babies (as cited in Ginsburg, 1998, p. 249).

Even if Willke may have espoused the alleged parallels between the civil rights movement's use of civil disobedience and the anti-choice movement's use thereof, he ultimately was most concerned about the public reception of these tactics. The media's portrayal of protestors as a "bunch of kooks, religious fanatics" threatened the possibility of overturning *Roe*, thereby saving a few unborn children while sacrificing thousands more. Even as the direct-action faction's strategies only represented a fraction of anti-choice tactics, these were nonetheless those that received the most media coverage (Doan, 2007; Ehrlich & Doan, 2019). In sociologist James Davison Hunter's words: "When Operation Rescue emerged in the late 1980s, with dramatic blockades of clinics and colorful leaders like Terry, it and all its direct action derivates quickly became the face of the anti-abortion movement" (as cited in Ginsburg, 1998, p. 239).

1.3 "Woman Protective Anti-Abortion Argument": Saving Mothers, 1990s-2000s

Following the movement's public relations crisis, emergent anti-choice leaders echoed Willke's concerns about Operation Rescue's tactics. Religious fundamentalism, harassment, and extreme violence had repulsed the "middle majority" of Americans, who felt morally ambivalent about abortion. This "middle majority" was almost crippled by conflicting feelings, whereby they simultaneously valued women's reproductive freedom yet conceptualized fetal life as something beyond some insentient clump of cells (Reardon, 1996). In the face of this moral dilemma, the "middle majority" found comfort in absolving itself from any moral responsibility and refused to impose its beliefs on women (Ehrlich & Doan, 2019; Huff, 2014; Saurette & Gordon, 2015; Siegel, 2008). To continuously decry pregnant women for aborting what the "middle majority" already perceived as "unborn babies" was thus ineffective. If instead the anti-choice movement could reframe the issue and scientifically demonstrate the injurious effects of abortion on the pregnant woman, this "middle majority" might be convinced that a procedure they otherwise deemed necessary in ensuring and expanding women's reproductive freedom warranted further regulation (Doan & Ehrlich, 2017; Siegel, 2008). I will only briefly address some of these strategies since it is the focus of the project.

Legal scholar Reva Siegel (2008) originated the notion of “Woman Protective Anti-Abortion Argument” (WPAA), which she defined as “a political discourse that seeks to persuade voters who ambivalently support abortion rights that they can help women by imposing legal restrictions on women’s access to abortion” (p. 1669). Importantly, this moment was not so much the emergence of a novel strategy as the popularization of what had hitherto been a marginalized strategy relegated to the fringes of the movement. Crisis Pregnancy Centers (CPCs) had, since their inception in the 1970s, always sought to render abortions obsolete by supporting women, emotionally and materially, through an unplanned pregnancy (Ehrlich, 2018; Matthiesen, 2021; Siegel, 2008). The Crisis Pregnancy Center Map (2022) project, led by Drs. Andrea Swartzendruber and Danielle Lambert out of the University of Georgia, defines CPCs as nonprofit, overwhelmingly evangelical Christian centers that primarily aim to deter pregnant women from undergoing abortions by mimicking the appearance and services provided by abortion clinics. These centers are run by often unqualified, female groups of volunteers who provide basic medical care and abortion counseling (Ehrlich & Doan, 2019; Kelly, 2012). Some centers offer STI testing and ultrasounds, in addition to abstinence, parenting, and religious classes. These centers have been widely critiqued for often providing inaccurate and/or misleading information about sexual and reproductive health (Bryant-Comstock et al., 2016; Swartzendruber et al., 2018). While centers in the first part of the 1970s were scattered across the nation, with no cohesive identify or centralized organization, by 1975, the Alternatives to Abortion, International (AAI) boasted over 700 affiliated centers throughout the country that were operated by over 50,000 volunteers (Matthiesen, 2021). There are now approximately 2,500

CPCs through the country, many of which receive state funding through "Alternative to Abortion" programs or diverted Temporary Assistance for Needy Families (TANF) funds (Wormer, 2021).

Early CPC volunteers quickly mobilized the therapeutic discourse of Post-Abortion Syndrome (PAS), an alleged variation of Post-Traumatic Stress Disorder (PTSD). PAS was originated by Dr. Vincent Rue and then doctoral student Anne Speckhard in 1992. They defined the syndrome as "a type of PTSD that is characterized by the chronic or delayed development of symptoms resulting from impacted emotional reactions to the perceived physical and emotional trauma of abortion" (Speckhard & Rue, 1992, p. 105). Women in the anti-choice movement embraced this therapeutic ailment upon hearing Rue speak about abortion's harm at the NRLC's convention in 1982 and thereafter created Women Exploited by Abortion (WEBA) (Siegel, 2008). Despite the American Psychological Association's repudiation that PAS was not a legitimate psychological illness, WEBA popularized PAS in anti-abortion circles by disseminating its literature and publications through the Christian Broadcast Network (Ehrlich & Doan, 2019; Siegel, 2008). A growing network of CPCs referenced PAS to support abortion patients and to deter future patients from undergoing the procedure.

The mutually constitutive expansion of the therapeutic discourse of PAS and the growing network of CPCs were nonetheless castigated by the remainder of the movement for much of the 1980s and 1990s. Most notably, President Ronald Reagan had requested that his Surgeon General, C. Everett Koop, mimic his successful anti-smoking campaign and postulate that abortions posed a public health threat (Adler et al., 1992; Ehrlich & Doan, 2019; Saurette & Gordon, 2015). Despite Koop's fervent anti-abortion sentiments, he ultimately refused to do so after 15 months of diligent research that showed there was insufficient scientific evidence to conclusively determine abortion’s consequences on women (Adler et al., 1992). Koop further denounced the women-centric approach since he was concerned that it distracted from what was perceived to be the ultimate moral concern: fetal life (Doan & Ehrlich, 2019; Saurette & Gordon, 2015; Siegel, 2008). In his view, the pro-woman focus risked rationalizing abortion procedures as morally benign if they were deemed innocuous for abortion patients.

And yet, by the late 1990s it became increasingly clear that neither the policy nor the direct-action faction of the movement were achieving any meaningful progress. And, as I mentioned, the movement was increasingly plagued by public perception of the movement as being radical, fundamentalist, violent, and deeply misogynistic. Indeed, polls indicated that Americans felt ambivalent about abortions and were increasingly concerned about clinic protests and violence (Siegel, 2008). In a blog post, Dr. John C. Willke explained that, upon leaving the NRLC, he felt compelled to create a new organization, Life Issues Institute, to rectify the pro-life movement’s erasure of women’s rights and health:

> My message tonight is not what I said five or ten years ago. Five or ten years ago my emphasis would have been on the right to life and on saving babies. But now I want to tell those who are involved in women’s helping centers that they are doing what I believe is the most important single thing that the pro-life movement is doing in our time (Willke, 2001).

Willke, as a distinct figure in the early right-to-life efforts, was having to reconceptualize this earlier strategy in favor of one that helped women. Indeed, market research had found that Americans believed that “pro-life people were not compassionate to women and that we were only ‘fetus lovers’ who abandoned the mother after birth” (Willke, 2001). And the best way to remedy the movement’s previous erasure and/or abandonment of pregnant women was to “showcase just how compassionate the movement is to women” (Willke, 2001). The vast, existing network of female-ran CPCs was the best manifestation of the movement’s compassion for pregnant women, according to Willke. In other words, what had previously been a marginalized strategy, castigated by the mainstream movement, became the locus of future anti-abortion efforts. This infrastructure of CPC was, in this framing, the proof that the movement could best represent and protect women’s genuine interest.

Just a few years earlier, David C. Reardon (1996) effectively developed the WPAA strategy in his book, *Making Abortion Rare: A Healing Strategy for a Divided Nation.*[15] Decades of concerted efforts to convince the public that the fetus is always already a human has proved effective in that, according to Reardon, “70% of aborting women believe that what they are doing is morally wrong (...) but, given the pressures they face, they feel it is the *only* thing they can do” (1996, ix). However, abortion patients and “the vast majority of citizens” nonetheless perceive abortion as an “evil necessity”. Reardon anticipated that:

> The end is certain. It won’t be the moral arguments that topple the abortion industry; it will be women’s rights. Ironic, isn’t it? But this time it will the *authentic* rights of women which transform our nation. Specifically, these include the right to know about abortion’s risks, the right to be screened for predisposing risk factors, the right to be offered safer alternatives, and the right to sue abortionists and hurt the only thing they care about - their bank accounts” (1996, ix).

The anti-choice movement was thus best positioned to protect women from greedy abortion providers and to help them materialize their “authentic rights”. Women were turning to abortion out of desperation, according to Reardon. And the best way to protect them was to refute and remedy *Roe*’s assumptions that a good and compassionate physician could guide pregnant

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[15] Reardon received his biomedical ethics doctorate from Pacific Western University, an uncredited university (Rose, 2011). He remains a prominent anti-choice ‘researcher’ who founded the Elliot Institute for Social Science Research in 1988 to perform “research, education, and advocacy for women, men and families who are at risk of or who have been harmed by abortion” (Elliot Institute).

women through their reproductive decision. Since the "abortion industry" was far from *Roe*'s imagined patient-physician relationship, according to Reardon, the best mechanism to protect pregnant women was to protect them as patients. The informed consent doctrine, meant to promote and protect patient autonomy, was a perfect artifact with which to nominally promote women's reproductive freedom while imbuing an otherwise medical process with religious belief about the sanctity of life. Feminist discourses of choice and autonomy thus got reconceptualized to promote women's "choice" to become mothers, unencumbered by external obstacles and pressures. In many ways, Reardon's call to mobilize discourses of feminism was part of a larger strategy that appropriated feminist arguments to claim that women had been pressured by modernity and feminism to abdicate their inherent desire to become mothers (Schreiber, 2008).

The WPAA materialized in 2006 when South Dakota enacted an abortion ban following a 2005 report by the South Dakota Task Force to Study Abortion, which relied on the testimonies of 180 abortion patients collected by Operation Outcry for a lawsuit on behalf of the original plaintiffs in *Roe v. Wade* (1973) and *Doe v. Bolton* (1973). Justice Kennedy referenced these same affidavits in 2007 in the *Gonzalez v. Carhart* decision that proscribed a later-term abortion procedure. The *Gonzalez* (2007) Court found that:

> The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she developed a doctor to pierce the skill and vacuum the fast-developing brain of her unborn child, a child assuming the human form.

The opinion articulated, and further legitimized, the WPAA strategy of paternalistically using the informed consent doctrine to protect pregnant women from the unsubstantiated threat of abortion regret. In this framing, the retroactive knowledge of a procedure's gruesome details compounded the "grief more anguished and sorrow more profound" that women experienced after terminating their pregnancy. Abortion was thus cast as inherently harmful for terminating the life of the "unborn child (…) assuming the human form". And the State had a corresponding duty to protect women from regret, grief, and sorrow by ensuring that "so grave a choice is well informed".

Finally, Americans United for Life (AUL), largely considered the "law firm of the pro-life movement", has been instrumental in implementing the WPAA into law (Becker, 2022). The AUL is a nonprofit law firm, founded in 1971 by a group of academics and lawyers, which has introduced over 400 abortion bills, 200 legal briefs, and drafted dozens of anti-abortion model legislation. According to legal scholar Mary Ziegler, the AUL was the major "legal architect" behind the WPAA legislative and litigative strategy since the 1990s (Becker, 2022). In 2013, it developed the model legislation "Women's Right to Know Act" as a part of its *Defending Life* "pro-life playbook" (Americans United for Life, 2013; Ehrlich & Doan, 2019; Khazan, 2015).

The WPAA has proven incredibly successful at incrementally restricting abortion access. Political scientist Amanda Roberti (2021) examined 1,706 state-level abortion bills between 2008-2017 and concluded that 70% of these used the pro-woman framing and the remaining ones relied on the fetal personhood frame. Of this 70%, Roberti identifies two subsets of women centered abortion restrictions: (1) educational bills that seek to provide abortion patients with what is deemed as necessary information to make their abortion decision and (2) protective bills that aim to shield patients from the alleged physical and/or psychological harms of abortion.[16]

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[16] Targeted Regulation of Abortion Providers (TRAP) laws are an example of these protective bills that seemingly look to ensure women's medical safety and health, while effectively rendering abortion services nearly inaccessible.

Informed consent statutes, which impose atypically stringent disclosures of often misleading and/or false information, are a legislative iteration of the WPAA, or what Roberti (2021) terms "educational bills" (Daniel et al., 2016; Roberti, 2021; Rose, 2011). These statutes, which are based on the AUL's model legislation "A Woman's Right to Know", implement mandatory waiting periods and ultrasounds, and compel abortion providers to disclose information about fetal development (and occasionally about fetal pain), information about the alleged physical and emotional risks of abortion, and information about private and public agencies that may be able to help the pregnant woman through pregnancy, childbirth, and childrearing (Guttmacher Institute, 2016; Richardson & Nash, 2006; Rowlands & Thomas, 2020; Sanger, 2008; Tobin, 2008). Legal scholars and political scientists have argued that informed consent bills (re)produce pregnant women as decisionally incapacitated (Ehrlich, 2014; Ehrlich & Doan, 2019; Siegel, 2007; 2008) and reconceptualize patient autonomy in neoliberal terms that compel abortion patients to engage in cost-benefit analysis to make the "right" decision (Denbow, 2015; Roberti, 2021).

1.4 Conclusion

Dobbs v. Jackson (2022) and Texas Senate Bill 8 (SB8) have shown the ephemeral and calculating nature of the WPAA. The pro-woman strategy was just one, amongst many, of the tactics the anti-choice movement has resorted to throughout the decades. At any moment, movement strategies responded to, mimicked, reconceptualized, or entirely contested pro-abortion discourses and larger political trends.

These laws, which target abortion providers and clinics, have forced clinics to undergo often unnecessary and particularly costly renovations (Guttmacher Institute, 2018). Despite the fact that less than 0.5% of abortion patients require hospitalization, these laws can require that providers have admitting privileges at a nearby hospital and/or require that clinics meet the standard of ambulatory surgical centers.

In the years immediately after the *Roe* decision, a primarily Catholic movement was deeply invested in pursuing legislative and constitutional change. A large focus of this strategy was to use the discourses of science and liberalism to demonstrate that the fetus was a legal entity who deserved the rights and protections as afforded by the Constitution. Visual culture and medical technologies were pivotal in rendering the otherwise invisible and recluse fetus into a child-like, seemingly autonomous entity. This has been compounded by feticide laws, originally developed to protect pregnant women from third-party perpetrators, that have been weaponized to arrest, detail, and compel medical treatment if the woman's actions, or lack thereof, were deemed threatening to fetal life. Further portraying the fetus as the latest descendant of enslaved Black people or Jews during the Holocaust enables anti-abortion activists to simultaneously align themselves and their mission with the civil rights movement, while still retaining discourses of individual responsibility that casts women, Black people, and Jews as already corrupted by liberalism and modernity. Overall, this is a strategy largely inscribed within liberal institutions that relies on the secularizing discourse of science and the universalizing discourse of rights in the quest to expand fetal rights at the cost of women's (reproductive) freedom.

Given the only incremental success of the early right-to-life strategy, an energized, radical, evangelical Christian faction of the movement shed the secularizing discourses of liberalism and science in the late 1980s-1990s. If the fetus is a person, and abortion is murder, it warrants a proportional, immediate response, justifying illegal tactics such as sit-ins and property destruction. Waiting for legislative change could not rescue fetal life most immediately threatened by scheduled abortions. Pro-life protestors thus focused their resources and attention on abortion clinics, providers, and patients; "nongovernmental" actors without the resources to combat unrelenting harassment and bouts of extreme violence. Operation Rescue's "rescues" were emblematic of the anti-choice efforts through the late 1980s and 1990s. This strategy culminated in the murder of ultimately nine abortion providers or clinic staff throughout the early 1990s. Even if extreme violence was, statistically, very improbably it did imbue all "nonviolent" protest with the pervasive threat of violence. This was a strategy contingent upon fear and (the threat of) violence that operated beyond the bounds of legal institutions, which were denounced as ungodly and blasphemous.

In the late 1990s-early 2000s, the movement once again shifted strategies and espoused one that prioritized women's rights and health. What initially started as a therapeutic discourse about post-abortion syndrome, as an alleged subset of PTSD, morphed into legal precedent that curtailed abortion access on the basis of paternalistically protecting women from the supposed physical and psychological harm of abortion. This led to the mobilization of the informed consent as a mechanism that nominally promoted patient autonomy, while bombarding pregnant women with often misleading and dubious information that inscribed religious understandings of fetal life, pregnancy, and motherhood into law and medical practice.

The appropriation of the informed consent doctrine in abortion statutes is the focus of this project. My aim is to explore how these statutes, and the concurrent and mutually constitutive "abortion regret" discourse, negotiate and ultimately reconceptualize notions of autonomy, consent, and coercion to produce motherhood as women's rational and innately preferred "choice". Since this project is a genealogy of these statutes that necessitates exploring some of their "conditions of possibility", I will next turn my attention to the competing claims about the appropriate scope of medical authority that circumscribed and informed abortion jurisprudence in the 1970s, which instituted the medicalized framework easily appropriated by ensuing anti-choice efforts.

CHAPTER 2

The Informed Consent Doctrine as "Shield and Sword": Medical Authority, Patient Autonomy, and Abortion Politics

At the time of writing, there are 12 states that have enacted near-total abortions bans following *Roe v. Wade*'s reversal under *Dobbs v. Jackson* (Abortion Finder, 2023; Haines et al., 2022; McCann et al., 2023). Additionally, Georgia has a six-week ban in effect, another four states have later-term bans, and eight states have bans that are currently blocked but that may eventually make their way into law. Of those 12 states, only some allow abortions in the event of rape or incest. But all have instituted some form of medical exemption. Most of these simply state that abortions are legal when "necessary to preserve" the patient's life or in the event of "medical emergency". Others are more detailed, such as Kentucky's trigger law, House Bill 148, enacted in 2019 that proscribes abortions unless necessary to "prevent the death or substantial risk of death due to a *physical condition* [emphasis added], or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman".

These medical exemptions have attracted considerable criticism from physicians and medical organizations for their ambiguity (Bailey & Epstein, 2022; Glenza, 2022; Goodman & Ghorayshi, 2022; Hart, 2022; Lurye, 2022). What constitutes a "medical emergency" can be a deeply subjective and fraught decision that is often compounded by the potentially time-sensitive nature of certain medical conditions. Pregnant people who would benefit from an abortion because they have higher risk, though not immediately life-threatening, pregnancies have been forced to continue their pregnancy until it reaches a more deadly juncture (Kekatos, 2022). There have been many accounts of physicians having to delay, halt, or entirely withhold care as they consult with lawyers. As indicated by HB 148, and its emphasis on "physical condition", states are attempting to define medical emergencies exclusively as those that pose physical threats, thereby proscribing abortions for psychological reasons and further restricting physicians' discretion to determine what constitutes a therapeutic abortion. As the anti-choice movement has grown increasingly suspicious of medical expertise, it has come to see these exemptions as a path to "abortion on demand", since, historically, the ambiguity around what constituted a medically necessary abortion has been interpreted broadly (Ziegler, 2022). Mary Ziegler (2022) recently traced how anti-choice efforts in this post-*Roe* era are already focused on eliminating these exceptions and criminalizing all abortions, including life-saving ones.

In all these moments, physicians' authority and discretion over medical care is progressively curtailed as they find themselves having to consult with lawyers to make sure they are following laws written by legislators with little to no medical knowledge. While this level of governmental oversight over therapeutic abortions is unprecedented, abortions have, since the mid-19th century, been a site across which medical authority has been contested, negotiated, and perpetually reconfigured. At times, the abortion decision has been almost entirely relegated to the pregnant woman, as was the case before the procedure's criminalization in the late 19th century (Duden, 1993; Mohr, 1978), and as was partially the case during the first trimester under *Roe v. Wade*. But since its criminalization, there has been an unrelenting dispute between the medical establishment and the State as to who was the rightful and foremost decision-maker. The State mostly deferred to physicians to determine what constituted a therapeutic, hence legal, abortion as opposed to a nontherapeutic and criminal abortion through the first half of the 20th century and after 1973. However, this medical discretion was perpetually contingent upon the State's willingness to recognize and protect it as such, creating a sphere of medical privacy around the physician or, later, around the patient-physician relationship under *Roe*. One of the anti-choice movement's incremental, yet incredibly effective, strategies has been to push back on State enacted and protected medical paternalism and substitute it with State oversight.

The history of abortion is thus a history about medical decision-making and contests over the rightful and authoritative decision-maker. This chapter will trace some of the different historical moments during which the abortion decision was relegated to different stakeholders. More specifically, I will put this history in conversation with the history of the informed consent doctrine. The doctrine, irrespective of its actual effectiveness, was a legal and theoretical attempt to democratize the decision-making process and redistribute what had previously been exclusive medical authority to the patient. It emerged just as physicians and the women's movement called for abortion's decriminalization. The former sought to repeal abortion laws and advocated for increased discretion over abortion procedures, effectively seeking to legalize the abortion practices they had been undertaking for decades. To the contrary, the women's movement wanted complete authority over the abortion decision, free from state oversight or medical paternalism. As I will explore in the third chapter, the *Roe* decision largely relegated the abortion decision to physicians and its access to the state of medicine; a move that would quickly be usurped by the anti-choice movement when *Roe*'s prescribed patient-physician relationship failed to materialize as such.

This chapter will first trace the American Medical Association's professionalization quest during the mid to late-19th century and its concomitant attempt to exert full decisional authority over what constituted a therapeutic abortion. For decades thereafter, physicians enjoyed unhindered discretion over the (abortion) decision. Some doctors provided abortions when a pregnancy threatened a woman's life, while others more indiscriminately provided abortions to preserve the woman's overall, physical or psychological, wellbeing. Medical developments in the mid-20th century rendered therapeutic abortions decreasingly necessary and the previously obfuscated disagreements as to what constituted a woman's health, hence what constituted a therapeutic abortion, came to light. Physicians sought to repeal abortion laws and to expand the scope of therapeutic abortions. Feminists usurped these efforts and, instead, called for "abortion on demand". This fracture between physicians and feminists was reflective of larger shifts and fissures within the medical establishment, as patients, lawyers, and judges attempted to recalibrate physicians' uncontested decisional authority and redistribute it to patients. The informed consent doctrine was an important materialization of these attempts, as case law incrementally expanded patients' right of refusal and, ultimately, their right to refuse treatment, even if contraindicated. Patient autonomy seemed to sit side-by-side with physicians' paternalism. And yet, as I will conclude, the informed consent doctrine, both in its legal and ethical formulation and implementation, was never quite able to clearly center patient autonomy. In fact, many of these early articulations of the informed consent doctrine produced a restricted understanding of self-determination, whereby the patient's autonomy, by definition, was always circumscribed and conditioned by the profession's commitment to the patient's wellbeing.

2.1 Physicians' 19th Century Professionalization Quest: The First Wave of Medicalization

This first section is an overview of the ways in which the history of abortion is inextricably linked with the history of medicine. More specifically, I attempt to demonstrate that abortion procedures and women's bodies have continuously been sites of struggle and negotiation surrounding medical authority.

Following British Common Law, at the beginning of the nineteenth century, abortion in the Unites States was only proscribed after quickening (Luker, 1984; Mohr, 1978; Saurette & Gordon, 2015; Smith-Rosenberg, 1985). As understood at the time, quickening was when the pregnant woman first experienced fetal movement, usually between the fourth to sixth gestational month (Luker, 1984; Mohr, 1978). Being the only external symptom potentially accessible to others that distinguished a pregnancy from otherwise symptomatically similar illnesses, physicians recognized quickening as proof of pregnancy (Mohr, 1978; Withycombe, 2019). The other symptoms women experienced during pregnancy, such as nausea, breast tenderness, an expanding belly, and missing their "menses" all potentially explained a variety of other ailments. Since the treatment for these sicknesses and the expulsion of a pregnancy required the same procedure, to criminalize abortions would have implied the criminalization of otherwise necessary medical treatments (Mohr, 1978). As such, only the termination of a confirmed, post-quickening pregnancy was banned.

Even if common law proscribed post-quickening abortions, enforcement proved particularly difficult, if not impossible. It was the woman's embodied experience of her pregnancy, available almost exclusively to her, that initially identified her as a pregnant woman (Duden 1993; Mohr, 1978; R. Siegel, 1991). Men largely accepted women's authority in confirming a pregnancy (Duden; 1993). This bodily experience thus translated into a particular form of bodily expertise, which physicians and midwives were forced to defer to. Since there were no reliable technologies of pregnancy corroboration, and the abortion procedure resembled other medically necessary procedures, abortions went largely unregulated, free from systematic state intervention. Medical and popular literature further illustrated that abortions were relatively quotidian procedures that drew little public attention or outcry (Mohr, 1978). Health guides openly described abortion methods to pregnant women and medical volumes informed physicians how to use abortifacients. While these volumes denounced the use of poisons and purgatives as potentially dangerous, they generally did not stress the attendant risks of abortions, and largely portrayed these risks as acceptable by then-current medical standards.

And yet, medical references to abortions progressively decreased throughout the latter half of the century, as the newly formed American Medical Association (1847) medicalized and criminalized pregnancy terminations (Mohr, 1978). A surge of regulation occurred between 1860 and 1880. Twenty-one states proscribed abortions altogether over those two decades. The criminalization of abortion was one means by which institutionally trained physicians could demonstrate professional expertise and distinguish themselves from their untrained counterparts.

Unlike the medical profession in England, which carried a distinct and elite status, the medical field in the United States until the late nineteenth century was defined by the democratic culture in which it emerged. While regular physicians looked to legitimize their profession, they were met with resistance from a skeptical public that preferred domestic and democratized medicine (Mohr, 1978; Starr 1982). Given this public preference, the absence of licensing laws, and the emergence of medical schools as diploma mills, irregular physicians overflowed the market (Mohr, 1978). Irregular physicians were generally lay providers, with little, or no, official medical training. In contrast, regular physicians attended (prestigious) medical schools and attempted to implement medical societies, licensing programs, and professional journals (Mohr, 1978; Starr, 1982).

Given the unobstructed and unregulated access to the medical profession, the field was constituted of three factions. At the top, regular, established physicians catered to a particularly wealthy clientele and obtained professorship positions at elite medical institutions (Starr, 1982). Most of the field was composed of regular physicians, who had received some form of medical instruction, either through internship or official medical training. Finally, the bottom faction was comprised of largely untrained providers, who the top two-tiers considered to be quacks and imposters. The top and bottom factions of the field largely benefited from the status-quo, given the former's professional and financial success and the latter's access to a field that would otherwise be inaccessible to them in a regulated medical field. In this democratized medical market, the generally young, professionally and financially unestablished, regular physicians were losing their clientele to their lay, irregular counterparts. They thus actively sought the professionalization of the field in looking to protect their professional status and economic profits. The AMA was thus founded in 1847 as a concerted attempt at professionalization (Starr, 1982).

However, unestablished regular physicians faced a crisis in public perception since current medicine was largely ineffective at curing most illnesses (Mohr, 1978). By grasping onto the medicalization of abortion, the AMA was able to demonstrate their professional expertise. If they were not able to save lives, they would focus on saving the life of the unborn and of the pregnant woman. This required changing popular perception of both the moral value of fetal life and of the dangers of abortion. Regular physicians thus rebutted the notion of quickening and argued that life started at conception (Luker; 1984; Mohr, 1978; Petchesky, 1984; R. Siegel, 1991). Fetal movement was just one gestational development amongst many others. They portrayed the fetus as an already human (generally male) precursor to the future child, who, in its capacity for growth, demonstrated autonomy (R. Siegel, 1991). Abortions interrupted the development and life of the unborn child. Refuting the quickening doctrine thus worked on multiple fronts towards professionalization: 1) It demonstrated regular physicians' professional knowledge and expertise, which 2) engendered a reconceptualization of fetal life and 3) enabled them to position themselves as the saviors of the unborn. In turn, this justified their requests for professional and licensing regulations (Luker, 1984; Mohr, 1978). The AMA's quest to criminalize abortions was initiated by professional anxieties in an era of unregulated and unlicensed medical practice and their efforts were not in vain. By 1900, every jurisdiction in the country had banned most abortions (Mohr, 1978).

2.2 Interprofessional Threats to Medical Discretion

Through much of the first half of the twentieth century, abortion remained illegal unless necessary to preserve the woman's life. (Adler et al., 1992; Luker, 1984; Schwartz, 1972). Medical professionals were entrusted with the responsibility, and hence authority, to determine which medical conditions warranted a therapeutic abortion (Luker, 1984). Criminalization throughout the early 1900s did not eliminate abortions. Instead, criminalization worked to distinguish medically necessary abortions from criminal abortions and physicians had complete, unchallenged discretion over this categorization process. "Strict constructionists" only provided abortions when the woman's *physical* life was threatened. Even when a woman was deemed suicidal because of an unwanted pregnancy, these physicians prescribed compulsory institutionalization before they would provide an abortion for psychological reasons. To the contrary, "broad constructionists" were willing to provide abortions to protect a woman's physical or psychological health. These physicians were thus willing to terminate a pregnancy if compulsory motherhood would threaten the woman's emotional wellbeing, if the pregnancy was a product of rape or incest, or if there were indications of fetal anomaly. In other words, physicians held greatly diverging understandings of what constituted health, and hence, what constituted a therapeutic abortion. By framing abortion access in medical and technical terms that eclipsed moral claims, physicians were able to exclude other parties – such as lawyers, legislators, ministers, and women – from this decisional process.

However, developments in medical knowledge and technologies between the 1920s and 1950s eradicated many of the medical ailments that necessitated abortions to preserve a woman's life (Schwartz, 1972). For example, the inventions of intravenous glucose-feeding and anti-nausea medications that curbed excessive pregnancy vomiting eliminated the most prominent rationale for therapeutic abortions (Luker, 1984). Tuberculosis, which frequently necessitated abortions, was virtually eradicated. By 1936, women with only one kidney could safely bring a pregnancy to term and developments in cardiology enabled many patients with cardiovascular or renal disease to have a safe pregnancy.

These medical innovations brought to the forefront professional disagreements that had previously been obscured (Hart, 2022; Luker, 1984). As long as most abortions had been necessary to save the woman's physical life, "strict constructionists" had found no reason to question their colleagues' medical practices. By 1963, the rate of all therapeutic abortions performed for psychiatric reasons rose to 80% from 10% in 1943 (Adler et al., 1992).[17] As therapeutic abortions were increasingly replaced by abortions to preserve the woman's psychological health, "strict constructionists" started questioning their liberal colleagues' abortion practices and numbers. The latter's discretion to gauge individual circumstances when determining an abortion's necessity was increasingly threatened and eroding. They were concerned that their criteria for providing abortions would not hold up in a court of law. Early efforts to reform abortion laws in the 1960s were thus spearheaded by physicians. They wanted to ensure that abortions performed to protect a woman's psychological health, in the event of rape or incest, or in the event of what would later be termed "fetal deformity" were legally

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[17] Women (overwhelmingly those with the means to do so) sought out psychiatrists who would corroborate and testify that they displayed suicidal ideations and would likely commit suicide if unable to terminate their pregnancy (Schwartz, 1972).

permissible. In other words, “broad constructionists” wanted to ensure that the abortions they were already providing were unequivocally deemed legitimate and legal and that they would be free from governmental oversight, regulation, and punishment.

These efforts were deeply couched in medicalized terms and reified physicians’ discretion over the decisional process. The American Law Institute (ALI), an organization of judges, lawyers, and law professors, proposed a 1962 Model Penal Code, which was emblematic of early reform efforts:

> A licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse (as cited in Greenhouse & Siegel, p. 25).

The code’s language was primarily concerned with shielding physicians from liability and not with enacting women’s reproductive choice (Greenhouse & Siegel, 2012). Its focus was on determining which procedures physicians were “justified” to provide; a justification that was contingent upon the physician’s belief about “substantial risk”. While the code did require that a second physician corroborate the procedure’s necessity, it ultimately reified physicians’ discretion and authority by allowing them to perform abortions based on their own determination, free from scrutiny by their conservative colleagues or by other external parties. The model code was quickly adopted by twelve states. “Broad constructionists” were starting to successfully legitimize and legalize the abortion practices they had been undertaking for decades.

2.3 External Threats to Medical Authority

The ALI's code was an important step in reforming existing abortion laws and expanding the scope of permissible therapeutic abortions in the years before *Roe v. Wade* (1973). However, it did little to help most women who did not seek abortions under traumatic and/or therapeutic circumstances. By the end of the 1960s, the women's liberation movement had largely usurped reform efforts and advocated for repeal on all abortion restrictions. Importantly, the movement reconceptualized abortion, not just as a medical procedure, but as a fundamental right (Condit, 1990; Greenhouse, 2006; Greenhouse & Siegel, 2012; Luker, 1984; Siegel 2010). In this framing, women ought to have complete decisional freedom and physicians simply effectuated the procedure. Without abortion access, hence without the ability to control one's reproductive capacities, other hard-won rights, such as the right to vote, were largely meaningless. If women could not control their reproductive processes, they would forever be stifled by (the threat) of uninterrupted pregnancy, childbirth, and child rearing. If women had any chance at equality, at being able to participate and contribute to politics, society, and the economy, they needed to be freed from the perpetual threat of compulsory motherhood. Abortion, in this lens, materialized and promoted women's rights, equality, and liberty. Women would no longer be valued exclusively as mothers; they would finally gain social recognition and status beyond their reproductive organs and be granted full-fledged human dignity and self-determination. Since women bore the physical, psychological, emotional, social, political, and financial ramifications of unwanted pregnancies and compulsory motherhood, activists argued that they should have complete, unchallenged decisional autonomy over their reproductive decisions. In other words, feminists called for women to be free to access abortion at any gestational stage, for any reasons. They demanded "abortion on demand" unobstructed by medical paternalism.

In February 1969, Betty Friedan, founding president of the National Organization for Women (NOW), spoke at Chicago at the First National Conference on Abortion Laws. Her speech marked the merging of the women's rights and abortion rights movements (Greenhouse & Siegel, 2012). It was emblematic of the movement's views on abortion:

> Women are not seen seriously as people. So this is the new name of the game on the question of abortion: that women's voices are heard. Women are the ones who therefore must decide, and what we are in the process of doing, it seems to me, is realizing that there are certain rights that have never been defined as rights, that are essential to equality for women, and they were not defined in the Constitution (…) when that Constitution was written only by men. The right of woman to control her reproductive process must be established as a basic and valuable human civil right not to be denied or abridged by the State. So must we address all questions governing the reproductive process (…). Reform, don't talk to me about reform – reform is still the same – women, passive objects. Reform is something dreamed up by men, abortion reform (Friedan, 1969, as cited in Greenhouse & Siegel, 2012).

Repeal efforts diverged greatly from physicians' reform goals (Siegel, 2010). The former centralized "women's voices" and freedom to "control her reproductive processes", while the latter sought to reify physicians' discretion and protect it from governmental oversight and from women's requests that doctors become mere technicians.

2.3.1 The Women's Health Movement: Contesting Medical Paternalism

Abortion was also an important concern for the women's health movement, which grew out of the women's liberation and the civil rights movements. The movement is often identified with the Boston Women's Health Book Collective (BWHBC)'s *Our Bodies, Ourselves* (*OBO*). In May of 1969 in Chicago, twelve women participated in a two-hour workshop titled "Women and Their Bodies" during a women's liberation conference (Davis, 2007; Heather & Zeldes, 2008; Kline, 2010). Sharing their frustration about judgmental, unforthcoming, and dismissive physicians, they planned to create a list of "reasonable" obstetricians-gynecologists (OB-GYNs).

When this proved largely impossible, they decided to host workshops where members would share information concerning their health and bodies that they had been tasked with researching. Membership skyrocketed and participants, eager to share and discuss their personal medical experiences, compelled the collective to switch their presentations to discussions and to compile their note cards into an inexpensive newsprint. After selling 225,000 copies, the collective published an expanded version with Simon & Schuster, a particularly difficult and daunting decision that forecast ensuing disagreements and conflicts (Kline, 2010). Regardless, the book remained popular and has since undergone many revisions and expansions.

OBO was revolutionary. Indeed, many scholars agree that the women's health movement and *OBO* were central in pushing back on medical paternalism and for reconceptualizing medical knowledge production, decisional processes, and the patient-physician relationship (Davis, 2007; Imber, 2008; Kline, 2010; Rothman, 1991; Ruzek, 1978; Starr, 1982). *OBO* grew out of women's dissatisfaction with the medical establishment, which they encountered relatively frequently throughout their reproductive lives. (Kohler Riessman, 2003; Ruzek, 1978). Routine OB-GYN examinations and pediatrician visits left many women frustrated and feeling helpless. Patients reported often feeling dismissed and judged. They had difficulties getting information about their prognosis or treatment path. Physicians' unwillingness to divulge information and knowledge made it hard for patients to have an agency over their treatments.

OBO attempted to guide women's quotidian reproductive lives by integrating members' and readers' experiences. In a particular instance, a reader, Frances, asked her doctor for a prescription of Furacin, a nonsulfa antibiotic preparation, mentioned as a treatment for vaginitis in *OBO* (Kline, 2010). While her physician obliged, she was disheartened to learn from her pharmacist that it had been discontinued. She called her physician back to get his recommendation on the pharmacist's suggestion to alternatively try Betadine or Vagisec. Frances reported that her physician did not care which she tried and did not inform her that Vagisec would be useless since it did not have antibacterial properties, something she learned later. While seemingly trivial, this story has two important elements. First, it is emblematic of the obstacles women faced when trying to access even the most basic care for a quotidian disorder. Many women wrote to the BWHBC to narrate their difficulties finding a sympathetic physician with effective treatment for vaginitis. Historian Wendy Kline (2010) argues that vaginitis garnered little attention from physicians because it was not life-threatening, or considered serious, and yet was hard to cure. Second, Frances wrote to the BWHBC because of her dissatisfaction with the book's incorrect suggestion to try Furacin for vaginitis. One of *OBO*'s strengths was that the collective edited, modified, expanded, or redacted the material according to readers' reactions, recommendations, or frustrations. Even the original version was composed of letters, thereby helping readers to simultaneously feel supported and less isolated, while teaching them that their lived, embodied experiences mattered. Sociologist Kathy Davis (2007) argues that this collaborative format helps explain the book's international popularity. Indeed, much of the content covered in the U.S. edition was specific to a particular space and time and could not effectively be globally replicated. However, the epistemological format of revising editions according to readers' reactions was an easily mimicable model.

One of *OBO*'s most revolutionary characteristics was that it underscored the importance of embodied knowledge at a time that prized distant, supposedly unbiased and objective, technical and medical knowledge. As such, it compelled women, and patients more generally, to reconceptualize themselves. Their lived experiences, while not necessarily more important than the physician's medical expertise, needed to be acknowledged and considered in the decisional process. Patients were thus encouraged to understand themselves as informed and contributive parties, who were tasked with evaluating their physician's prognosis and recommendations and gauging it against their embodied experience. *OBO* thus presumed and produced a particular subject: patients were no longer encouraged to be docile and passively obedient. Instead, the very epistemological basis of *OBO* emboldened readers to critically read, question, and ultimately contribute to all forms of knowledge production.

Sociologist Catherine Kohler Riessman (2003) argues that successful medicalization, the process whereby previously moral, social, or legal problems are redefined as medical ones under medical jurisdiction, is often a complex, multidimensional, and inconsistent process. Complicating literature that portrays medicalization as a linear path whereby the medical establishment usurped phenomena such as alcoholism, fatness, or addiction, Riessman (2003) argues that medicalization necessitates that subjects internalize a medical framing and vocabulary, and importantly, that they understand themselves as patients. As such, medicalization efforts have proven more or less effective and have mobilized various institutions and discourses. In particular, Riessman argues that women have had different reactions to medicalization throughout the centuries. At times, women have an interest in medicalization. For example, women were the ones who demanded access to a combination of scopolamine and morphine, which engendered "twilight sleep" during childbirth. Not only did it free them of the physical traumas of childbirth, but medicalization also gave upper-middle class women access to more surgical interventions and oversight at a time when women were having fewer, hence more emotionally valuable, children. At other times, they have pursued different forms of medicalization by only accepting some elements of medicalization or by entirely rejecting medicalization.

The women's health movement of the late 1960s and early 1970s was a reaction, in part, to the medicalization of reproductive healthcare. As I discussed at the beginning of this chapter, the criminalization of abortion throughout the second half of the 19th century were medicalization efforts that displaced women's embodied knowledge in favor of regular physicians' alleged technical and medical expertise. Childbirth moved from the home to hospitals, replicating many of the practices of invasive and traumatic surgery. However, women's reactions to medicalization looked different in the late 1960s and early 1970s. Even *OBO*'s content speaks to different reactions. Generally, it interpellated informed and cautious, if not skeptical, patients as consumers. Even so, it presumed that its readers remained patients because they still depended on physicians' expertise and knowledge. However, in other aspects, the women's health movement did call for complete de-medicalization, especially as it related to abortion.

The Abortion Counseling Service of Women's Liberation, more commonly known under the pseudonym Jane to protect its members' identities, started as an underground abortion referral and counseling service in Chicago, IL in 1969. When the founders realized the male abortionist they had been using was not a physician, two of the members learned the skills to provide abortions, which they found to be surprisingly easy and uncomplicated (Kline, 2010). Between 1969 and 1973, Jane arranged and performed over 11,000 illegal abortions (Gordon, 1990; "Jane", 1990). Most members who decided to stay learned how to perform abortions. This was an important moment for members' sense of empowerment and autonomy. They no longer had to rely on male providers. In fact, they focused on offering the very support and care that so often lacked during most therapeutic and criminal abortions at the time. For many women accessing criminal abortions, the process was fraught with fear and uncertainty. Women reported being only met with a brief request for payment before undergoing the procedure (Lessin & Pildes, 2022). In the worst circumstances, women were left to die. Cook County Hospital in Chicago had dedicated a ward to women suffering from septic abortions ("Jane", 1990; Lessin & Pildes, 2022). It was often full. Jane members were thus committed to not only providing safe and more affordable procedures but to make sure that each woman understood what was going to happen, that she received the emotional support and care she needed, and that she left with clear post-operative instructions (Gordon, 1990; Kline, 2010). Not only had they rendered male physicians obsolete, but they also learned to provide a safer, more supportive, and more caring abortion experience for women.

Much like their BWHBC counterparts, the Jane members were committed to a democratization of gynecological knowledge. One of the members, Ruth Surgal ordered boxes of *OBO* to distribute to every woman who received an abortion through Jane ("Jane", 1990; Kline, 2010). Patients were encouraged to gain control over their health and bodies. However, Jane members additionally envisioned starker de-medicalization (Gordon, 2010). Their very organization and practices were based on the notion that abortions did not require any specialized medical knowledge and could be provided by any conscientious, trained lay person. Ruth, troubled by the group's lack of additional gynecological knowledge, later asked her doctor to teach her and a few other members how to perform pelvic exams. The Janes started bringing mirrors to work and asked their patients whether they would be interested in looking at their own cervix and learning how to do a self-exam. When most patients declined, the members stopped asking and simply showed them. While the practice was later contested (it does seem ironic to effectively sidestep patients' consent in an organization frustrated with medical paternalism), it did speak to the members' commitment to self-help and embodied knowledge. And, importantly, this did work towards reconceptualizing the patient-physician relationship. Not only did women have the necessary skills to give each other control over their reproductive processes, they were increasingly armed with the experiential and medical knowledge to become informed, critical, and engaged consumers.

The women's health movement was emblematic of a growing legal, scholarly, and cultural distrust and disdain towards physicians and the medical establishment. While the women's health movement was central in contesting medical authority, it had its roots in the civil and health rights movements (Nelson, 2016). Previous movements had denounced abysmal living conditions, such as unsanitary housing and inadequate access to clean water and healthy foods, as perpetuating cycles of poverty, especially amongst people of color. Activists thus advocated for safer living conditions and better access to healthcare free of rampant medical racism. Many of the early activists in the women's health movement had been involved in these earlier efforts, only to be disappointed by pervasive sexism. These earlier movements centered race and class, without considering the medical establishment as a patriarchal institution that both represented and reified larger patterns of misogyny. In other words, the women's health movement finessed its critique of the medical establishment, but it emerged in a wider context that was growing increasingly skeptical of the medical establishment.

2.4 A Shifting Medical Landscape

2.4.1 Medical Utilitarianism

As the story is so often told, a culmination of publicized medical abuses gained notoriety starting in the mid-20th century. It was obvious that, for decades, the medical establishment's monopoly and resulting discretion had both enabled and obscured rampant medical atrocities that mistreated, misled, maimed, and occasionally murdered research participants. In the name of medical progress and the greater good, researchers had enacted experimental treatments on subjects unbeknownst to them, had failed to disclose potential adverse effects and risks, and had used vulnerable communities whose very living conditions vitiated their ability to consent all in their quest to develop novel medical treatments (Gere, 2017). The stories have often been told elsewhere. My purpose, here, is not to contribute to these excavations but simply to gesture to some of the cases that engendered the conceptualization and institutionalization of the informed consent doctrine.

The 1946 Nuremberg Medical Trial, which opened criminal charges against Nazi physicians accused of willingly participating in crimes against humanity and war crimes, made the uncomfortable reality apparent that Allied countries had similarly engaged in abusive, exploitative, and utilitarian experiments that victimized already marginalized communities in the name of medical progress (Gere, 2017; Manson & O'Neill, 2007). The trial engendered the Nuremberg Code of 1947, which is recognized as the first formal and authoritative statement that delineated the basic principles of ethical medical experiments. Its first tenet centered consent:

> The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision (The Nuremberg Code, 1947).

But the Nuremberg Code generated different reactions, as some American researchers tried to espouse it and others entirely ignored it (Gere, 2017). In an event that propelled the abortion debate into public awareness, *Life* magazine published a cover story on August 10th, 1962 depicting Sherri Chesse Finkbine grappling with "the wracking moral question of abortion" (Greenhouse & Siegel, 2012). Finkbine, the host of a popular children's television program in

Phoenix and mother of four, was ultimately forced to travel to Sweden to terminate the desired pregnancy after her procedure in the United States was cancelled (Condit, 1990). Her physician had recommended she terminate her pregnancy after learning that she had been taking her husband's sleeping pills he had procured while in Europe. The tranquilizer contained pure thalidomide and had been linked to an epidemic of babies born without limbs. While the Food and Drug Administration (FDA) never approved the sedative, American doctors had distributed samples to thousands of patients without warning them of its experimental status.

By 1965, over six million women were estimated to have taken the pill (Kline, 2010; Ruzek, 1978). Planned Parenthood reported that seventy percent of its patients seeking birth control requested a prescription for it. Introduced at the dawn of the sexual revolution, the pill promised women the freedom to engage in non-reproductive, potentially pleasurable sex, unrestricted by men's consent to, or even awareness of, contraceptive use. This promise and excitement were quickly replaced by skepticism and frustration. Initial research, funded by population control organizations, was performed on poor women in Puerto Rico and Haiti. Women experienced severe adverse effects, such as blood clots and heart attacks, despite their physicians' repeated reassurances that it was safe.

Between 1945 and 1970, approximately three million women were prescribed diethylstilbestrol (DES) to prevent miscarriages, despite evidence of its ineffectiveness (Ruzek, 1978). Oncologists determined that it was linked to increasing rates of vaginal adenocarcinoma, a form of rare vaginal cancer even amongst older women, amongst young girls. Physicians did not inform their patients whether they had been given DES during their pregnancy and public health agencies, such as the FDA, the National Health Institute, or the National Center for

Diseases Control, refused to initiate a national campaign to inform women who had been exposed to DES.

For years, the FDA refused to categorize intrauterine devices (IUDs) as drugs, which allowed the invention and marketing of the devices without medical testing (Ruzek, 1978). Between the 1960s and 1970s, approximately 3 million American women and over 7 million women abroad received IUDs. Women died, were rendered sterile, hemorrhaged, and experienced miscarriages, infection, crippling pain, and unwanted pregnancies because of the unregulated use of IUDs. Infamously, the Dalkon Shield, shaped like small fish with spikes on either side meant to prevent the uterus from expelling the device, was inserted into 2.5 million women (Horwitz, n.d.). According to a 1973 study on the safety of IUDs performed by the Center for Disease Control and Prevention (CDC), the device was the most popular IUD and marketed on the premise of its safety, at a time when physicians and women were increasingly concerned about the pill's dangers. Researchers discovered that the devices' strings were improperly attached, would disintegrate, and attract bacteria into the uterus, which caused miscarriages, septic infections, infertility, spontaneous abortions, and, in some instances, death. It was determined that it was five times more likely to engender pelvic inflammatory disease (PID) than other IUDs (Kolata, 1987). The distributer, the A.H. Robins Company, which produced the cough medicine Robitussin, claimed that the severe adverse effects were caused by poor insertion practices and that the device was no more dangerous than other IUDs. Regardless, over 300,000 women filed lawsuits against the company. While the FDA requested that all sales be suspended in October 1974, it was not until October 1985 that A.H. Robins recalled the device and filed bankruptcy after settling approximately 7,600 claims for $245 million. Finally, on May 28th, 1976, under President Gerald Ford, the FDA was mandated to regulate all IUDs as medical devices.

These are only some of the gynecological and experimental abuses that garnered much public, professional, and legislative outcry. Eugenic anxieties coupled with a male-dominated medical field rampant with sexism were worked through and upon women's bodies. Patients in general, and women more particularly, were not given the decisional opportunities to have agency and autonomy over their medical treatments. Issues around medical utilitarianism enacted in medical experiments engendered similar conversations around consent in healthcare contexts. However, consent to care grappled with the additional difficulty that patients often necessitate care in circumstances in which they cannot give consent, such as when they are incapacitated (Manson & O'Neill, 2007). Despite some similarities, the issues and proposed solutions in healthcare, as opposed to medical research, followed a different trajectory.

2.4.2 Medical Paternalism and Beneficence

By and large, bioethicists and historians agree that some physicians did seek consent, to varying degrees, in the years before World War II (Faden & Beauchamp, 1986; Katz, 2002; Tauber, 2005). But there was no uniform, institutionalized way of doing so. Our contemporary understanding of consent as materializing a patient's self-determination did not exist; it was physicians, instead, who had authority over determining what would benefit the patient's well-being. To whatever extent physicians thus sought consent, it was likely in hopes of improving the patient's prognosis or compliance and not out of concern for the patient's autonomy (Faden & Beauchamp, 1986; Katz, 2002).

In fact, physicians espoused the Hippocratic oath's commitment *primum non nocere* – "above all, do no harm", which included the belief that lying (by omission) could protect patients from the compounded hopelessness of learning about their incurable illness or unavoidable death (Faden & Beauchamp, 1986, p. 10). According to the AMA's 1847 Code of Ethics, since "the words or the manner of the physician" could shorten a person's life, they were tasked to be "the minister of hope and comfort to the sick" (p. 94).

Overwhelmingly, physicians either remained silent, simply assuming their patients would compliantly obey their prescriptions (Katz, 2002), or engaged in "benevolent deception" (Faden & Beauchamp, 1986) or outright lies in hopes of either assuring consent or of protecting patients from unnecessary emotional anguish (Rothman, 1991). At best, physicians would inform patients of the risks of a particular procedure, giving them the opportunity to refuse. But physicians largely assumed that patients lacked the knowledge and rationality to make educated medical decisions. Patients were thus exhorted to honor, trust, and obey their physicians (Katz, 2002; Kurtz, 2000. And since physicians before World War II often encountered patients during at-home visits and shared their patients' socioeconomic, cultural, racial, and racial backgrounds, it was more generally presumed that physicians could make paternalistic decisions that accounted for their patients' lived circumstances (Rothman, 1991). The profession's beneficent quest to minimize harm and maximize patient wellbeing and health circumscribed much of medical decision-making for centuries before World War II.

2.4.3 The Emergence of the Informed Consent Doctrine

The informed consent doctrine was meant to mitigate the inherent and historical power asymmetry that had defined the patient-physician relationship. Irrespective of the ethical principles physicians and patients espouse, the very nature of the patient-physician relationship implies that the former is frequently sick, injured, fearful, and ignorant while the latter is knowledgeable, experienced, and often emotionally distanced. Paternalistic proclivities are simultaneously legitimized and compounded by this inevitability. But for the first time, patients' autonomy was meant to supersede, or at the very least complement, physicians' paternalism. While the Nuremberg Medical Trial had first officially articulated the importance of research participants' consent, the term "informed consent" was first used as such in 1957 under *Salgo v. Leland Stanford Jr. University Board of Trustees.* After an aortography left Martin Salgo permanently paralyzed in his lower extremities, the California Court of Appeals found that: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment" (*Salgo v. Leland*, 1957). The *Salgo* Court, for the first time, compelled that physicians disclose "any facts which are necessary to form the basis of an intelligent consent by the patient", thus calling for more comprehensive disclosure. Previous cases, in the early 20th century, had simply protected patients' right to be free from "offensive (uninvited) contact", hence protecting their refusal right (Katz, 2002).[18] Put differently, the *Salgo* decision was starting to articulate an understanding of the relationship between information, consent, and patient's self-determination that transcended a more limited view that patients had the right to understand what was being done to them. This was more fully developed in 1960, under *Nathanson v. Kline*, when the Kansas Supreme Court stated:

> Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

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[18] Under *Pratt v. Davis* (1905) and *Schloendorff v. The Society of New York Hospital* (1914), courts intervened in cases in which patients had not given consent to the enacted procedure (Katz, 2002). These were not cases, as it would later be, in which some iteration of consent was given. These were much more explicit physical violations that were treated under battery law.

Patients did not just have the right to refuse procedures, they had the right to refuse "life-saving surgery" that the "doctor might well believe (…) is desirable or necessary". The Kansas Supreme Court recognized, even if implicitly, that patients might refuse a procedure for reasons beyond their physical health. Physicians could not deceive their patients, even if they believed it to be necessary in light of the patient's well-being. The *Nathanson* Court further stated that physicians ought to disclose possible therapeutic alternatives. Patients' decisional authority was starting to supersede physicians' as the Court recognized patients' ability to consider not only their tolerance for particular risks, but their ability to consider other medical interventions that they might find preferable, despite their physician's recommendations.

Twelve years later, the D.C. Court of Appeals introduced the "reasonable patient" standard, replacing the "community practice" standard of disclosure, under *Canterbury v. Spence* (1972). Hitherto, courts had still deferred to physicians to determine the scope of necessary information. Under *Canterbury*, the Court sought to delineate, in unprecedent detail, what information the patient needed to make an informed decision. It acknowledged that:

> to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves (*Canterbury v. Spence*, 1972).

The Court thus distinguished medical knowledge about diagnosis, prognosis, treatment risks, and alternative from the judgment necessary to determine what information the patient may find relevant (Katz, 2002). Materializing and protecting patients' self-determination therefore necessitated an externally imposed standard, which no longer deferred this judgment to the physicians themselves. The Court developed the “reasonable patient” standard that compelled physicians to impart information that a “reasonable person” might find “material” when considering “whether or not to forego the proposed therapy” (*Canterbury v. Spence*, 1972).

Decades, if not centuries, of medical paternalism enacted in the name of beneficence was seemingly being replaced with patient autonomy (Faden & Beauchamp, 1986; Katz, 2002; Kurtz, 2000; Pellegrino, 1994; Rothman, 1991; Sherwin, 1998). Case law in the 1960s and early 1970s sought to reconfigure and recalibrate the patient-physician relationship in favor of patients’ self-determination right. Medical decisions were no longer to be exclusively relegated to physicians. Instead, physicians were asked to shed light on their medical recommendations by informing the patients of the risks, benefits, and alternatives of their recommended treatment. Patients were given the right to not only refuse but to additionally consider alternatives. In other words, patients had the right to make their medical decisions while considering the larger circumstances of their lives that transcended traditional medical concerns. Patients could make medical decisions, even if contraindicated. The informed consent doctrine thus sought to redistribute, to democratize, the decisional process, thereby protecting patients from medical paternalism while promoting their self-determination.

And, importantly, both the “informed” and “consent” descriptors of the doctrine both presumed and sought to materialize a distinct and novel form of autonomy. At its basis, the doctrine presumes a rational, self-aware agent with the intellectual capacities to understand and consider information divulged by physicians (O’Regan, 2020). This information was then the basis upon which they could make an informed decision to either refuse, consent, or choose a proposed alternative. This was a new iteration of consent, quite unlike the one physicians sought, to whatever extent, in the years before WWI. Consent was both the foundation and materialization of a patient's autonomy, hence of their rational capacity to consider medical information and make a resulting decision. Even as the very process of consenting to the procedure unavoidably curtailed the patient's bodily integrity and autonomy, the act of consenting was understood as an extension and an enactment of the patient's inherent autonomy.

2.4.4 Autonomy v. Beneficence?

And yet, these efforts were primarily instituted by "external" stakeholders, such as lawyers, judges, and medical ethicists (Katz, 2002; Pellegrino, 1994; Rothman, 1991). Most physicians were adamantly opposed to this since they continued to believe that patients lacked the composure, knowledge, and experience to make informed, rational decisions. Like their predecessors, physicians in the 1960s and 1970s were concerned that disclosing a procedure's risks would deter patients from necessary medical procedures, with deleterious consequences. Despite the courts' articulation of the informed consent doctrine, it still took years before consent seeking practices that promoted patients' autonomy were more uniformly instituted across medical practice. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982) found that only 14% of polled physicians reported mentioning treatment alternatives and only 9% thought of consent practices as materializing the patient's decisional freedom. It appears that the 59% of physicians who did "generally" inform patients about conditions and treatment and the 47% who disclosed risks did so for concerns beyond the patient's autonomy.

And autonomy is a notoriously ambiguous, protean, and deeply theoretical ethical principle that is hard to protect and materialize, in practice. This is where it is important to distinguish the doctrine's ethical and theoretical framework and articulation from its legal implementation (Faden & Beauchamp, 1986). Indeed, a common critique is that, despite its theoretical aspirations, patients have few legal recourses unless they experience tangible, quantifiable, physical harm as a result of being misinformed or uninformed (Kurtz, 2000). There are no legal remedies for situations in which a patient's consent is vitiated but they do not experience any ill-effects from incomplete or neglectful informational processes. Legal scholar Mary Donnelly (2011) further argues that there are instances in which courts have been unwilling to recognize a patient's consent as a materialization of their autonomy, as in cases of physician-assisted suicide or when patients request to have a healthy limb amputated. Donnelly (2011) thus concludes that "in practical terms, the most prominent consequence of the right of autonomy in respect of healthcare decision-making has been the legal recognition of a right to refuse treatment" (p. 53).

Even the cases previously discussed, largely lauded for originating the patient's self-determination right, are fraught with exceptions and normative legal definitions that inherently curtail patients' autonomy. The cases were tried as negligence and not battery, which "allowed judges to defer gracefully to medical judgment" while placing "additional burdens on patients by requiring proof that they would have refused the proposed treatment if they had been fully informed" (Katz, 2002, p. 69). These earlier cases further deferred to medical judgment in discerning the scope of relevant information, despite their diametrically opposed imposition that doctors disclose all relevant information. But even as the *Canterbury* decision sought to recalibrate this power asymmetry, it subscribed to the normative "reasonable patient" standard. Physicians were not compelled to consider the idiosyncratic informational preferences of individual patients since doing so would "make an undue demand upon medical practitioners" (*Canterbury v. Spence*, 1972). They needed, instead, to conjure the image of a "reasonable" patient who, by definition, prioritized their physical wellbeing and health over other nonmedical, ideological beliefs. In the name of some seemingly objective measure of "reasonableness", medical paternalism and physicians' subjective priorities were repackaged under the normative prescription to disclose what a reasonable, rational patient would consider material information.

But even the ethical and theoretical articulations of the doctrine lend itself to normative understanding of what constitutes self-determination. The National Research Act, enacted on July 12th, 1974, instituted the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) that was tasked with identifying "the basic ethical principles that should underlie the conduct of biomedical and behavioral research". They identified three principles in the Belmont Report based on a four-day retreat at the Belmont Conference Center: "respect for person", "beneficence", and "justice". "Respect for persons" presumed two ethical convictions. First "that individuals be treated as autonomous agents" and, second, that those deemed incompetent still receive protection. It defined an autonomous individual as being "capable of deliberation about personal goals and acting under the direction of such deliberation". To thus respect someone's autonomy entailed giving "weight to autonomous persons' considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others". Ruth R. Faden and Tom L. Beauchamp (1986), who penned the seminal *A History and Theory of Informed Consent*, similarly defined autonomy as "external nonconstraints and the presence of critical internal capacities integral to self-governance" (p. 8).[19] Patient autonomy thus necessitated a sphere of noninterference, protected from paternalism, and the "critical internal capacities" with which to self-govern.

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[19] Tom Beauchamp, a philosopher, joined the Commission after the four-day retreat and was tasked with writing the Belmont Report. Beauchamp (2004) later reported for the Belmont Oral History Project that: "what I wish the Commissioners had done is to keep the differences between the tree principles straighter than they did. In particular, I thought the first principle – the principle of respect for persons – was a kind of mishmash of considerations of beneficence and non-maleficence rolled into respect for persons (…)".

Being autonomous, hence free from external encroachment, was inseparable from the capacity "of deliberation". In fact, the latter engendered the former. Espousing a Kantian definition of autonomy, patients act autonomously when subsuming their temporary, fleeting desires in favor of their rationally identified interests (Denbow, 2015). Rationality and ensuing decisional capacity both presume and legitimize autonomy. As such, the very notion of autonomy lends itself to a specific understanding of freedom and liberty, with an inherently prescriptive precept that compels individuals to make rational choices. Only those with requisite decisional capacity can be free from governmental oversight and regulation.

The doctrine's emphasis on autonomy as a type of rational self-rule is best exemplified and reified through its capacity requirement. To this day, scholars debate how to evaluate patients' capacity and how to grapple with patients deemed decisionally incompetent (O'Neill & Manson, 2008). This uncertainty and ambiguity points to the fact that distinguishing decisional capacity from incompetence is a deeply normative process of evaluation, which ultimately categorizes people into groups with the requisite capacity as opposed to those who necessitate surrogate decision-makers (Donnelly, 2011). Autonomy, accordingly, can be an inherently exclusionary right only accorded to those deemed to have the rationality, reason, and restraint to make informed medical decisions unencumbered by "mere desires" (O'Regan, 2020).

A Presidential Commission was instituted in 1981 at the behest of a Congressional mandate to study "the ethical and legal implications of the requirements of the informed consent to (…) undergo medical procedures". The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research (1982) sought to move beyond informed consent case law to reconceptualize the decisional process as a shared one between physician and patient guided by two central values: "promotion of a patient's well-being and respect for a patient’s self-determination” (p. 41). It decried the “caricatures” of the models of “medical paternalism” and “patient sovereignty”, whereby both positions attempted to “vest exclusive moral agency, ethical wisdom, and decision-making authority on one side of the relationship, while assigning the other side a dependent role” (President’s Commission, 1982, p. 36). Instead, beneficence and autonomy needed to stand side-by-side in pursuit of the “high ideal” of “mutual participation and shared decision-making” (p. 39).

In pursuit of this goal, the Commission articulated more explicit and nuanced definitions of beneficence and self-determination than both case law and the Belmont Report had. It recognized “health” as an ambiguous, protean, and ultimately deeply personal notion that may, very well, be supplanted by other goals, as in the case of “hang-glider enthusiasts who risk life and limb” (President’s Commission, 1982, p. 43). Given the lack of objective medical criteria in many situations and patients’ subjective preferences, an individual patient’s well-being could often only be ascertained through individual judgment, which was best left to “the person involved” as is the case in “societies that respect personal freedom”. The Commission (1982) additionally relied on Isaiah Berlin’s *Two concepts of liberty* to define patient’s self-determination as both “a shield and a sword” (p. 45). The former ensured that patients were protected from excessive paternalism or external encroachment, while the latter ensured “creative self-agency”, whereby individuals could create “their own character” and take “responsibility for the kind of person they are” (p. 46). In this framing, self-determination had intrinsic value beyond its potential to improve a patient’s prognosis who felt agency over their treatment. The Commission’s espousal of patient well-being and autonomy seemed to transcend the *Canterbury*’s espousal of the normative “reasonable patient” standard and the Belmont Report’s notion of autonomy that centered so strongly on autonomy as rational self-regulation.

But before a reader could too quickly deduce that a patient's well-being and self-determination were largely synonymous and tantamount, the Committee undertook two rhetorical steps that seemed to foreground beneficence. Of course, self-determination could be curtailed in light of public health concerns. But it could further be restricted if the individual's immediate decisions were incongruent with "their own values or goals" (President's Commission, 1982, p. 48). In other words, the Commission echoed the notion of self-determination as self-regulation, whereby the individual curbs impulsive and instinctive desires in favor of their rationally determined best-interest. Patient self-determination was divided into two levels or manifestations: when acting as their own, immediate decisionmaker and when "securing (…) their own goals". When these two were misaligned, and a patient's immediate decisions threatened their goals, "overriding an individual decision is usually justified on the ground of promotion of well-being rather than of respect for self-choice" (p. 48). Without any further deliberation or explanation, well-being had replaced and usurped the patient's decisions, thereby promoting health as the ultimate value and rendering an individual's values and well-being synonymous. Medical decisions could be curtailed in the name of beneficence since the patient's well-being was presumed to be the ultimate motivation and expression of self-determination.

In fact, the Commission (1982) explicitly articulated and acknowledged patient self-determination as inescapably operating within the confines of beneficence. These were, after all, medical decisions that were inherently made in hopes of "helping patients and avoiding harm":

> Thus, the well-being principle circumscribes the range of alternatives offered to patients: informed consent does not mean that patients can insist upon anything that they might want. Rather, it is a choice among medically accepted and

> available options, all of which are believed to have some possibility of promoting the patient's welfare (…). In sum, promotion of patient well-being provides the primary warrant for health care (President's Commission, 1982, p. 43).

Within an always confined sphere of possibilities, patients had the autonomy to make one choice amongst others. Patient autonomy was, by definition, inseparable and ultimately secondary to their well-being even as the Commission was set on treating them as tantamount. To be sure, medical decision-making was reconfigured and democratized in ways that sought to interject the patient's preferences and choices throughout the decisional process. But this was patient autonomy, perpetually defined by the field's commitment to beneficence, and not some wider notion of individual self-determination.

Ultimately, the informed consent doctrine emerged at a moment when marginalized communities were making rights-based claims to receive further legal recognition and protection (Faden & Beauchamp, 1986; Katz, 2002; Pellegrino, 1993, 1994; Rothman, 1991). It was, in many ways, a product of its time and of what Paul Starr (1982) termed the "generalization of rights" in its attempt to recalibrate and democratize medical decision-making so that patients' preferences, values, and ultimately autonomy received more consideration and protection.
The informed consent doctrine, as an encapsulation of newly articulated patient rights, channeled and mitigated concerns shared across social movement against authoritative institutions. So "just when courts were defining an expanded privacy right, the bioethicists were emphasizing the principle of autonomy (Rothman, 1991, p. 245). But patient autonomy, at best, complemented physicians' beneficent concern for their patients' well-being and health. Patient autonomy, as articulated by case law and ethical principles, emerged as a distinct and particular iteration of

self-determination that protected and effectuated patients' choices within the medical profession's larger commitments to beneficence.

2.5 Conclusion

This chapter is, in many ways, a synopsis of the state of medical decision-making from the mid-19th century through the early 1970s and the ways in which the State has, at times, deferred almost all decision-making to physicians and, at others, sought to regulate decisional processes that redistributed some agency to patients. Physicians' monopoly and their largely unbridled authority and discretion, which resulted from their successful professionalization quest, got questioned and incrementally reconfigured leading into the *Roe v. Wade* decision in 1973. And abortion has been a site across which different anxieties and competing claims about the scope of medical authority have been repeatedly contested, negotiated, and legitimized. Starting in the mid to late-1800s, doctors discredited quickening as the moment when fetal life started and reconceptualized it as one gestational stage amongst many. In this framing, physicians sought to protect fetal life from ignorant or murderous women and abortion providers. By the turn of the century, physicians had successfully professionalized their field and had gained complete authority and discretion over the abortion decision. This discretion was both internally and externally threatened in the mid-20th century and a constituency of physicians sought to expand the scope of therapeutic abortions in an attempt to legalize the procedures they had been providing for decades.

The women's movement usurped these early reform efforts as they attempted to repeal abortion laws. Abortion, according to feminists, was not just a medical procedure but an emancipatory technology and, as such, as fundamental right. The women's movement advocated for abortion “on demand”, unencumbered by the state oversight and encroachment, with physicians acting as technicians there to effectuate their abortion decision.

This contest over who was the foremost and rightful abortion decision-maker mimicked larger fissures within the medical field starting in the 1960s and 1970s. Atrocious medical abuses had maimed, paralyzed, and even murdered unwilling or ignorant research participants in the name of medical progress. Courts became simultaneously concerned with decades of medical paternalism, whereby physicians’ beneficent commitments had completely eclipsed patients’ autonomy. To whatever extent consent seeking practices did occur before World War II, it was likely in hopes of improving patient prognosis and compliance, and not in hopes of enacting patients’ self-determination.

The informed consent doctrine was first articulated as such in 1957 and was incrementally expanded until the early 1970s. Patients acquired the right of refusal and, ultimately, the right to refuse treatment even when contraindicated. In all these moments, even if implicitly, courts presumed that information engendered rational and voluntary consent which, in turn, materialized patients’ self-determination. The doctrine thus sought to recalibrate and mitigate the inherent power asymmetry that had dictated patient-physician relationships by redistributing (some) decisional authority to patients.

And yet, the doctrine, both in its legal application and theoretical framing, was never quite able to clearly prioritize patient autonomy over physicians’ paternalism. Patient autonomy has never quite superseded their well-being. The very fact of being a patient means, by definition, that individuals are first and foremost treated, medically and legally, in light of their health. Within this constraint, the informed consent doctrine is then meant to promote their autonomy. This means that, in practice, it has proven largely impossible to promote patients’ autonomy and the law has only intervened to protect patients' refusal right and to protect them, retroactively, in cases of quantifiable and tangible physical harm. And the very notion of autonomy, and its reliance upon normative understandings of rationality and capacity, presumes a narrow understanding of self-determination as medical self-regulation. Patients can only difficulty make potentially irrational, irresponsible, contraindicated medical decisions that may nonetheless align with their idiosyncratic and ideological proclivities.

The abortion procedure embodies a particular fraught and contested position within medicine. It can be, even if increasingly rarely, a medical treatment that can save pregnant people from debilitating, if not deadly, consequences. It is, as of now, a procedure that can only be provided or effectuated by healthcare workers. And yet, it is simultaneously a procedure with much broader societal implications. It can materialize and enable pregnant people's freedom to live a life unencumbered by the inescapable and pervasive consequences of an unplanned pregnancy and of compulsory parenthood. Abortion's liminal position, as both emancipatory technology and medical procedure, means that abortion patients have found themselves in a fraught position where their (reproductive) freedom is delineated by abortion's status as a medical procedure continent upon physicians' willingness to effectuate it. As we will see in the following chapter, the professional anxieties to safeguard medical discretion from governmental regulation and patients' demands that plagued much of abortion's history and medicine's recent history in the 1960s and 1970s continued to circumscribe early abortion jurisprudence.

CHAPTER 3

The Informed Consent Doctrine in Early Abortion Jurisprudence: Reconfiguring the Privacy Right and Shepherding the Abortion Decision

In 1992, under *Planned Parenthood v. Casey*, the Supreme Court upheld an informed consent requirement on the basis that:

> (…) we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.

The decision has since been widely decried for instituting scientifically dubious and ideologically driven informational requirements, thereby wedging the State's "preference for childbirth" between the otherwise protected physician-patient relationship. For some scholars, *Casey* was a watershed moment that wrote into legal precedent the anti-choice movement's strategy of weaponizing the informed consent doctrine (Manian, 2009; Saurette & Gordon, 2015; Tobin 2008). In this framing, *Roe v. Wade* (1973) sits on one end of the spectrum, for largely recognizing women as autonomous and agentive decision makers, and *Casey*, by treating women as ignorant, sits on the other end. And, ultimately, *Casey* gave way to *Gonzalez v. Carhart* (2007), in which the Court proscribed a later-term, occasionally safer, abortion procedure based on the unsubstantiated claim that "some women come to regret their choice to abort the infant life they once created and sustained".

The overall project is concerned with examining the "abortion regret" discourse, popularized under *Gonzalez*, and the concomitant use of the informed consent doctrine to incrementally curtail abortion access. I argue, in my fourth chapter, that the "abortion regret" discourse produced motherhood as the rational and retroactive choice, despite women's abortion decisions. This discourse emerged in a larger context in which women had genuine reproductive choices, but these choices were perpetually prone to external scrutiny. And the informed consent doctrine, in its conceptualization and implementation, is meant to promote and protect patient autonomy. Put differently, this strategy presumes and (nominally) upholds pregnant people's choices and autonomy, all while mobilizing these to paradoxically curtail access to a reproductive technology that materializes women's freedom. I wanted to understand how the anti-choice movement was so effective at deploying discourses that emerged out of pro-abortion efforts and victories. This chapter is thus concerned with analyzing early abortion jurisprudence, with a particular focus on *Roe v. Wade* (1973), *Doe v. Bolton* (1973), and *Planned Parenthood of Central Missouri v. Danforth* (1973), all cases that instituted or protected abortion rights. While I will conclude by examining some anti-choice victories in the late 1970s-early 1980s, these do not allow me to explore the medicolegal discourses first adopted in abortion victories that would later make their way into anti-choice tactics. Put differently, I analyze early jurisprudence's conceptualization and reconfiguration of the abortion right to better understand how these discourses were so seamlessly internalized into incredibly successful anti-choice efforts.

In this chapter, I argue that the Court, even in the cases that instituted and protected abortion rights, articulated a restricted understanding of privacy that first legitimized medical paternalism and oversight over women's abortion decisions and then used the informed consent doctrine, as a proxy for the State's interest in women's abortion decision, to formalize women's decisional processes. In all these moments, physicians' authority and other medicolegal mechanisms were used to forestall "abortion on demand". In other words, I argue that *Casey*, and ensuing anti-choice judicial and legislative efforts that mobilized the informed consent doctrine to curtail abortion access, are not a departure from *Roe* but its culmination and logical conclusion.

The first section will trace the conflicting claims made by *amicus* briefs to demonstrate the various stakeholders' requests over who ought to have authority over the abortion decision. Abortion, going into the *Roe* decision, was a site across which different anxieties about the medical profession and women's shifting roles in society were negotiated. Echoing feminist legal scholars, I will then argue in the second section that *Roe*'s first-trimester privacy right was always a restricted one, to be shared between patients and their physicians. While women had a right to privacy, it was free from state encroachment but not from medical paternalism. Women were imagined as making their abortion decision in consultation with their physician, who was tasked with considering the circumstances of their lives to determine the procedure's necessity. The abortion decision was a medical decision, with its attendant commitments to well-being and health. The decision instituted a privacy right that was circumscribed by the medical profession's commitment to beneficence. This form of privacy, freed from state infringement but subject to medical paternalism, was contingent upon the Court's image of a good and compassionate physician who acted as a consultant, if not therapist, in guiding the woman's decisional process. And the informed consent doctrine, as conceptualized by the American Medical Association and by the Court, served partially as a mechanism to protect physicians from becoming mere technicians who acquiesced to women's abortion demands. The fact that, in practice, women could access abortion largely "on demand" during the first trimester, thereby reflecting a gap between the Court's prescriptions and actual medical practice, delineated much of the anti-choice's immediate and future strategy. I will further argue, in the third section, that the Court instituted an atypical informed consent requirement, under *Planned Parenthood v. Danforth*

(1976) in an attempt to materialize the physician's consultative role. The Court's conceptualization of the informed consent doctrine shifted accordingly in ways that reconfigured *Roe*'s first-trimester privacy right and replaced medical paternalism with state paternalism. I will conclude by examining abortion cases in which the Court argued that the abortion right did not translate into the State's responsibility for materializing access to the protected right. These funding cases coalesced with previous abortion jurisprudence to more broadly create a context in which abortion patients were encouraged to make the "right" abortion decision and were punished when acting "irresponsibly".

3.1 The Two Sides of Privacy

Since much of the chapter is concerned with tracing how the Supreme Court first conceptualized and then repeatedly reconfigured pregnant women's privacy right, I want to briefly define two different, though deeply interrelated, implications of the privacy right. Lawyer Rhonda Copelon (1990) distinguishes the "negative character and the positive potential of the privacy right" (p. 28).[20] Privacy's "negative character" is a potential result of what Isaiah Berlin (1969) defines as negative liberty, which is the right to be left alone. Within an ambiguous, contested, and ever-shifting arena of self-regarding acts, individuals have the right to engage in the world unrestrained by others and by the government. So long as one's acts do not infringe upon another's freedom or harm another, advocates of negative liberty argue that individuals ought to be left to their own devices. Feminist legal scholars and reproductive justice scholars have critiqued this iteration of privacy since it ignores larger systems of oppression and delegates responsibility for their causes and solutions to individuals (Copelon, 1990; MacKinnon, 1996;

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[20] While similar, Copelon's two characterizations of the privacy right are not to be confused with Isaiah Berlin's (1969) notion of negative and positive liberty. While the former, for Berlin, is often associated with privacy and refers to a sphere of governmental non-interference, the latter refers to individuals desire for self-governance. Copelon is concerned with further distinguishing different iterations and consequences of the privacy right.

Roberts, 1997; Solinger, 2001). Government neutrality thus translates into what historian Sara Matthiesen (2021) has termed state neglect: individualizing discourses of privacy and choice, which compel individuals to bear full responsibility for their decisions, absolve the state from having to rectify and mitigate oppressive circumstances, effectively creating a larger context of latent, inescapable, and harmful neglect.

And yet, privacy cannot be so quickly dismissed since, in its "positive potential", it enables and materializes individuals' self-determination. When left to their own devices and freed from potentially tyrannical governmental oversight and societal impositions, individuals can pursue the trajectories of their lives as they most authentically desire to. And this sphere of noninterference ought to protect individuals' freedom to make bad decisions, to make hasty and potentially irrational choices. John Stuart Mill (1979), in his concern for the tyranny of the majority, emphasized this sphere of noninterference in which individuals were to be freed from governmental, and even societal, encroachment. He further argued:

> His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right (Mill, 1979, p. 9).

Within this arena of self-regarding acts, individuals cannot be compelled to act differently, even if it would be in their best interest. And the strongest reason for noninterference is that when the public does interfere, "the odds are that it interferes wrongly and in the wrong place" (Mill, 1979, p.81). Individuals understand the circumstances of their lives and know themselves better than anyone else could, thereby making any form of paternalism, irrespective of its good intent, likely futile if not deleterious.

And I hope to demonstrate, throughout this chapter, that the Supreme Court never imagined or articulated a first-trimester privacy right in which abortion patients were completely free from governmental and medical oversight, whereby they would have been allowed, in completely isolation, to make their own, potentially fraught or mistaken, abortion decision. The privacy right, as imagined by the Court, was a medical one that was circumscribed by physicians' authority and commitment to beneficence. And I think it is important to distinguish the abortion decision from pregnant women's decisional processes, or what Carol Sanger (2008) terms the "deliberative path". Grounding herself in John Locke's work, Sanger argues that the decisional process or path whereby we come to choose one particular alternative, as opposed to another, needs the same recognition and protection as the choice in and of itself. As it relates our voting rights, for example, we not only have the right to vote for our preferred candidate, but the process we undergo to determine which candidate to vote for is similarly protected. To infringe upon and circumscribe the decisional process, while upholding "women's right to choose", ultimately reconfigures what it means to have a right to privacy, hence a right to abortion.

3.2 Therapeutic Abortions or Abortion on Demand?

As I discussed in the previous chapter, since the AMA's professionalization quest in the mid-19th century, there has consistently been a dispute over who ought to have authority over the abortion decision. *Roe* was no exception. Reflecting larger legislative and professional efforts, medical organizations sought to safeguard physicians' authority over determining what constituted a therapeutic, hence legal, abortion. In contrast, the *amicus* briefs filed by women's organizations and Sarah C. Weddington's oral arguments largely reflect efforts to frame abortions as a potentially emancipatory technology over which the pregnant woman, alone, ought to have the discretion to decide if, when, and how to undergo an abortion.

In a brief filed on behalf of the American College of Obstetricians and Gynecologists (ACOG), the American Psychiatric Association (APA), and some of the most noteworthy and influential physicians and department heads, the *amici curiae* stated that:

> *Amici* believe that the restrictions imposed by the Texas statute on the performance of medically indicated therapeutic abortions interfere with the physician-patient relationship and with the ability of physicians to practice medicine in accordance with the highest professional standards. *Amici* are also concerned with the burden the law places on physicians to interpret, at their peril, a statute whose meaning and scope are not clear (*Roe v. Wade*, 1973).

The brief articulated three interests that the medical organizations were concerned with protecting: 1) the physician-patient relationship, 2) the physicians' ability "to practice medicine in accordance with the highest professional standards", and by extension, 3) the legal "perils" of potentially misinterpreting an ambiguous and contested statute. In effect, *amici* wanted to safeguard medical authority from judicial and legislative oversight. They were not vested in expanding the scope of permissible abortions that would, in turn expand women's (reproductive) freedom, but just in legalizing "medically indicated therapeutic abortions". The very redundancy of "medically indicated" and "therapeutic" speaks to the concomitant, though more latent, interest of keeping at bay a world in which physicians simply effectuated patients' demand for nontherapeutic abortions.

The APA Board of Trustees' Statement on Abortion more explicitly addressed the professional commitments and attempts to carve out an additional, yet complementary, sphere of expertise that would appraise women's abortion demands and keep "abortion on demand" at bay:

> A medical decision to perform an abortion is based on the careful and informed judgments of the physician and the patient. Among other factors to be considered in arriving at the decision is the motivation of

> the patient. Often psychiatric consultation can help clarify motivational problems and thereby contribute to the patient's welfare (*Roe v. Wade*, 1973).

The need to "clarify motivational problems" worked to pathologize women's motivations as being potentially irrational, abnormal, or concerning, while simultaneously producing women as incapable of discerning the complexity of their own motivations. The psychiatrist was thereby centered as the additional expert needed to elucidate and unravel these motivations and determine which are aligned with the patient's well-being from those that would threaten it. Put differently, this presumed that some abortion demands, and hence abortion procedures, were based on legitimate and necessary motivations, while others were unnecessary, ill-informed, and potentially harmful. Overall, both professional statements demonstrated not only an attempt to forestall governmental regulation, but further illustrated the professions' efforts to restabilize physicians' authority in the face of feminists' demands for abortion on demand. In this framing, physicians and psychiatrists were almost exclusively those who could be entrusted with the abortion decision, since neither the government nor pregnant women had the medical or psychiatric expertise with which to determine which abortions would be necessary and which would be contraindicated.

This medicalized framing of abortion access is quite striking when contrasted with the emancipatory claims made by feminists, which made their way into Sarah R. Weddington's oral arguments and into the *amicus* brief filed on behalf of women's organizations, such the American Association of University Women, the National Board of the Young Women's Christian Association, and the National Organization for Women (NOW). According to the brief, the abortion right ought to be considered so fundamental and so central to a woman's equality as to almost precede other civil rights, such as parents' right to choose their children's educational path, the right to choose one's marriage partner, or the birth control right. Abortion was thus "a woman's right, as part of the most elementary concepts of human freedom, dignity and equality, to determine the time when and the circumstances under which she will bear children" (*Roe v. Wade*, 1973). Weddington's oral arguments echoed the claim that an unwanted pregnancy had such encroaching and inescapable consequences as to rob women of their ability to participate as productive members of society.[21] During the oral arguments on December 13th, 1971, she highlighted the far-reaching implications of an unwanted pregnancy, which explained why women ought to have the choice what to do with the pregnancy:

> So, a pregnancy to a woman is perhaps one of the most determinative aspects of her life. It disrupts her body. It disrupts her education. It disrupts her employment. And it often disrupts her entire family life. And we feel that, because of the impact on the woman, this certainly and as far as there are any rights which are fundamental is a matter which is of such fundamental and basic concern to the woman involved that she should be allowed to make the choice as to whether to continue or to terminate her pregnancy (*Roe v. Wade*, 1973).

As she further detailed, high school students were compelled to drop out and employed pregnant women were regularly forced to quit their jobs without access to maternity leave, unemployment, welfare, or disability. Since employers did not have to rehire mothers, women found themselves robbed of most opportunities to earn money, could not rely on state support, and were effectively entirely dependent on a husband, if married. An unwanted pregnancy could thus fundamentally upend a woman's educational or professional path, perpetually forcing her into financial dependence. Weddington thus defined compulsory motherhood as an "irreparable injury" that could not be "compensated by some sort of monetary reward". This was not the type of

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[21] Weddington was a 26-year-old graduate from the University of Texas School of Law in Austin who had never tried a case before (Seelye, 2021). Some of her friends were actively referring university students to illegal abortionists. Concerned they could be prosecuted as accomplices, they asked Weddington to investigate the matter further. She reached out to Linda Coffee, who later became her co-counsel during the *Roe* trial.

physiological and psychological harm Justice Blackmun would later enumerate in the *Roe* decision. This was a form of harm that limited women's ability to participate freely and equally as productive members of society capable of financial independence. Abortion was not exclusively a medical procedure but a liberatory technology necessary for women's independence and equality.

In light of this, Weddington, even if implicitly, advocated for unrestricted abortion access. The premise of the appellee's case, represented first by Jay Floyd and then by Texas Assistant Attorney General Robert C. Flowers, rested on the claim that the State had an interest in fetal life, an issue that the Justices repeatedly pressed Weddington about. When asked whether she would lose the case if the fetus was a person, she responded instead that it would, only then, necessitate "a balancing of interest" (*Roe v. Wade,* 1973). But since the State had neither demonstrated any compelling interests nor proved that life started at conception, there were no interests to balance and no reason to curtail women's liberty.

During oral re-arguments on October 11th, 1972, the Justices further inquired about the scope of abortion access. Since there existed no legal precedent recognizing the fetus as a person and given the inescapable and extraordinary consequences of motherhood, Weddington argued that there was no "indication to show that the constitution would give any protection prior to birth" (*Roe v. Wade*, 1973). Despite her best efforts to sidestep the question of fetal life and personhood, it was clear that she was ultimately advocating for abortion access at any gestational stage. Any time restrictions were "overly broad". Justice Blackmun concluded the re-arguments by inquiring: "I take it from your recent remarks that you are urging upon us abortion on demand that the woman alone [decides], not in conjunction with her physician". Ultimately, Weddington acknowledged that the physician had a right to refuse providing an abortion, in much the same way that a woman ought to have the right to undergo an abortion unrestrained by "the first doctor a woman goes to". While she acknowledged physicians' right to refuse treatment, she simultaneously underscored the necessity for women to be free to procure an abortion, irrespective of a physician's personal proclivities and beliefs. In this view, physicians were needed to effectuate the procedure, if they so wished, but could not restrict women's abortion access.

To briefly recapitulate, the oral arguments and *amicus* briefs represent the dispute between physicians advocating for repeal and feminists' requests for unrestricted abortion access. The former conceptualized almost exclusively of abortion as a medical treatment whose necessity was to be determined by the woman's physician and psychiatrist. The *amicus* brief filed on behalf of ACOG and the APA paint a picture of professional organizations primarily concerned with retaining professional discretion and authority over the procedure, only acknowledging women as patients with limited ability to evaluate the impact of their motivations on their own well-being. To the contrary, feminists defined abortion as an emancipatory tool, necessary for women's liberation and equality. Without abortion, women would be perpetually relegated to second-status citizenship, forced to depend on men for financial stability and survival. In light of this, women ought to have unchallenged decisional freedom over their reproductive processes, unobstructed by the State's interest in fetal life and unrestrained by physicians' judgment. While these various stakeholders ultimately all advocated for (a degree of) decriminalization, they disagreed over who the rightful and foremost decision-maker ought to be.

3.3 The *Roe* Decision and its Limitations

Briefly, *Roe v. Wade* (1973) held that the Texas criminal abortion laws violated the Due Process Clause of the 14th Amendment, "which protects against state action the right to privacy, including a woman's qualified right to terminate her pregnancy". Since pregnant women's privacy right was a restricted and qualified one, according to the Court, Justice Blackmun developed the trimester framework in an attempt to balance women's rights and the State's interest in women's health and fetal life. Throughout the first trimester, when the procedure was "relatively safe" and "mortality rates were (...) as low or lower than rates of normal childbirth", "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician". As the pregnancy developed, "the risk to the woman increases". The State "retains a definite interest in protecting the woman's own health and safety" and states were able to regulate abortion providers and clinics accordingly. Finally, following viability, states were allowed to regulate "and even proscribe abortion except where necessary in appropriate medical judgement for preservation of life or health of mother".

According to feminist legal scholars, *Roe* was largely a work of erasure. It obscured the gendered and nativist nature of the 19th Century AMA's professionalization quest to criminalize abortion by focusing its historical account exclusively on the AMA's perceptions around fetal life (Ehrlich, 2018). By adopting the Due Process Clause, as opposed to the Equal Protection Clause, it further erased feminist claims about abortion's emancipatory potential (Ginsburg, 1985, 1992; Greenhouse, 2008; Siegel, 2010).[22] Not only did the decision obscure the feminist claims that made their way into the oral arguments and *amicus* briefs, but it also preemptively erased the ways in which a sex equality analysis elucidated the relationship between women's

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[22] Both Reva Siegel (2010) and Linda Greenhouse (2008) have delineated the political and legal variables that may explain why the Court did not reach for "sex equality as the normative basis for abortion rights" (Siegel, 2010, p. 1900). Of course, the Court's deference to medical authority, as articulated by Justice Blackmun himself, was an attempt to overcome the issue's contentious nature and use medicine's veil of objectivity and neutrality. The privacy argument had, additionally, been mobilized by feminists in an attempt to disassociate the abortion debate from attempts to ratify the Equal Rights Amendment (ERA) (Siegel, 2010). Ruth Bader Ginsburg argued that the decision should have nonetheless been decided on sex equality grounds (Ehrlich, 2018; Ginsburg, 1985, 1992; Greenhouse, 2008; Siegel, 2010).

subordination and their (lack of) reproductive freedom.[23] Some scholars have further argued that the privacy right, as conceptualized and mobilized by the Court, inherently reinscribed traditional gender norms because it ensured governmental noninterference instead of explicitly articulating and protecting women's right to self-determination, bodily integrity, and individualism. In other words, the decision ensured that women could make the first-trimester decision to terminate a pregnancy unencumbered by the state interference, but it did not elucidate and articulate the relationship between reproductive control and liberation. Taking it a step further, Catharine A. MacKinnon (1996) argued that abortion, in a larger context of gender inequality in which women do not have control over their sexuality, further "facilitates women's heterosexual availability" (p. 990). By obscuring the sexual and material circumstances under which women have unwanted pregnancies, the notion of privacy perpetuates and upholds women's subordination (Copelon, 1990; MacKinnon, 1996). Privacy, in this framing, does "not require social change", it reifies systems of domination and suppression under the guise of freedom.

Other scholars have further argued that it was the patient-physician relationship that was protected under *Roe*'s conceptualization of the privacy right. In some readings, the *Roe* decision could be interpreted more "as a doctor's bill or rights than (…) a feminist manifesto" (Greenhouse, 2008, p. 42), whose "insulation of medicine does not support the progressive cause, but the conservative one" (Ahmed, 2015, p. 110) that "catalyzed the most massive politicization of medicine in American history" (Hunter, 2006, p. 196) because it "occurred at the precise moment when the authority of medicine was itself under challenge" (Hunter, 2006, p.

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[23] It was not until Ruth Bader Ginsburg's dissent in *Gonzalez v. Carhart* (2007) that Ginsburg was able to articulate the relationship between abortion access and women's self-determination and freedom. This concerned anti-choice activists who thought that her dissent could become the basis for an ensuing abortion victory that enshrined the abortion right in a sex equality framework, thereby forcing the anti-choice movement to grapple with questions of women's equality and liberation (Siegel, 2010).

195). Not only did the decision, in its technical detail yet theoretical ambiguity, delineate the very language and rationales with which to curtail abortion access (Appleton, 1985; Ginsburg, 1985), it deferred judicial oversight to physicians.[24] This had two important ramifications: first, physicians were "injected (…) into the most intimate details that weigh in the woman's deliberation whether to terminate her pregnancy" (Appleton, 1986, p. 198), thereby entrusting physicians with "decisions which required normative rather than scientific judgements, under a mask of professional expertise" (Hunter, 2006, p. 197). Second, this meant that abortion access was always "vulnerable to erosion and attack, from within and without the medical community" (Asaro, 1983, p. 61). "Conscience clauses", for example, protect physicians who are unwilling to provide abortions for moral or ideological reasons.[25] And, of course, the trimester framework meant that abortion access would always be contingent upon the current state of medical affairs. States' ability to further regulate and even proscribe abortions were determined by the ambiguous and perpetually changing moment of viability. Foreshadowing her opinion in

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[24] Ruth Bader Ginsburg (1985) argued that the decision's trimester framework "stimulated the mobilization of a right-to-life movement and an attendant reaction in Congress and state legislatures" (p. 381). Indeed, the *Roe* decision wrote into precedent the very ways in which states could restrict abortions, thereby effectively compelling states to legitimize and enact restrictions under the guise of medical regulation. This is precisely the gist of Targeted Regulation of Abortion Providers (TRAP) laws that compel physicians to have hospital admitting privileges and/or mandate that abortion clinics adhere by the standards set for ambulatory surgical centers (ASCs), such as installing hospital-grade ventilation systems, inspecting fire extinguishers monthly, or meeting larger spatial requirements for procedure rooms (Guttmacher Institute, 2020). All these measures are unnecessarily expensive and cumbersome when fewer than 0.5% of abortion patients necessitate hospitalization. At the same time, the Court's unwillingness to more explicitly delineate the relationship between (reproductive) privacy and women's equality and liberty meant that the decision did not "bar the sovereign, at least at the pre-viability stage of pregnancy from taking sides" (Ginsburg, 1985, p. 386).

[25] Conscience clause laws enable healthcare workers to refuse services because of moral or religious objections. While these laws have since been greatly expanded as to protect all healthcare workers and other medical interventions, such as genetic counseling, infertility treatment, or STI testing, the original purpose was to protect physicians who refused to provide abortions and sterilizations on religious grounds (Feder, 2006). These legislative efforts first started after the *Roe* decision when the Church Amendment was enacted later in 1973, which proscribed public officials from requiring that entities receiving public finds perform abortions or sterilizations if contrary to their religious beliefs or convictions. By 1978, almost all states had enacted some version of conscience clause laws. The Trump administration further expanded religious refusal laws in 2019 that protected anyone, from a receptionist to a hospital board member, for refusing to facilitate or provide medical care they were religiously opposed to (Sanger-Katz, 2019). Healthcare workers are not only protected when refusing to provide services, but even when refusing to refer patients elsewhere.

Planned Parenthood v. Casey (1992), Justice Sandra Day O'Connor condemned *Roe*'s trimester framework for inextricably tying abortion access to current medical technology:

> As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health are moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception (…). The *Roe* framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues. (…) the Court's framework forces legislatures (…) to speculate about what constitutes "acceptable medical practice" at any given time. Without the necessary expertise or ability, courts must then pretend to act as science review boards and examine those legislative judgments (*City of Akron v. Akron Center for Reproductive Health, Inc.*, 1983).

Justice O'Connor was famously opposed to abortion rights and was responsible for penning the *Casey* decision that overturned the trimester framework in favor of the notoriously ambiguous undue burden framework. Even so, her critique was shared amongst abortion rights scholars who were concerned with the Court's deference to medical judgment, technology, and innovation. First, as Justice O'Connor points out, abortion access was perpetually vulnerable to change according to current medical standards. Second, the judiciary was responsible for upholding physicians' discretion. Physicians' authority was relatively unrestricted under the trimester framework, while forever contingent upon courts' willingness to recognize and uphold it as such. Finally, it compelled the judiciary to evaluate evidence and testimonies by medical organizations and rule accordingly, pretending "to act as science review boards". I expand upon this literature and focus on *Roe*'s first-trimester privacy right and how it was conceptualized, reconfigured, and ultimately restricted.

3.4 The *Roe* Decision: The Second Wave of Medicalization

The Court largely espoused ACOG and the APA's conceptualization of abortion primarily as a medical treatment against the potential physical and psychological harm of compulsory motherhood, thereby effacing feminist claims about the procedure's emancipatory potential. In this framing, abortion was primarily a medical *treatment* and not a medical procedure that materialized and facilitated women's equality and freedom. The issue to be resolved was the harm of an unwanted pregnancy, not the cultural, civil, societal, and economic ramifications of women's continued oppression:

> The detriment that the State would impose upon the pregnant woman by denying this choice is altogether apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by childcare. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors for the woman and her responsible physician necessarily will consider in consultation (*Roe v. Wade*, 1973).

I do want to acknowledge, in light of later cases that produced abortions as harmful, how important and revolutionary it was for the Court to recognize the risks of compulsory motherhood and give women the freedom, even if just implicitly, to engage in nonreproductive, potentially pleasurable, heterosexual sex. Justice Blackmun recognized the "specific and direct harm medically diagnosable", the "distressful life and future", the "psychological harm", and the potential "stigma" of compulsory (single) motherhood.[26] However, by focusing exclusively on physical and psychological harm, without additionally considering the consequences of

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[26] By some estimates, women were pregnant every other year before they had access to reliable and safe reproductive technologies with which to control their reproductive processes (Riessman, 2003). At the beginning of the 19th century, women gave birth to more than seven children, on average, with 5.8 of those surviving into childhood (Klepp, 2009), and even more pregnancies that ended in miscarriage or stillbirths (Leavitt, 1986). Historian Judith Walzer Leavitt (1986) found that most women throughout the 18th and 19th centuries, and even into the early 20th century, were acutely aware that "a possible death sentence came with every pregnancy" (p. 20), which forced them to reflect on their potentially impending mortality throughout their pregnancies. And even if they would not die during childbirth, "it could maim them for life (…) and force them to bed for the rest of their lives" (p. 28). The injurious, if not deadly, consequences of childbirth deeply defined women's experiences and much of their lives were vested towards anticipating and recuperating from childbirth.

compulsory motherhood on women's educational, professional, economic and political lives, the Court internalized the definition of abortion as a medical treatment over which physicians, and not pregnant women, had the foremost and rightful authority.

To be sure, *Roe* did inscribe the abortion right based on the privacy right as alluded to in the penumbra of the Bill of Rights. Even so, the Court also distinguished it from previous cases that instituted the privacy right since "the pregnant woman cannot be isolated in her privacy". As such, her privacy right was a qualified and restricted one, incomparable to privacy as it related to "marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education" (*Roe v. Wade*, 1973).[27] The pregnant woman's second and third-trimester privacy right was thus increasingly curtailed as other state interests accrued relevance. And yet, even her first-trimester privacy was always subject to some degree of oversight by physicians. In fact, in its summary, the Court relegated the first-trimester "abortion decision and its effectuation" to the "medical judgment of the pregnant woman's attending physician". Put differently:

> The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is *inherently, and primarily, a medical decision* [emphasis added] and basic responsibility for it must rest with the physician (*Roe v. Wade*, 1973).

In this framing, physicians' "right to administer medical treatment according to his professional judgment" was protected from state encroachment that would restrict medical discretion. The Court did not simply relegate the procedure's *effectuation* to the physician, which would have

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[27] As instituted under "*Eisenstadt* and *Griswold*, *Stanley*, *Loving*, *Skinner* and *Pierce* and Meyer" (*Roe v. Wade*, 1973).

circumscribed physicians' role to an exclusively medical and technical one. Instead, physicians were further tasked with the "abortion decision" that "in all its aspects is inherently, and primarily, a medical decision". Since the physician was responsible for considering the psychological circumstances of a woman's life, he was more broadly called upon to contemplate otherwise nonmedical, lived conditions as medical variables. In other words, the decision blurred the lines between medical and nonmedical circumstances, thereby expanding physicians' purview to appraise the lived circumstances of their patients under the guise of medical expertise. And, importantly, since it was primarily a medical decision, it was the physician, and not the pregnant woman, who had "basic responsibility" over it.

At best, "the woman and her responsible physician necessarily will consider in consultation" the psychological and physical factors as delineated by the Court (*Roe v. Wade*, 1973). The Court adamantly refused to concede the appellant's argument that "the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses". Even during the first trimester, women were never left entirely unencumbered and unsupervised. Women were never left "alone" in their decisional processes. At best, the Court imagined a decisional process to be shared between the patient and her physician, whereby the latter's medical expertise was reconceptualized and expanded as to consider the lived, personal, and ultimately nonmedical circumstances of a woman's life. As such, the *Roe* decision seemed to develop an already restricted notion of privacy even during the first trimester. Women were free from governmental interference, but always vulnerable to medical paternalism and oversight. They could not make their own, isolated decisions, nor could they make a wrong, irresponsible, or contraindicated decision since "basic responsibility" lay with the physician. State oversight was thus repackaged as medical paternalism at a time, as I discussed in the previous chapter, that increasingly saw physicians' discretion and authority contested and reconfigured.

And the Court's conceptualization and allusion to the informed consent doctrine worked as a mechanism to protect physicians' authority from the woman's inclination to "terminate her pregnancy at whatever time, in whatever way, and for whatever reason". In attempting to "resolve the issue (…) free of emotion and of predilection", the Court "inquired into (…) medical and medical-legal history" (*Roe v. Wade*, 1973). Justice Blackmun traced the AMA's evolving position on abortion throughout the centuries, from one that advocated for "general suppression" in 1857 to one that "asserted that abortion is a medical procedure that should be performed by a licensed physician" in 1970. Indeed, on June 25th, 1970, the AMA's House of Delegates adopted the resolution that:

> Whereas, abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demand; and, whereas, the standard of sound clinical judgment, which, together with informed patient consent should be determinative according to merits of each individual case, therefore, be it resolved that abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon (…) (p. 221).

The AMA was clearly seeking to (re)produce abortions as medical procedures over which physicians had rightful authority. More importantly for our purposes, since "sound clinical judgment (…) together with informed patient consent should be determinative according to the merits of each individual case", it presumed that some abortions were unwarranted because they were "contrary to the best interest of the patients". It was "due consideration for the patient's welfare" and "sound clinical judgment" that protected both physicians from "mere acquiescence to the patient's demand" and patients from contraindicated abortions. In this framing, patients requested abortions that were not in their best interest and "welfare". In other words, these evaluative medical practices simultaneously sought to protect physicians from becoming mere technicians there to effectuate their patients' whims and wishes, while also protecting women from their own, potentially harmful, demands. While Justice Blackmun did not explicitly comment on the statement, he summarized it as such in the opinion: "The preamble emphasized the 'best interest of the patient', 'sound clinical judgment', and 'informed patient consent', in contrast to 'mere acquiescence to the patient's demand'" (*Roe v. Wade*, 1973). His rendering of the resolution created a dichotomy between the patient's best interest, discovered through sound clinical judgment, and the physician's abdication of his authority to the patient's uninformed and potentially harmful demands. And "informed patient consent" worked in conjunction with "sound clinical judgment" to establish the procedure's necessity and merits. Arguably, the informed consent doctrine, as imagined by the AMA and Justice Blackmun, thus served as a purpose to inform presumably ignorant women who were demanding unwarranted and potentially harmful abortions.

What is remarkable about this understanding of the informed consent doctrine is how it contrasted with contemporary conceptualizations thereof developed in case law between 1957 and 1972. As I discussed in the previous chapter, the doctrine gained larger traction as a way of democratizing medical decisional processes so research subjects and patients could be better protected from medical paternalism (Rothman, 1991). Medical abuses led to the explicit right to opt-out, to refuse, treatment. Patients could only genuinely consent if given the opportunity to refuse treatment, even if contraindicated by their physicians. The informed consent doctrine, as it was being understood and implemented, served to protect patients from overeager medical practitioners ready to sacrifice their patients' wellbeing and/or autonomy on the altar of medical development. The doctrine's commitment to patient autonomy was thus materialized by giving patients the opportunity to refuse treatment, even if refusal could aggravate a disease or ultimately be fatal.

In this instance, it was physicians' refusal right and judgment that was protected from overeager and ignorant patients and not the opposite. Indeed, the entire premise of the informed consent doctrine and physicians' judgment, as imagined by the AMA and the Court, was to counter the "patient's demand". The AMA and the Court were not imaging a world in which physicians compelled unwilling patients to undergo abortions, as had been the case for so many other experiments and treatments, but instead presumed that patients were requesting abortions. Advocating for "informed patient consent", in an instance when patients seek out and request the procedure, serves a different purpose than when physicians prescribe a treatment otherwise foreign to their patients. It ensures that women's decisions are well-informed and deliberate, which presumes that women's initial abortion decision may be frivolous and/or ignorant, if not deleterious. Not unsurprisingly, the AMA seemed to reach for the doctrine as technology of medical paternalism and gatekeeping, not a defense against it.

Ultimately, the *Roe* decision, while obviously revolutionary for recognizing women's abortion right, also constituted the medicolegal framing that would easily be usurped by immediate and future anti-choice efforts. As so many scholars have critiqued, the trimester system delineated the very vocabulary and legal mechanisms with which to restrict abortion access. But even the first-trimester privacy right was always a qualified and restricted one. As the Court imagined it, women consulted with their physician to determine the procedure's necessity, thus presuming that women did not quite have the decisional capacity to do so on their own and expanding physicians' role beyond a purely medical and technical one. Some abortions were thus deemed necessary, whereas others were unnecessary, despite the fact that first trimester abortions were safer than childbirth and despite the fact that fetal personhood had not yet been established, scientifically or legally. Put differently, physicians were tasked with considering whether *nontherapeutic* abortions were necessary according to some ambiguous and ultimately subjective criteria, even as the Court reached for medical history in an attempt to bypass the issue's contentiousness and moral nature. And Justice Blackmun seemed to gesture towards a conceptualization of the informed consent doctrine that acted as a protective mechanism against "abortion on demand" by ensuring that physicians did not become mere technicians and by ensuring that women's potentially harmful demands were countered by "sound clinical judgment". Women's first trimester right was thus always, at best, one in which women's decisional processes were to be overseen and potentially redirected by physicians. The abortion decision, as imagined by the Court, was first and foremost a medical decision with all its attendant consequences. The decision's "basic responsibility" thus lay with physicians. The privacy right was collapsed with a right to make a medical decision, in line with the patient's well-being, in consultation with her physician. A doctrine otherwise meant to protect patients against medical overreach and paternalism was re-imagined as one that sought to imbue medical paternalism into women's reproductive decisions.

3.5 The *Doe* Decision: The Good Physician

And *Roe*'s deference to medical paternalism was contingent upon the Court's image of a "good" and "sympathetic" physician. Repeatedly, the Court argued that doctors, by the very nature of their profession and expertise, were best placed to evaluate the circumstances of a woman's life when determining a procedure's necessity. This is most striking in *Roe*'s accompanying decision, *Doe v. Bolton* (1973). The ruling, released on the same day as the *Roe* opinion, modified and affirmed a 1968 Georgia law, which was modeled upon the ALI Proposed

Draft discussed in the previous chapter. The 1968 Georgia law criminalized abortion unless the procedure was 1) recommended and provided by a physician, 2) in a hospital, 3) approved by a hospital board of three physicians, and 4) confirmed by two Georgia-licensed physicians in cases in which the pregnancy was a) a threat to the woman's life or health, b) had fetal defects, or c) was the verifiable product of rape. The Court found that the medical regulations were unconstitutional but for the "provision requiring that the physician's decision rest upon his best clinical judgment" that was "not unconstitutionally vague" since the physician's discretion operated for "the benefit, not disadvantage, of the pregnant woman (*Doe v. Bolton*, 1973).

Notably, the Court reversed the statute's hospital board approval requirement on the grounds that "the woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited by this statutorily imposed overview" (*Doe v. Bolton*, 1973). In other words, the Georgia law worked to undermine individual physicians' professional judgment and discretion by imposing a hospital review board. To the extent that the pregnant woman did factor in the decision, she was imagined primarily as a patient with the correlated right to "receive medical care", itself contingent upon "the physician's right to administer it".

Interestingly, Justice Blackmun rejected the appellants' claim that committee members might not authorize an abortion because of their personal views concerning extramarital relations, for example. Rather indignantly, he wrote:

> This approach obviously is one founded on suspicion and one that discloses a lack of confidence in the integrity of physicians (…). The appellants' suggestion is necessarily somewhat degrading to the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so called 'error', and needs. The good physician – despite the presence of rascals in the medical profession, as in all others, we

> trust that most physicians are 'good' – will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling (*Doe v. Bolton*, 1973).

Justice Blackmun thus portrayed physicians whose commitment to their patients would overshadow their moral and ideological inclinations. As I discussed in the previous chapter, the women's health movement had brought to the forefront the extent to which many patients encountered cold, dismissive, misogynistic, and often ineffective obstetricians whose bedside manners reflected larger patterns of sexism and discrimination. To thus imagine obstetricians whose "sympathy and understanding (…) probably are not exceeded by those who participate in other areas of professional counseling" likely flew in the face of women's lived experiences.

But even if we acknowledge the Supreme Court as a rather insulated and conservative institution not necessarily in-touch with social movements' grievances and without the inclination or duty to engender social change (Ginsburg, 1985; Siegel, 2010), the Court would have still been aware of the AMA's attempt to protect physicians' moral beliefs. The *Roe* decision quoted the AMA's House of Delegates additional abortion resolution in its footnotes that found that "Neither physician, hospital (…) shall be required to perform any act violative of personally-held moral principles" (American Medical Association, 1970). Not only did the AMA clearly conceptualize abortions as medical treatments over which physicians ought to have almost exclusive authority and discretion, it further sought to protect physicians' moral and ideological inclinations from having to simply enact abortion patients' demands. Justice Blackmun, despite *Roe*'s reference to the AMA's conscience clause, castigated the appellants for "suspecting" and ultimately "degrading (…) the conscientious physician, particularly the obstetrician". To the contrary, he conjured the image of "the good physician" who "will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling". Put differently, obstetricians could be entrusted, even more so than therapists, to prioritize their patients' wellbeing and to conscientiously consider their patients' "mental welfare, the woes, the emotions, and the concerns (…) the human frailty, so called 'error, and needs". Physicians, by their very profession and experience, could thus be tasked with 1) evaluating life circumstances beyond the scope of their training, and thereby, 2) shepherd women through their abortion decision.

3.6 The *Danforth* Decision: From Medical Paternalism to State Oversight

While it would take some years before the anti-choice movement engaged in more concerted efforts to undermine physicians' character, it quickly sought to disprove and undermine the consultative patient-physician relationship as envisioned by the *Roe* Court. Abortion practices did, in fact, vary greatly in the years after the procedure's legalization.[28] And it was precisely this discrepancy between the Court's imagined and prescribed relationship and the reality of medical practice that enabled the anti-choice movement to use the *Roe* decision to unravel abortion rights by further encroaching upon the first-trimester privacy right.

In 1976, under *Planned Parenthood v. Danforth*, the Court ruled that a Missouri's parental and spousal consent requirements and its prohibition of saline amniocentesis abortions after the 12th gestational week were unconstitutional. The Court reasoned that neither parents nor spouse could encroach upon a woman's abortion decision when the woman's first-trimester

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[28] Most hospitals did not provide abortions, which meant that most procedures were offered in clinics that specialized in pregnancy terminations (Reagan, 1997). Women who had experienced illegal abortions prior to 1973 sought to collaborate with physicians who had either treated victims of botched abortions or had provided illegal terminations themselves, creating a sometimes fraught alliance in which women viewed physicians as patronizing while doctors perceived women as overly demanding (Schoen, 2015). Regardless, these groups instituted a network of abortion clinics that sought to remedy the harms of criminal abortions by offering safe and affordable abortions. At the same time, high demand coupled with insufficient providers meant that abortion services could be costly and lower quality as some looked to maximize their profit. Some "clinics" engaged in outright deceptive and illegal activity, such as a Chicago location that told nonpregnant women they needed a $150 abortion (Kline, 2010). With feminist health centers on the one hand and profit-driven clinics on the other, the landscape of abortions services was far from homogenous in the years immediately after *Roe.*

privacy right trumped all other compelling state interests. If the State could not interject into her decisional process, neither could husbands or parents. It further posited that the proscription of saline abortions after the first trimester deeply curtailed women's abortion access given the procedure's popularity and safety. The decision did important work in delineating women's privacy right and safeguarding it from parental and spousal infringement. It was, in many ways, a victory for abortion proponents. And yet, in the same vein, it upheld a written consent requirement at any gestational stage, thereby using the informed consent doctrine as a proxy and materialization of the State's interest in women's decisional processes that further circumscribed their first-trimester privacy right.

Americans United for Life (AUL), largely recognized as the anti-choice movement's legal machinery, filed an *amicus* brief in support of the Attorney General of the State of Missouri, John C. Danforth. *Amicus curiae* argued that the *Roe* and *Doe* decisions had underscored the qualified and restricted nature of women's privacy right to abortions. While the Supreme Court had only enumerated three state interests, women's health, medical standards, and the potentiality of life, that could rightfully infringe upon women's privacy right, there were "persuasive reasons to believe that those interests mentioned were never envisaged as exclusive" (*Planned Parenthood v. Danforth*, 1976). And the "present state of medical knowledge" in 1976 necessitated the revision of the State's compelling interests. According to evidence submitted by AUL, "there was little or no consultation by the doctor with the woman prior to her decision to abort concerning the factors the Supreme Court held should be necessarily considered (…)". The cross-examination of one of the defendant's witnesses, Dr. Gerald Anderson, further indicated that "he considered himself a technician primarily". Put differently, the very situation the *Roe* Court had attempted to keep a bay had come to fruition. Women were requesting abortions, which physicians were merely effectuating without the rigorous consultations imagined by the Court. Accordingly, the *amicus* brief argued that "the statutory requirement for an informed consent is both necessary and proper".

Of course, the appellee, Attorney General John C. Danforth, could have argued that the consent requirement ought to be upheld on the basis that abortions were proving to be harmful, thereby necessitating that patients be informed of those risks. Given the heterogenous landscape of abortion practice in the years immediately after 1973, it could have been possible that procedures had remained unsafe. This was overwhelmingly not the case. According to historian Johanna Schoen (2015), abortion's legalization "opened the procedure to scientific inquiry and debate. Virtually overnight, abortion became one of the most studied procedures in the United States" (p. 25). And the research conclusively determined that abortion practices were very rapidly becoming safer, sepsis rates were decreasing, sepsis wards were closing, and fewer women were dying from abortions (Cates et al., 2005; Schoen, 2015).[29]

Instead, the Attorney General argued that a "woman's decision to terminate a pregnancy is stressful and tenuous" and, by the nature of pregnancy and abortions, necessarily hurried (*Planned Parenthood v. Danforth*, 1976). A woman may additionally be "frequently exposed to conflicting pressures" from loved ones. While the brief recognized that "a thoughtful dialogue between doctor and patient (…) of the decision (…) is a laudable ideal", these consultations were not taking place. Instead, abortion patients encountered providers previously unbeknownst to them who did "not counsel the patient" during the hastened "26 minute" average long procedure.

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[29] The Joint Program for the Study of Abortion (JPSA), the main program responsible for studying different procedures' outcomes, concluded that vacuum aspiration was safer and quicker than dilation and sharp curettage, which had previously been used during first-trimester abortions (Cates et al., 2005). Not only did new techniques and practices emerge, but physicians' skills also improved as they accessed more consistent and reliable training. Deaths from illegal abortions dropped from 39 in 1972 to only two in 1976, while deaths from legal abortions dropped from three deaths per 100,000 abortions in 1975 to approximately one death in 1976. Abortion access was also related to decreasing maternal mortality rates.

This previously unavailable evidence indicated "the necessity of adopting measures designed to *improve the quality* [emphasis added] of the decision-making process" to "formalize" and "increase the pregnant woman's opportunity to reflect upon a stressful and serious decision".

In other words, appellees and *amicus curiae* advocated for encroaching upon women's privacy right on the basis that the State had additional compelling interests, previously indiscernible under criminalization. This was the State's concern with the *quality* of her decisional process, with ensuring that she was making an informed, weighted decision after taking the "opportunity to reflect upon a stressful and serious decision". In a way, it was simply the materialization of *Roe*'s prescription that patients make their abortion decision in consultation with their physician. Whereas the State, under *Roe*, had deferred judicial oversight to physicians, thereby trusting doctors to oversee and guide women's reproductive decisions, by *Danforth*, the Court articulated an interest in protecting women's decisional processes from abortion providers' negligence. And the informed consent process was the way with which to "formalize" women's decisional process and encourage them to further contemplate this "stressful and serious decision" in order to, ultimately, "improve the quality of the decision-making process". In this framing, women were not allowed to make debased abortion decisions and the State needed to ensure that women were taking the time to do so, unencumbered by external parties such as spouses, parents, or even physicians. *Roe*'s medical paternalism enabled but was ultimately replaced by *Danforth*'s State paternalistic interest in the quality of the woman's decisional process.

Indeed, the Court all but fully embraced the briefs' rhetoric concerning the fraught nature of the abortion decision and the State's resulting interest in ensuring that women's decision was well informed and considered. It found that:

> The decision to abort, indeed, is an important, and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent (*Planned Parenthood v. Danforth*, 1976).

This was quite a departure from the *Roe* opinion, which had emphasized the emotional, psychological, and physical consequences of compulsory motherhood, or "the post-birth burdens of rearing a child" according to Justice White's concurring opinion in *Roe v. Wade* (1973). By *Danforth*, the Court has internalized the view that the abortion decision was "an important, often stressful one" that necessitated the State's assurance of her "awareness of the decision and its significance". It is not entirely clear how Justice Blackmun, who also penned this decision, came to conclude that the abortion decision was a fraught one since there is no further elaboration, footnotes, or references to the *amicus* briefs. He simply seemed to share the District Court's opinion that the abortion decision "of course, is often a stressful one". The very use of the adverb "of course" seems to indicate that both the lower court and the Supreme Court shared the unsubstantiated presumption that the abortion decision was a daunting one. Nor is it entirely clear what the "nature and consequences" of abortion are since these are not delineated, only alluded to.

But the Justices must have presumed those consequences to be so potentially grave and harmful as to warrant a written consent requirement "despite the fact that apparently no other Missouri statutes, with the exceptions referred to in n.6, requires a patient's prior written consent to a surgical procedure" (*Planned Parenthood v. Danforth*, 1976). As indicated in the ruling's footnotes, “the only other Missouri statutes concerned with consent for general medical or surgical care related to persons committed to the Missouri State chest hospital (…) or to mental or correctional institutions”. The Missouri State chest hospital, founded in 1907 and previously known as the Missouri Rehabilitation Center, had first housed tuberculosis patients and eventually treated all types of pulmonary and cardiac diseases by 1971 (Missouri State Archives, 2021). Justice Blackmun further reasoned in the opinion that: “We see no constitutional defect in requiring it only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions”.

Put differently, written consent requirements had hitherto only applied to institutionalized patients. Patients in “mental or correctional institutions” were the often marginalized and oppressed populations that had historically been used to test experimental treatments, either unbeknownst to them or against their wishes. These were vulnerable populations for whom consent was particularly important in protecting against medical utilitarianism and paternalism. Abortion patients were effectively categorized amongst patients who had traditionally been the victims of medical abuses or amongst patients who faced disproportionally high medical risks, as in cases “where the surgical risk is elevated above a specified mortality level”. The written consent requirement would have not been quite as striking or atypical had it only been required throughout the second and/or third trimester, as the procedure did, in fact, become riskier. And it would have been reasonable to protect institutionalized patients from physicians with eugenic tendencies and proclivities. However, the written consent requirement in question was mandated at any gestational stage, even when the procedure was proving increasingly safer, especially when compared to the alternative of childbirth, and despite *Roe*’s first-trimester privacy right.

This begs the question of how the Court made sense of the informed consent doctrine and what work it was assumed to do.

Interestingly, the *Danforth* Court, unlike the *Roe* Court, espoused the doctrine as it was conceptualized at the time: as a mechanism to rectify the inherent power asymmetry between patients and their physicians by protecting patients' decisional freedom. Citing the lower court, the Supreme Court found that the written consent requirement "insures that the pregnant woman retains control over the discretions of her consulting physician (*Planned Parenthood v. Danforth*, 1976). Even as the *Danforth* opinion continued on the trajectory of upholding the "judgment of the responsible attending physician" when determining viability, its understanding of the informed consent alluded to a slight shift in its willingness to perpetually defer to physicians. In contrast to the abortion decision's "basic responsibility" resting with physicians under *Roe*, the *Danforth* decision seemed concerned with promoting women's "control over the discretion of her consulting physician". The Court was starting to recognize shifting relationship dynamics between abortion patients and their physicians, even as it felt that "the consent requirement does not single out the abortion procedure, but merely includes it within the category of medical operation for which consent is required". Consent thus acted as a remedial and legitimizing act. Remedial because it attempted to correct the patient-physician relationship's inherent power differential, legitimizing because it sought to include and treat abortions as other medical operations.

But even as the Court construed the abortion procedure as just another medical operation, it did institute an uncommon requirement that only required consent "for some type of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions (*Planned Parenthood v. Danforth*, 1976). In this framing, it was constitutional to impose an unusual requirement because certain procedures, such as those with increased mortality risks, warranted additional governmental regulation. Not only was it only institutionalized patients who had similar consent requirements, but the only other procedures with similarly atypical consent requirements were those that were more involved, such as intracardiac procedures, or those with higher fatality risks. The Court thus produced abortion patients as particularly vulnerable, while producing the abortion procedure as atypically fraught and stressful.

Indeed, the *Danforth* decision engendered a pattern of categorizing abortions as distinct medical procedures with far-reaching implications beyond those from other medical procedures. This language rapidly made its way, verbatim, into anti-choice efforts. Two years later, under *Belotti v. Baird* (1979), the Court upheld a Massachusetts' parental consent requirement on the basis that parents were best placed to guide their child through a decision with such pervasive consequences. Without evidence or further explanation, the Court reasoned that "the abortion decision has implications far broader than those associated with most other kinds of medical treatment" (*Belloti v. Baird*, 1979). And again, two years later, the Court made the unsubstantiated claim that the abortion decision was one with "potentially traumatic and permanent consequences" (*H.L. v. Matheson*, 1981). Of course, these decisions are different from those previously examined since they grapple with minors' decisional processes and the State's resulting interest in protecting potentially vulnerable teenagers.[30] Regardless, the Court

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[30] Though, it is also important to note that "the law generally treats a pregnant teen who instead chooses motherhood as fully competent to make this decision on her own" (Ehrlich, 2014, p. 342). Legal scholar Susan F. Appleton (2011) compared five cases grappling with reproductive regret and concluded that courts have remedied prenatal decisions when an adult entered voluntarily into a surrogacy contract she later sought to overturn, as in the case under *Matter of Baby M* (1988), but have been unwilling to do so when a teenager, who had originally signed over her parental rights, sought to reclaim these, as happened under *Re Adoption of D.N.T.* (2003). In the former, the surrogate, a consenting adult, was deemed incapable of making a reproductive decision before experiencing the depth of maternal love, while, in the later, a teenager who gave birth and was consequently already a parent when foregoing her parental rights was held responsible for her decision.

had clearly shifted away from its acknowledgement, under *Roe*, of the potentially deleterious consequences of an unwanted pregnancy and of compulsory motherhood. Instead, the Court quickly internalized largely unsubstantiated or dubious anti-choice claims that abortions were harmful, with "implications far broader than those associated with most other kinds of medical treatment" (*Belotti v. Baird*, 1978), and that the abortion decision was thus inherently an atypically fraught and stressful medical decision.

Returning to the *Danforth* (1976) decision, the unsubstantiated claim that the "decision to abort, (…) is an important, and often stressful one" thus legitimized using the informed consent doctrine as a mechanism of decisional supervision and oversight, thereby reconceptualizing and reconfiguring the first-trimester privacy right. The *Danforth* Court, echoing the appellees' brief and AUL's *amicus* brief, espoused the informed consent doctrine as a way to formalize a particular decisional process that protected women from their own potential ignorance and haste. While it was further meant to remedy the patient-physician relationship and promote women's decisional autonomy, it effectively replaced medical paternalism with a form of state paternalism. Indeed, the appellants had argued that the consent requirement was "violative of *Roe v. Wade* by imposing an extra layer and burden of regulation on the abortion decisions" (*Planned Parenthood v. Danforth*, 1976). *Roe*'s first-trimester privacy, which was always circumscribed by physicians' consultation and oversight, was thus renegotiated in ways that legitimized the beginning of governmental encroachment. Abortion patients had the freedom to choose an abortion, but the State had an interest in the content and quality of their decisional processes, which were by the nature of the informed consent doctrine, circumscribed by a commitment to well-being and health. As such, *Danforth* more broadly reconfigured and expanded the State's vested interests as to encapsulate the quality of women's decisional processes, thereby further encroaching upon women's first-trimester privacy right.

3.7 Funding Cases: Individualizing Responsibility

Simultaneously, abortion funding cases had made their way to the Supreme Court. The Court repeatedly reasoned that *Roe*'s privacy right did not translate into the State's responsibility to materialize the abortion right. Put differently, the Court articulated and reified a notion of privacy that has since been largely denounced by legal and reproductive justice scholars. In 1977, under *Maher v. Roe*, the Court held that states were not compelled to fund nontherapeutic abortions and that it was constitutional to compel prior showing of an abortion's medical necessity to receive Medicaid coverage, even if "similar requirements are not imposed for other medical purposes" because abortions "involve the termination of potential human life" (*Maher v. Roe*, 1977). More specifically, the *Maher* (1977) Court reasoned that even if "indigency (…) may make it difficult and in some cases, perhaps, impossible for some women to have abortions", pregnant women's indigency was "neither created nor in any way affected by the Connecticut regulation". Of course, the decision's framing presumed a certain understanding of the nature of poverty that erased the State's role in (re)producing poverty, thereby absolving itself from responsibility and shifting into onto individuals. Had the Court stopped there, it would have relied on a notion of privacy as governmental neutrality in which individuals, left to their own devices, could choose the trajectories of their lives but without the State's help in materializing these decisions. However, the *Maher* Court explicitly acknowledged that: "The State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there". *Roe*'s privacy right was thus redefined from one shared between physician and patient to one in which the State could not institute additional barriers to access but could, nonetheless, through its allocation of public funds, encourage and "influence" women to choose childbirth. Abortion patients' abortion choices may have been protected but their decisional processes were increasingly vulnerable to external influences.

The *Harris v. McRae* (1980) decision took this reasoning further by upholding the Hyde Amendment, which proscribed the use of federal funds for *therapeutic* abortions. Even as the *Harris* Court acknowledged that the *Roe* decision protected the "freedom of a woman to choose to terminate her pregnancy for health reasons" at any gestational stage, including during the third trimester, "it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices" (*Harris v. McRae*, 1980). Of course, in practice, this meant that only those with the necessary resources could afford an abortion. Rickie Solinger (2001) argues that these funding cases "provided a way to end poor women's 'inappropriate' and 'unearned' relationship to choice" (p. 15). In some of her previous work, Solinger (1998) argued that Black and Brown women's dependency was increasingly used to legitimize restrictions on their reproductive and sexual choices. Since women's poverty was seen as a product of bad, individual choices, and not the result of systemic oppression, they could not be trusted to make good choices. If impoverished Black and Brown women on welfare could not make "good" and responsible sexual and reproductive choices, taxpayers ought not be responsible for mitigating and remedying the consequences of these decisions. Solinger (2001) argues that these funding cases both emerged within, and reified, a larger context in which the public grew increasingly critical of poor women's sexual and reproductive decisions. These funding cases thus presumed and reified notions of privacy as a certain form of governmental noninterference that absolved the

State from responsibility in materializing choices, all while using State funds to influence abortion patients' decisions and encourage childbirth.

3.8 Conclusion

Even if the funding cases occurred a year or two after the *Danforth* (1976) decision, abortion jurisprudence during the 1970s and very early 1980s ultimately worked to further curtail *Roe*'s already qualified privacy right. Funding cases coalesced with decisions that instituted and protected the abortion right to develop a restricted first-trimester privacy right. Pregnant women, at best, were encouraged to engage in a rigorous, weighted decisional processes in consultation with their physician. And, importantly, the abortion decision was, first and foremost, a medical one circumscribed by concerns for health and well-being. When this consultative relationship did not materialize, in practice, the Court reached for the informed consent doctrine as a mechanism with which to formalize the decisional process and ensure the quality of women's abortion decision to be made "in a knowing, intelligent, and voluntary fashion", as Justice Stewart articulated in his concurring opinion (*Planned Parenthood v. Danforth*, 1976). Concomitantly, anti-choice funding victories conceptualized privacy not as a sphere of governmental neutrality, but as a sphere of governmental noninterference in which the State could not institute additional barriers to access but it could, nonetheless, distribute public funds in ways that encouraged childbirth. In all these moments, women were to be shepherded through their decisional processes or punished when making "irresponsible" sexual and reproductive decisions. Put differently, these two forms of privacy ultimately coalesced to produce a context in which women were compelled to be sexually and reproductively responsible while punishing those who were deviant.

The perpetually negotiation and reconfiguration of the privacy right was possible, in large part, because of the *Roe* ruling. As lawyer Rhonda Copelon (1990) put it: "*Roe v. Wade* is significant not simply because of the recognized right to abortion but because *Roe* refused to treat the right as absolute" (p. 30). Unlike access to birth control, established under *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972), which imagined a much more spacious sphere of non-interference the abortion right was always restricted and curtailed, even during the first trimester. This was precisely Sarah C. Weddington's argument during oral re-arguments when Justice Blackmun asked her whether she was "urging upon us abortion on demand" (*Roe v. Wade*, 1973). She responded that, according to *Eisenstadt v. Baird* (1972), "if the right of privacy is to mean anything, it is the right of the individual (…) to make determinations for themselves". And Roe's conceptualization of even the first-trimester privacy right was one in which pregnant women's right to "make determinations for themselves" was circumscribed by physicians' commitment to health and well-being.

Of course, the privacy right is, almost by definition, prone to restriction. The question has always been to determine at which point someone's actions are deemed private, and hence protected from governmental regulation, as opposed to the point at which they are deemed public-facing and susceptible to oversight. But, had the *Roe* decision not placed so much emphasis on the patient-physician relationship during the first trimester, it may have been harder for ensuing anti-choice lawyers and legislators to use the opinion to unravel abortion access. Had the *Roe* Court simply imagined an uncircumscribed first-trimester privacy right, in which women could unequivocally access abortion on demand, it may have been harder to thereafter institute additional mechanisms with which to oversee and guide women's decisional processes.

And this brings us back to *Planned Parenthood v. Casey* (1992). The decision was deceiving to both abortion proponents and anti-choice activists. While it articulated one of the most robust and eloquent judicial defenses of abortion's necessity to women's autonomy, it also replaced *Roe*'s trimester framework with the notoriously ambiguous undue burden framework, thus injecting the state's interest for "normal childbirth" at any gestational stage into women's decisional processes. Under *Casey*, the Court continued the trajectory of mobilizing the informed consent doctrine as a materialization and proxy of the State's interest in women's decisional processes. However, *Danforth*'s concern with assuring abortion patients considered the "significance and consequences" of the procedure was replaced with the State's interest in childbirth: "to promote the State's interest in potential life, the State may take measures to ensure that the woman's choice is informed" (*Planned Parenthood v. Casey*, 1973).

Casey was not a monumental departure from previous abortion jurisprudence that instituted or protected the abortion right. It was, I hope to have demonstrated, the logical culmination of the Court's perpetual involvement in women's decisional processes. Abortion patients were always tasked with considering specific, delineated *medical* criteria before making their abortion decision. To what extent they had a right to self-determination, it was circumscribed by the decision's espousal of the abortion procedure as a medical decision over which the physician had some (significant) authority and discretion in light of their patient's well-being. Pregnant women were always compelled to be good decision makers who chose "necessary" abortions and engaged in quality decisional processes. And by extension, they were always produced as potentially ignorant, ill-intentioned, and therefore needing counseling and atypical medicolegal mechanisms that formalized their decisional process. What changed, under these different rulings, was whether physicians or the State would be the supervising entity and how either party understood women’s health and whether motherhood, or abortion, threatened their well-being. Early abortion jurisprudence that enshrined the abortion right in a medical framework was the perfect vehicle for ensuing anti-choice efforts that nominally lauded and protected women’s rights, while paradoxically working to curtail abortion access in the name of women’s health.

CHAPTER 4

Abortion Regret: Rationalizing Motherhood

On June 24th, 2022, the Supreme Court overturned *Roe v. Wade* (1973) under *Dobbs v. Jackson.* The Court largely ignored what recriminalizing abortions would do to pregnant people (Ziegler, 2022). Instead, it focused on tracing what has since been denounced as a "flawed interpretation of abortion criminalization" to rationalize its reversal of *stare decisis* (American Historical Association, 2022; Cline Cohen, 2022; Schuessler, 2022).[31] The Court deemed that the privacy right, as first articulated under *Griswold v. Connecticut* (1965), could not buttress the abortion right. The decision revealed the temporary and calculating nature of what legal scholar Reva Siegel (2008) termed the Women's Protective Antiabortion Argument (WPAA). According to Siegel, prominent anti-choice activists in the 1990s started calling for a strategy that would be more appealing and palatable to the "middle majority" of Americans, who simultaneously valued fetal life *and* women's (reproductive) freedom. Convincing this constituency that abortion harmed women legitimized an onslaught of incremental restrictions that require parental consent, compel abortion patients to undergo counseling and/or waiting periods, mandate that patients view the ultrasound, and/or that they be informed of fetal gestational age, stage, pain, and/or the unsubstantiated link between abortion and breast cancer, future infertility, and possible psychological trauma (Guttmacher Institute, 2022; Vanderwalker, 2012). Many of these statutes are titled with variations on a "Women's Right to Know Act" and espouse the claim that abortion

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[31] The American Historical Association and the Organization of American Historians (2022) released a statement that the Court ignored the *amicus* briefs filed on their behalf that traced the criminalization of abortion and that provided: "plentiful evidence, however, of the long legal tradition, extending from the common law to the mid-1800s (and far longer in some American states, including Mississippi), of tolerating termination of pregnancy before occurrence of "quickening," the time when a woman first felt fetal movement. The majority of the court dismisses that reality because it was eventually—although quite gradually—superseded by criminalization. In so doing the court denies the strong presence in US "history and traditions" at least from the Revolution to the Civil War of women's ability to terminate pregnancy before the third to fourth month without intervention by the state".

patients must be warned of the alleged harms of abortion (Daniels et al., 2016). None of these strategies, or their legitimizing discourses, seemed to make their way into the *Dobbs* ruling.

However, for a couple decades, the anti-choice movement resorted to making the argument that abortion harmed patients. This strategy was first instituted in Crisis Pregnancy Centers (CPCs) in the late 1980s (Huff, 2014; Siegel, 2008). As I mentioned in Chapter 1, CPCs are overwhelmingly evangelical Christian centers, managed by often untrained women volunteers, that often mimic the appearance of abortion clinics and provide similar services, such as counseling, free pregnancy tests, ultrasounds, and STI testing to patients facing an unplanned pregnancy (Ehrlich & Doan, 2019; Guttmacher Institute, 2012). CPC volunteers focus on helping (potential) abortion patients and seek to support them, both emotionally and materially through an unplanned pregnancy, in hopes of deterring them from undergoing an abortion. For years, anti-choice leaders denounced this focus on women and argued that it deterred from the true moral issue at stake: fetal life (Reardon, 1996; Rocca et al., 2020; Siegel, 2008). However, it became obvious, by the early 1990s, that efforts to overturn *Roe v. Wade* and to pass the Human Life Amendment (HLA) had proven futile. Dr. David C. Reardon published *Making abortion rare: A healing strategy for a divided nation* in 1996, which articulated the new anti-choice strategy.[32] The book targeted fetal-centric anti-choice activists who, at best, had ignored the pregnant woman or, at worst, had actively decried her murderous and selfish abortion. He argued that protecting abortion patients necessarily translated to saving fetal life given the inextricable and loving maternal-fetal bond. Reardon (1996) identified two ways of curtailing abortion access: to (1) "expand the legitimate rights of women so that they are clearly superior to the

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[32] Reardon, who remains a prominent anti-choice 'researcher' and figure, founded the Elliot Institute for Social Science Research in 1988 to perform "research, education, and advocacy for women, men and families who are at risk of or who have been harmed by abortion" (Elliot Institute). It is a nonprofit 501(c)(3) tax exempt organization that reports operating on an annual budget below $100,000 (Elliot Institute, 2009).

imputed rights of abortionists" (p. 39), which (2) was contingent upon mobilizing "the *authentic* rights of women" and helping women who are "seeking abortions not because they believe it is the right thing to do, they feel it is the *only* thing to do" (p. ix). The next chapter will explore how the movement mobilized the informed consent doctrine to erode the physician-patient relationship as imagined by the *Roe v. Wade* (1973), *Doe v. Bolton* (1973), and *Danforth v. Planned Parenthood* (1976) courts. This fourth chapter will focus on the movement's mobilization of the "authentic rights of women".

The "abortion regret" discourse is a particular iteration and strategy of the WPAA that was written into legal dicta under *Gonzalez v. Carhart* (2007) and that focuses on the "authentic rights of women". While I will discuss regret's idiosyncratic features in more depth later, I echo literature that theorizes regret by defining it as the retroactive evaluation of one's past decision whereby one comes to yearn for the previously available alternative (Appleton, 2011; Donath, 2015; Landman, 1993; Watson, 2009). By extension, "abortion regret" is the retrospective wish to have brought an aborted pregnancy to term. When I mention the "abortion regret" discourse, I will be referring to a whole set of practices, institutions, and statements that produce a particular understanding of women and motherhood, whereby certain statements appear irrefutably true, while others are obscured as nonsensical (Carabine, 2001; Foucault, 1980).[33] As such, I am not

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[33] The focus on "abortion regret" has largely erased discussions about maternal regret, an understudied, stigmatized, and taboo topic. Orna Donath (2017) is recognized as the first scholar to study maternal regret, which she defines through ethnographic research as the retrospective yearning to have foregone motherhood. Importantly, she only interviewed women who had raised their children and did not interview women who brought their pregnancy to term and put the child up for adoption. The participants adamantly reported loving their children very deeply, but often hated parenting so much that they wish they had never become mothers. If they had the opportunity to choose again, they would not have chosen motherhood knowing what they learned later. Donath distinguishes her work from scholarship that examines maternal ambivalence or that studies the hardships of parenthood. She argues that this research can obscure and distill maternal regret into narratives that further naturalize and romanticize motherhood as an experience that demands unconditional sacrifice but that is nonetheless worthwhile. Researchers are starting to examine the prevalence and causes of maternal regret and increasingly advocate that it be used as a counterweight to the discourse of "abortion regret" (Doan & Ehrlich, 2022; O'Reilly, 2022).

interested in determining the validity and statistical relevance of post-abortion emotional injuries. I am instead concerned with understanding the conditions under which "abortion regret" could emerge as a legible and commonsensical discourse that produced women as particular subjects.

This chapter is a genealogy of "abortion regret", in which I attempt to trace some of the necessary circumstances and conditions for its emergence, legibility, and resonance. I start by examining Post-Abortion Syndrome (PAS), an alleged mental disorder, as an earlier therapeutic iteration of "abortion regret". I argue that PAS could only be legible as the revolutionary 1980 third edition of the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM-III*) introduced the Post-Traumatic Stress Disorder (PTSD) diagnosis. Classifying PAS as a variant of PTSD worked to produce the abortion procedure as an inherently and unavoidably traumatic one that warranted specialized care. I then argue that the "abortion regret" discourse eschewed much of PAS' pathologizing language, while retaining its core premise that abortion decisions are deviant, abnormal, and irrational. Indeed, I will argue that "abortion regret" paradoxically rehabilitates women as rational decision makers *and* as mothers. Motherhood becomes women's ultimate, even if delayed and retroactive, rational choice. I will conclude by examining the discourse of "abortion relief", which I define as the set of pro-abortion scholarly and journalistic practices that seek to rebut the "abortion regret" discourse by underscoring the number of abortion patient who, in fact, experience relief in the years after their procedure. I argue that regret and relief exist on a continuum whereby women's choices are perpetually vulnerable to being evaluated and categorized. In other words, the very process of attempting to complicate the "abortion regret" discourse upholds and perpetuates the very thing it attempts to repudiate. As such, I take claims about "abortion relief" as refuting yet upholding, complicating yet materializing, the "abortion regret" discourse and its practices of evaluating and categorizing pregnant women's choices.

4.1 Post-Abortion Syndrome: Pathologizing Abortion

Post-Abortion Syndrome (PAS) was first defined by Anne Speckhard and Vincent Rue in "Postabortion Syndrome: An Emerging Public Health Concern" in 1992.[34] They defined the syndrome as "a type of PTSD that is characterized by the chronic or delayed development of symptoms resulting from impacted emotional reactions to the perceived physical and emotional trauma of abortion" (Speckhard & Rue, 1992, p. 105). The symptoms generally rest upon the assumption that while abortion trauma is repressed, it is nevertheless expressed through intrusive nightmares, negative thoughts, flashbacks, unacknowledged grief, and/or denial. Women who terminate their pregnancies are those primarily afflicted by PAS, though anyone who provides abortions or experiences the abortion of a loved one is also vulnerable to it.

Both in 1992 and between 2006-2008, the American Psychiatric Association (APA) instituted task forces to determine the validity of PAS as a psychiatric disorder since Speckhard and Rue's work was repeatedly denounced as methodologically flawed and inconsistent (Adler et al., 1992; Ehrlich & Doan, 2019; Gordon & Saurette, 2015; Huff, 2014; Major et al., 2009; Rocca et al., 2020). These tasks forces concluded, upon examining the most methodologically rigorous research on post-abortion emotional sequela, that most women do *not* experience pathological post-abortion emotional trauma. Instead, women experience a variety of post-abortion emotions, no more traumatizing or pathological than any emotional reactions to quotidian life stressors (Alder et al., 1992; Major et al., 2009). And yet, in spite of the APA's

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[34] Anne Speckhard is currently an adjunct associate professor of psychiatry at Georgetown University, who researches anti-terrorism initiatives. Vincent Rue, a prominent anti-choice researcher who has testified at numerous congressional and court hearings, is a psychotherapist who founded the now inactive Institute for Pregnancy Loss (Siegel, 2008).

ongoing dismissal of the validity of PAS, it has remained a contentious issue that has attracted the attention of scholars and of the media (Watson, 2009).

As I mentioned in the introduction, I am not interested in further engaging the conversation surrounding PAS' validity as a psychiatric disorder. The very process of perpetually casting doubt on scientific matters upon which professional organizations have reached a consensus is a widely recognized conservative strategy (Oreskes & Conway, 2011).[35] Instead, I am more interested in examining the conditions under which PAS emerged, which rendered it legible, and what work it did. I will argue that categorizing PAS as a variant of Post-Traumatic Stress Disorder (PTSD) worked to produce the abortion procedure as an inherently traumatic one warranting specialized post-operative care.

PAS would have been nonsensical without the release of the third edition of the *Diagnostic and Statistical Manual of Mental Disorder* (*DSM-III*), in 1980, and the volume's Post-Traumatic Stress Disorder (PTSD) entry. In contrast to the two previous editions that focused on the causes of mental illnesses, the third volume took a novel nosological approach to mental disorders. This means that mental disorders were categorized by symptoms and the revised edition attempted to remain "neutral with respect to the causes of mental disorders" (APA, 2019; Young, 1995). Both the *DSM-III*'s publication and the PTSD entry were fraught with contestation and debate (Mayes & Horwitz, 2005; Young, 1995). Even as this was the case, the *DSM-III* gave all psychiatrists a common language around which to diagnose and treat patients. Given its emphasis on observable and categorizable symptoms, it was expected that most providers could diagnose a patient displaying specific symptoms with the same disorder,

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[35] News articles both illustrate and perpetuate the ongoing uncertainty surrounding PAS with titles such as "Is There a Post-Abortion Syndrome?", "Post-Abortion Stress Syndrome – Does it Exist?", or "Post-Abortion Syndrome: Is It Real?" (Babbel, 2010; Bazelon, 2007; Raypole, 2020)

thereby providing diagnostic consistency in a field that had previously been defined by its lack of a shared interpretive frame (Mayes & Horwitz, 2005). The *DSM-III* "transformed the little-used mental health manual into a biblical textbook specifically designed for scientific research, reimbursement compatibility, and, by default, psychopharmacology" (Mayes & Horwitz, 2005, p. 263). In other words, the *DSM-III* became a central artifact of professional authority by codifying and systematizing patient diagnosis and treatment reimbursement.

The emergence of PAS thus rested upon a theoretical shift, within the psychiatric field, towards symptomatic diagnosis. More particularly, PAS would have likely been unintelligible without the atypical PTSD entry, which identified the cause of trauma in a volume generally looking to abandon its etiological approach. This classificatory move worked to portray abortion procedures as difficult and stressful life events, which caused emotional turmoil that was likely triggered during moments of infertility, and that necessitated specialized intervention and rehabilitation.

Post-Traumatic Stress Disorder (PTSD) was first introduced as a mental disorder in the *DSM-III.* Paradoxically, the defining characteristic of PTSD distinguishing it from otherwise symptomatically similar, if not identical, disorders such as "depression, anxiety disorder, or panic disorder" was its etiological approach (Young, 1995). In other words, PTSD's idiosyncratic focus on traumatic events beyond the scope of "usual human experience" distinguished it in a volume that generally looked to remain "neutral" about the causes of mental disorders.[36] By the revised third version, those "usual human experience" included "simple

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[36] The atypical etiological entry's incorporation in an otherwise nosological manual was "inextricably connected with the lives of American veterans of the Vietnam War, with their experiences as combatants and, later, as patients of the Veterans Administration (VA) Medical System" (Young, 1995, p. 108). Its integration was a deeply fraught and political issue. The first *DSM* edition had a similar entry, though it stated that "gross stress reaction" was exclusively experienced during combat and would subside when the individual exited the engendering situation (Scott, 1990). As Vietnam veterans returned home, initial reports seemed to indicate that existing diagnosis, such as depression, described and covered their psychological experiences. Yet, by 1978, years of concerted efforts by

bereavement, chronic illness, business losses, and marital conflicts" (*DSM-III-R*, 1987, p. 247). What distinguished normal reactions of sadness and loss from pathological experiences thereof was the extent to which the originating event was a quotidian and mundane event that all people likely experienced. Despite inclinations to the contrary, the PTSD entry was thus deeply normative in categorizing what constituted a traumatic, as opposed to 'normal', life event.

Categorizing PAS as a subset of PTSD, as opposed to any of the symptomatically similar disorders, allowed Speckhard and Rue to portray and classify abortions as traumatic events that transcended the scope of "usual human experience". Indeed, it would have been incoherent to even attempt to classify PAS as a subset of Major Depressive Disorder (MDD), for example, since doing so would have eliminated PAS' characteristic focus on abortions as the cause of emotional trauma. Since symptomatically similar disorders ignored the causes of those symptoms, classifying PAS under any other diagnosis would have effectively erased PAS' focus on abortions and merged it with the symptomatically similar disorder. Yet, in classifying PAS as a variant of PTSD, Speckhard and Rue were able to centralize abortion procedures as inherently traumatic, beyond the scope of normal human experiences, that caused similar symptoms to those who experience war or rape, for example.

Indeed, Speckhard and Rue were invested in denouncing and disproving perceptions of abortions as relatively quotidian and benign procedures (Siegel, 2008). For them, to continuously conceptualize abortions as mundane procedures worked to pathologize any woman who experienced post-abortion emotional turmoil. To instead portray the abortion procedure as traumatic thus normalized any post-abortion emotional trauma. As such, PAS was "an adaptive

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activists, psychiatrists, and veterans convinced the Committee on Reactive Disorders that their research demonstrated a "wide circle of victims within the war zone, and the similarities between these victim groups and those traumatized in other 'man-made' disasters" (Scott, 1990, p. 307).

response to a maladaptive decision to have an abortion" (Speckhard & Rue, 1992, p. 113). By thus casting abortions as "maladaptive decisions", Speckhard and Rue's diagnosis naturalized motherhood since it assumed, at its core, that women eventually come to desire children. Any deviation from this innate inclination, such as the decision to terminate a pregnancy, was recast as a maladaptive reaction that engendered considerable emotional turmoil.

At its core, PAS rests upon the assumption that women are driven by an innate desire to (eventually) become mothers. To deviate from this naturally prescribed role is psychologically traumatizing. In attempting to substantiate this belief, Speckhard and Rue used anecdotal evidence from women who experienced post-abortion emotional turmoil: "I don't know how it's possible, but I know I felt when my baby died. I could feel when its life was sucked out. It was awful. I have never felt so empty. I just wanted to die" (Speckhard & Rue, 1992, p. 107). Here, the woman already conceived of the fetus as her baby, with whom she shared some sort of telepathic and loving bond that enabled her to feel when "its life was sucked out" and it died. Since the fetus is already a baby, and by extension the pregnant woman is already a mother, the intentional act of terminating the pregnancy is a violent, murderous, and deviant act that engenders, in this woman's case, deep sorrow, emptiness, and the desire to die. More generally, for abortion to be considered so traumatic a procedure as to almost inevitably provoke psychological trauma assumes an understanding of the fetus as the unborn child, the pregnant woman as the already loving mother, and abortion as the murder of her unborn child. If motherhood is a woman's natural and innate desire and proclivity, an abortion can only ever be a "maladaptive" and destructive decision.

Classifying PAS as a subset of PTSD further worked in portraying post-abortion emotional trauma as largely inevitable. Another distinguishing characteristic of PTSD is symptomatic delay (Young, 1995). Delayed PTSD, a subset of PTSD, occurs when symptoms are triggered at least six months after the traumatic experience (*DSM-III-R*, 1987, p. 251). Individuals, incapable of coping with the pain of the initiating traumatic event, repress insufferable memories that nonetheless surface through a variety of symptoms and unhealthy behaviors. By categorizing PAS as a type of PTSD, Speckhard and Rue portrayed it as a disorder that any woman who had undergone an abortion might eventually experience. Even if women did not immediately experience the symptoms characteristic of PAS, they were forever susceptible to delayed PAS.

Importantly, these symptoms would be triggered by “miscarriage, stillbirth, infertility, hysterectomy, and menopause” (Speckhard & Rue, 1992, p. 110). In other words, women were particularly vulnerable to experience delayed PAS when faced with the physical inability of getting pregnant or bringing a pregnancy to term. In these moments, they would retroactively evaluate the previous decision to terminate a pregnancy and the aborted pregnancy would get reconceptualized according to their current desire, and inability, to have children. This likely would have been particularly threatening to a woman who understood herself as a future mother and terminated her pregnancy in hopes of being better prepared for motherhood later in life. The aborted pregnancy thus acquired augmented value in its potential scarcity and rarity. Given the inevitability of menopause, and the likelihood of experiencing any of the other reproductive difficulties, delayed PAS would thus be a particularly haunting threat for any woman delaying motherhood.

Finally, classifying PAS as a variant of PTSD legitimized it as a particular psychiatric disorder that warranted the professional expertise and intervention necessary to rehabilitate women who experienced post-abortion emotional turmoil. Allan Young (1995) argues that the emergence of PTSD rested upon a reconceptualization of memory. This new conceptualization of memory assumed that experiencing traumatic events could engender repressed memories that were nonetheless displayed through repetitive behaviors "over which the affected person exercised no conscious control" (Young, 1995, p. 4). This called for professional intervention since the traumatized individual was emotionally incapable of coping with the repressed, traumatic memories that nevertheless hindered "normal" functioning. Treating PTSD thus required a specialist capable of uncovering these repressed and insufferable memories, helping the person resume "normal", healthy, and quotidian behaviors.

It is no coincidence that Speckhard and Rue (1992) concluded their article calling for "specialized postabortion recovery treatment models and services – for example, postabortion counseling centers, peer support groups, and educational workshops for both the general public and professionals" (p. 115). By portraying abortions as so deeply traumatic as to cause women to repress their memories in attempting to grapple with the horror that they experienced, Speckhard and Rue could thereby call for specialized services, in much the same way that war veterans require therapeutic help to overcome destructive behaviors engendered by the experience of war.

Indeed, Reva Siegel (2008) argued that the therapeutic language of PAS emerged in conjunction with a growing network of Crisis Pregnancy Centers (CPCs). Dr. Vincent Rue, who originated PAS, had already been denouncing abortion's alleged emotional harm since the early 1980s (Bazelon, 2007; Siegel, 2008). After hearing him speak at the 1982 National Right to Life Committee convention, a group of attendees instituted Women Exploited by Abortion (WEBA), an organization meant to provide women with a "a safe place (…) to speak freely about her own pain and find healing and peace" (Siegel, 2008, p. 1659). Its membership grew to a few thousand throughout the 1980s and organizers distributed information about PAS through the Christian

Broadcast Network (CBN). The Catholic Church was simultaneously pouring funds towards opening more CPCs. In 1993, just a year after Rue and Speckhard published their article, Theresa Burke founded Rachel's Vineyard, a "post-abortion ministry" that held weekly support groups and weekend retreats to help women heal from post-abortion trauma (Bazelon, 2007). CPC volunteers increasingly relied on the therapeutic language of PAS to both deter prospective patients from undergoing abortions and to help women recover from post-abortion emotional harm.

However, both the therapeutic discourse of PAS and CPCs locations were marginalized within the larger anti-choice movement. Overwhelmingly, anti-choice leaders in the 1980s and 1990s denounced these early efforts to focus on abortion patients. Prominent activists thought that catering to women's psychological health detracted from the movement ultimate goal: saving fetal life. President Ronald Reagan, upon his advisers Dinesh D'Souza and Gary Bauer's recommendation, asked his Surgeon General, C. Everett Koop, to investigate whether abortion posed a public health threat (Huff, 2014; Rocca et al., 2020; Siegel, 2008; Tonn, 1996). Despite his anti-choice sentiments, Koop concluded that there was insufficient evidence to substantiate the claim that abortion psychologically harmed women. He urged movement leaders to redouble their fetal centric efforts: "The pro-life movement had always focused – rightly, I thought – on the impact of abortion on the fetus" (as cited in Siegel, 2008, p. 1664). Koop was concerned that framing abortion as a public health concern detracted from the immorality of murdering unborn children, thereby legitimizing the procedure unless it harmed patients (Reardon, 1996).

Ultimately, PAS rendered what was otherwise a deeply normative, moral, and religious understanding of motherhood and abortions into a supposed psychiatric disorder by drawing on the secularizing and authoritative language of psychiatry and the *DSM*-III. In turn, it portrayed abortions as inherently traumatic procedures that warranted therapeutic intervention. This discourse emerged in conjunction with a growing network of CPCs, which referenced PAS when deterring patients from undergoing an abortion and in helping women grapple with post-abortion emotional grief. For two decades, these efforts were marginalized and denounced within the larger movement, which continued to center saving fetal life as its ultimate moral and strategic goal.

When this proved ineffective, prominent anti-choice leaders started recognizing the strategic value of PAS and worked on repurposing and popularizing it. However, they needed a discursive approach that catered to a wider audience (Huff, 2014; Siegel, 2008). These leaders were increasingly concerned about catering to the "majority middle", who simultaneously understood the fetus as a human entity warranting some protections and who valued women's decisional freedom. Perpetually emphasizing fetal personhood had clearly been ineffective. However, the therapeutic language of PAS was similarly deemed too niche. Instead, they advocated for a strategy that countered accusations that the anti-choice movement did not care about women. If the movement could demonstrate that they were the ones to truly support women's rights and health, they could work towards incrementally restricting abortion access under the guise of protecting women from abortions. "Abortion regret" was a particular materialization of these women-protective efforts.

4.2 Regret: Yearning for a Foregone Choice

Most of the literature on abortion regret uses "regret" as an umbrella term to describe the plethora of complicated and painful emotions and behaviors patients experience post-abortion (Doan & Ehrlich, 2017; Ehrlich & Doan, 2019; Huff, 2014; Manian, 2011; Turner, 2008). Some of the scholarship examines what engendered these painful emotions (Kimport, 2012; Madeira, 2014; Rocca et al., 2013; Rocca et al., 2015; Rocca et al., 2020). Overwhelmingly, this scholarship agrees that abortion patients feel a variety of complicated, and sometimes conflicting, emotions. Some women experience sadness at the loss of their pregnancy. Others feel anger and resentment towards unsupportive family members or partners. Some patients experience regret because of the circumstances under which they made the abortion decision, thus regretting their relationship and sexual choices but not regretting the actual abortion (Watson, 2014). This research is important in diversifying and complicating the narratives that circumscribe abortion politics. It is important in emphasizing the point that women make reproductive decisions for a wide variety of multi-faceted reasons and no single emotional experience can encapsulate and represent this complexity. And it has been important for pushing back on the "abortion regret" discourse.

However, my purpose here is to conceptualize regret as a distinct emotion, which, despite its similarities to feelings such as shame or disappointment, does different discursive work. Regret, because it is engendered by having choices, centers a regretful, yet agentive and rational, subject in ways that shame and cannot do. And this has important implications for abortion politics. In this following section, I will thus define regret by distinguishing it from shame and guilt. This will help me then explore the circumstances under which the "abortion regret" discourse could emerge, be legible, and ultimately gain cultural resonance and traction, even across pro-choice texts.

Shame, guilt, and regret are all considered "self-conscious" emotions, whereby individuals consider the implications of their (in)actions (Lewis, 2016; Miceli & Castelfranchi, 2018). All three emotions are very similar and are often experienced simultaneously. And yet, according to some accounts, regret and guilt are different from shame in that the former tend to be more private, inward-looking emotions while the latter is contingent upon the possibility of public exposure (Micelo & Castelfranchi, 2018). Shame has received a lot of attention from affect theory scholars (S. Ahmed, 2015; Millar, 2015). It is also a central emotion in the PAS discourse and has thus garnered some individualized attention by abortion scholars (Millar, 2015). In all this work, shame's idiosyncratic characteristic is that it is simultaneously a deeply private, inward-looking feeling *and* an inherently outward-looking, public, and social emotion (S. Ahmed, 2015; Millar, 2015). Even if someone's shame stops them from disclosing their shame, they feel ashamed because they failed to abide by society's expectations, morals, and beliefs. The person understands, and therefore espouses and reifies, societal norms, while simultaneously imagining how another may judge them for their failure to abide by these norms. Shame thus centers relationships and even love, according to affect theorist Sara Ahmed (2015). If I do not care about other people's judgment, I do not feel ashamed. I feel shame *because* I value someone's judgment. Despite what can be deeply internal and private feelings of shame (our shame renders disclosure all the more painful and vulnerable, thereby compounding originating feelings of shame), it is an inherently social emotion on two levels: first, by acknowledging that one's behavior failed to achieve social values, shame acknowledges and accepts these values. Second, shame centers relationships and the fear of judgment by another for one's failure to abide by these norms. Sociologist Erica Millar (2015) thus argues that "abortion shame" reifies normative prescriptions of motherhood since abortion patients who experience shame understand how they deviated from their prescribed role as (future) mothers. These patients experience shame either because they failed to act sexually responsibly and did not use proper birth control practices or they feel shame because they acted in ways that renounced societal expectations of them as mothers. However, she further argues that the very act of experiencing shame reifies women's prescribed maternal role since they acknowledge, and hence espouse, that role, even as they deviated from it.

Regret similarly entails self-evaluation, but it is different in that it is not necessarily a public, outward-facing feeling. Regret is not a reflection of whether we abided, or not, by societal norms. And it most definitely does not carry the threat of public revelation and exposure that shame does. Regret's self-evaluation, unlike shame's self-evaluation, comes from gauging our previous decisions and choices (Landman, 1993; Donath, 2015). A choice we previously made comes to be reconceptualized as a mistake, whereby we wish to have chosen differently. The source of self-evaluation is thus different between shame and regret. The former is an internalized evaluation according to social norms and how our actions reveal our moral status. The latter is a retroactive evaluation of one's choice, which becomes a mistake upon realizing the consequences (or lack thereof) of one's decision.

Regret thus resembles guilt more than it resembles shame. In fact, scholars argue that the two are so similar that guilt entails "regret over the 'bad thing' that was done" (Landman, 1993, p. 54) and is often, though not exclusively, a reaction that a concrete action (Ahmed, 2015). Guilt is further understood by some scholars as a form of self-evaluation that happens irrespective of the threat of public exposure, unlike shame (Miceli & Castelfranchi, 2018). As I will argue throughout this chapter, "abortion regret" similarly operates in ways that individualizes responsibility and eclipses how cultural norms inform our appraisal of our actions. And while regret and guilt both center an agentive subject with (relative) control over their actions, I argue that regret presumes a decisional process contingent on the agent's recognition that they are multiple alternatives from which to choose.

And this is the distinguishing characteristic of regret: it presumes the (previous) availability of choices (Landman, 1993). While there is little to no research by affect theorists or abortion scholars that conceptualizes regret, psychologists and economists have paid a lot of attention to regret. Psychologists have found that people's experiences of regret are positively correlated to their sense of opportunities. In other words, the more someone believes they have the opportunity and freedom to make choices, the more likely they are to later experience regret (Roese & Summerville, 2005). Indeed, an individual's sense of responsibility and agency is what distinguishes regret from disappointment (Zeelenberg et al., 2000). Participants reported higher regret when they were responsible for a negative outcome, hence when they were labeled as "choosers", whereas participants felt more disappointment when they experienced negative outcomes because of random procedures. Regret is further compounded by "lost opportunity", which is the belief that these previously available opportunities are no longer available (Beike et al., 2008). Regret thus has two idiosyncratic characteristics: self-evaluation that engenders "self-blame", or "self-recrimination", for making a bad decision and the retroactive process of imaging what *could* have been had we not made the wrong decision (Connolly & Zeelenberg, 2002; Sugden, 1985). In other words, regret is about agency, bad choices, and self-blame. I'm regretful because I had the opportunity, the freedom, to choose differently.

4.3 From Rights to "Choice"

The "abortion regret" discourse emerged in a larger cultural context that underscored women's "right to choose". In 1986, the Supreme Court was just one vote away from reversing *Roe* in *Thornburg v. American College of Obstetricians and Gynecologists.* This reinvigorated a relatively dormant pro-abortion movement and spurred activists to develop a new defensive strategy that would appeal to a broader and more moderate constituency (Allen, 2014; Gerber

Fried, 2017; Tonn, 1996). To this end, strategists developed conservative messaging that eschewed feminists' earlier claims about women's rights and abortion's emancipatory potential. Instead, this new conservative approach sought to appeal to libertarians who feared big government's encroachment on "tradition, family, and property" (Saletan, 1998, p. 113). Abortion rights were saved from decimation, but at a cost. Strategists developed the motto: "Who Decides – You or Them?". Libertarians could thus align themselves with abortion rights without abandoning their commitments to traditional values and family sovereignty (Ross, 2016, Saletan, 1998; Solinger, 2001). The State could not encroach upon individuals' private decisions, but this rhetorical strategy still legitimized incremental restrictions such as parental and spousal consent requirements and funding restrictions. Individuals, and really parents and husbands, were free to make reproductive decisions but, in the same vein, the State did not bear the responsibility to materialize individuals' reproductive choices. The rhetorical shift away from fundamental rights to anti-government rhetoric worked to protect abortion rights, but only the restricted right to make a reproductive choice and not the right to access abortions.

Simultaneously, other factions within the pro-choice movement sought to personalize these lofty, legal discourses of choice by emphasizing the torment, decisional ambivalence, and moral agony that abortion patients experienced. Using the personal narrative of abortion patients proved effective on two fronts: not only did it render an otherwise abstract issue for many tangible and relatable, but it also served to demonstrate that women did not make their abortion decision frivolously and carelessly (Tonn, 1996). Instead, these narratives spoke to the deep moral anguish felt by pregnant women as they debated terminating what many had come to conceptualize as human life. Most of these accounts were unrepresentative of most patients' decisional and post-abortion experiences and were the product of extraordinary and traumatic circumstances. Regardless, generalizing these women's abortion experiences worked to simultaneously demonstrate abortion patients decisional and moral righteousness, thereby attempting to counter anti-choice accusation of women's murderous selfishness. The idealized abortion patient expresses ambivalence and reservation about abortions and conceptualizes her own termination as an act of desperation in reaction to circumstances, such as an unreliable partner or a fetal anomaly, beyond the scope of her control (Allen, 2014). And, importantly, these narratives, despite their best attempts to redeem abortion patients, both presumed, reified, and naturalized anti-choice claims about maternal instinct, fetal life, and hence about the morally ambiguous, fraught, and destructive nature of abortions (Allen, 2014; Tonn, 1996).

This larger rhetorical shift ultimately gave rise to the discourse of women's "right to choose", which has garnered considerable criticism from reproductive justice scholars, and remained a prevalent and broadly palatable motto (Smith, 2005). Most notably, Rickie Solinger (2001) argues that the "right to choose" "impossibly mixes 'right', a privilege to which one is justly entitled, and 'choice', the privilege to exercise discrimination in the marketplace among several options, if one has the wherewithal to enter the marketplace to begin with" (p. 6). In other words, women's (reproductive) choices are not understood as something they inherently are entitled to but something they can access, if they can afford them. Many reproductive justice scholars have echoed Solinger's argument that the "choice paradigm" effectively erases the conditions that circumscribe both women's access to abortion and their reasons for pursuing abortion (Luna & Luker, 2015; Price, 2010; Ross, 2016; Smith, 2005; Weingarten, 2012). In this lens, women who choose an abortion because they cannot afford (another) unplanned though potentially desired child are simply exercising their "right to choose". Similarly, this lens omits the financial circumstances that may prevent some women from accessing desired abortions. By centering women’s choice, both the State and taxpayers are absolved from bearing the financial responsibility for materializing women’s (reproductive) freedom. The “choice paradigm” thus underscores individual responsibility, thereby legitimizing decreased social support networks. Emphasizing any decision or behavior as someone’s autonomous choice deeply decontextualizes these choices from the constraints and circumstances under which people make these choices, thus nominally promoting a limited form of freedom while absolving the State from any responsibility in materializing the genuine availability of opportunities freed from financial and material restraints (Gill, 2008). It nominally retains a liberal understanding of negative freedom, which presumes and requires governmental neutrality, while erasing the material circumstances under which women make (reproductive) decisions (Roberts, 1995).

Importantly, women’s (reproductive) choices have continually been prone to scrutiny. The legalization of birth control and abortion expanded women’s ability to better control the trajectory of their lives as they acquired the ability to safely engage in non-reproductive heterosexual sex without the perpetual fear of pregnancy. And, if they had an unplanned and unwanted pregnancy, they could resort to abortion. However, reproductive justice scholars have argued that with these increased choices came increased individualized responsibility and increased scrutiny (Millar, 2015; Solinger, 2001). Women became almost exclusively responsible for engaging in effective and safe birth control practices (Millar, 2015). They were no longer shamed for engaging in nonreproductive premarital sex but were instead shamed for unwillingly getting pregnant when they had so many contraceptive choices. An unwanted pregnancy was thus understood as a woman’s failing to act responsibly and proactively and was a symbol of her poor choices. Women of color, and Black women in particular, have been particularly vulnerable to surveillance and scrutiny. Rickie Solinger (1998) has argued that choice and dependency form a continuum, whereby poor choices are understood as engendering dependency, and, in turn, dependency legitimizes more scrutiny of one's choices. In other words, poor women, under the "choice paradigm" are blamed for their poverty, which justifies increased judgment and regulation of their (reproductive) choices. This lens helps explain why legislators have successfully passed bills that both restrict poor women's ability to have children by compelling them to "choose" long lasting or permanent sterilization to access welfare payments *and* bills that curtail abortion coverage. In both cases, poor women are blamed for their bad choices. They are blamed for "irresponsibly" have children they cannot afford, and they are blamed for engaging in unreproductive sex. And yet, in all these cases, women's reproductive choices are externally evaluated by outside parties. "Abortion regret", on the other hand, is all the more powerful and productive because it centers the pregnant women as the decision makers *and* as the evaluators. It is women who scrutinize their own decisions and come to understand themselves as (temporarily) bad decision makers.

4.4 Abortion Regret: (Retroactively) Choosing Motherhood

The 2007 Supreme Court case *Gonzalez v. Carhart*, which upheld the 2003 so-called Partial-Birth Abortion Ban Act, was pivotal in writing the "abortion regret" discourse into legal dicta.[37] The 2003 ban proscribed Dilation and Extraction (D&X) abortion procedures. Both Dilation and Evacuation (D&E) and D&X procedures are later-term abortions that are performed throughout the second trimester and beyond. The former first requires the dilation of the cervix,

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[37] Dr. Martin Haskell first discussed the medical benefits of D&X procedures at the National Abortion Federation conference in 1992. The ACOG then named the procedure to its current medical name 'Dilation and Extraction' and publicized it as a safer later-term abortion procedure (Armitage, 2010). The National Right to Life Committee (NRLC) denounced this term for sounding like an "obscure, clinical sounding euphemism", instead coining the procedure "partial birth abortions". Policy advisor, Hannah Armitage, has argued that coining the procedure "partial-birth abortion was particularly effective in raising awareness and resulting repulsion concerning the procedure. By thus associating the procedure with infanticide, the NRLC altered the vocabulary and terms of the abortion debate (Armitage, 2010, p. 31).

which then allows for the insertion of forceps used to retrieve the fetus (Rovner, 2006). This often results in fetal dismemberment and incremental retrieval. D&E procedures thus pose the heightened risk of cervix perforation, excessive blood loss, and future infertility. Given these heightened risks, the American College of Obstetricians and Gynecologists (ACOG) favored D&X procedures as safer later-term procedural alternatives, in which the physician withdraws the intact fetus by its feet, following dilation. The fetal head is then punctured or suctioned, while remaining in the woman's cervix, allowing for easier passage. The Supreme Court upheld the 2003 ban proscribing D&X procedures, even as ACOG testified that these were "necessary and proper in certain cases" since they minimize medical risks for women undergoing abortions (*Gonzalez v. Carhart*, 2007). Justice Kennedy, writing for the majority stated that:

> Respect for human life finds an ultimate expression in the bond of love the mother has for her child … Whether to have an abortion requires a difficult and painful moral decision … While we find no reliable data to measure the phenomenon, it seems unexceptional to conclude some women come to regret their choice to abort the infant life they once created and sustained. See Brief for Sandra Cano et al. as *Amici Curiae* in No. 05-380, pp. 22-24. (…) The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who come to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form (*Gonzalez v. Carhart*, 2007, p. 28-29).

Regret, here, is the consequence of "a difficult and painful moral decision". Despite a lack of "reliable data", the Court assumes that some women regret their decision to "abort the infant life they once created and sustained"; a sentiment that is compounded by "grief more anguished and sorrow more profound" upon learning about the procedural techniques of the D&X. The abortion patient's regret, in this framing, is a direct result of a choice she comes to understand as a mistake, one she could have escaped had she entirely avoided an abortion or had she chosen the D&E as opposed to the D&X.

The *Gonzalez* Court's (mis)use of evidence has already been largely denounced (Ahmed, 2015; Appleton, 2011; Ehrlich, 2014; Ehrlich & Doan, 2019; Huff, 2014; Manian, 2011; Madeira, 2014; Siegel, 2008; Turner, 2008). The Court chose to ignore ACOG's *amicus* brief that testified to the procedure's medical necessity in some circumstances and, instead, cited the Brief of Sandra Cano, the Former "Mary Doe" of Doe v. Bolton, and 180 Women Injured by Abortion as Amici Curiae. The brief was filed by the conservative law center The Justice Foundation quoting affidavits collected by Operation Outcry on behalf of 180 "post-abortive women who have suffered the adverse emotional and psychological effects of abortion".[38] The 180 testimonies in the brief are just a sampling from approximately 2,000 narratives reporting women's post-abortion emotional trauma and pain. Operation Outcry's process of collection has been denounced as being methodologically flawed and biased since these women's anecdotes, while presumably true under threat of perjury, are unrepresentative. Regardless, these testimonies and the process of curating these for the brief provide insight into the ways in which the organization, and abortion patients, make sense of their abortion experience and of "abortion regret".

The brief's overarching premise was that *Doe v. Bolton*'s (1973) health exception had engendered a floodgate of abortions, without consideration for the psychological harm caused by abortions. Since *Doe* stated that an abortion was deemed necessary "in light of all factors – physical, emotional, psychological, familial, and the woman's age relevant to the wellbeing of the patient", women had effectively been able to access "abortion on demand". Decades later, it

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[38] Operation Outcry is the ministry of the Justice Foundation, which represented both Norma McCorvey, otherwise known as "Jane Roe" in *Roe v. Wade* (1973), and Sandra Cano, formally known as "Mary Doe" in *Doe v. Bolton* (1973), in their attempts to overturn the legalization of abortion (Siegel, 2008). Operation Outcry's purpose is to collect "legally admissible, written sworn testimonies from women hurt by abortion" to substantiate the claims that abortion harms women and that it terminates fetal life (Operation Outcry, n.d.)

was apparent, according to the brief, that abortion psychologically devastates women. The brief cited both the work by Dr. Vincent Rue, who originated PAS, and Dr. David Reardon, who is largely recognized as originating the Woman-Protective Antiabortion Argument. Their research was further corroborated by the "real life experiences of the post-abortive women", which resoundingly concluded that: "Typical responses from their sworn Affidavits included depression, suicidal thoughts, flashbacks, alcohol and/or drug use, promiscuity, guilt, and secrecy. Each of them made the 'choice' to abort their baby, and they have regretted their 'choices' (p. 17). Even as the painful experiences of many of these women vary, regret is often centered as the unifying, shared emotion that engenders "depression, suicidal thoughts, flashbacks, alcohol and/or drug use, promiscuity, guilt, and secrecy". In this framing, depression, suicidal ideations, hypersexuality, and addiction are symptoms of their mistake, which forever haunts them.

In their testimonies, women report experiencing a wide variety of often excruciating and devastating emotional consequences. Some believe that they are grappling with post-abortion syndrome and experience many of the symptoms associated with the alleged disorder. Some have difficulties either bearing or raising children, which they often understand as being engendered by their abortion. Many experience years, if not decades, of crippling mental anguish, have suicidal ideations, deal with addiction and overwhelming feelings of guilt, grief, pain, sadness, and anger. It is thus impossible to categorize all the varied and complex emotional experiences under a single emotional experience. However, there is generally a shared sense of responsibility for choosing the abortion.

In these anecdotes, many women have come to understand their abortion as their decision to murder their child. For example, Vanessa McDonald, from Texas, reported: "When I aborted my child 6 years ago, I wish I had known how much misery I would live in because of it. I killed my own baby – I should have been the one person in the whole world to protect and love her. I think about her every day and wish I had chosen to have her and know this precious baby. I am now overprotective of my 1-year-old little girl. I overcompensate because of my loss" (p. 48). Similarly, Elizabeth C. Patchet, from Wisconsin, describes: "Emotionally I have had a difficult time with grief, guilt, shame and regrets. The thought that I chose to kill two of my own children has been overwhelming. I am emotionally hardened as a result" (p. 73). In both cases, these patients grapple not only with the sense that they murdered their child, but that they chose to do so willingly and only later realized the depth of their mistake.

Often, what is conceptualized as a murderous choice is exacerbated by the fact that their choice is irrevocable and that they can never undo their mistake. Lori Crossman, from Michigan, lamented that her abortion "devastated me emotionally, mentally, and spiritually. I cannot go back and reverse my "choices" – I cannot get my children back. They are dead because abortion was legal and easy to access" (p. 44). Diane M. Hanson, from Colorado, describes that her abortion "changed my life, how I viewed myself, it took away my self-worth. It was devastating and caused several years of intense pain and sorrow. The hardest part was knowing 'it was my choice' that caused my baby's death and I couldn't do anything to change that or make it better" (p. 39). Often, the term "choice" is put in quotes as if to indicate that the women, in retrospect, realized that what was portrayed as a choice could not be a genuine and positive choice and was only a temporary and selfish solution. Karyn Schneider from California reported that: "It has been nine years since the abortion and honestly not one day has gone by when I haven't thought about what I did. I've suffered from depression, crying constantly, extreme agony, wishing I could have those moments back so I could choose life – to choose my child over my selfishness.

Absolutely *no* good has come of the choice I made killing my first child, struggling with fertility issues, longing for the one I had but then let go" (p. 61). Most of these women take full responsibility for making their abortion decision, and consequently, often feel that they deserve punishment. L.M.J, from Michigan acknowledged that "I take full responsibility for my poor decision regarding abortion. Had I known when I finally 'grew up' that I would be so psychologically damaged and suffered from so much pain and grief, I would have never gone through it" (p. 55). Even in circumstances when women did not yet forecast the depth of their future despair or when they blame the "abortion industry" for misleading them, they still feel responsible for believing the myth that abortions are harmless. For example, Jackie Lynn Garner, from Oklahoma, reported that: "I will always regret falling for the mistaken social belief that abortion was a quick and painless resolution to my unplanned pregnancy" (p. 42). Overwhelmingly, these women wish they would have chosen differently when they had the opportunity to do so. In other words, their regret is engendered by a sense of responsibility that comes from having had the agency and freedom to make their reproductive choices and only retroactively realizing their mistake. Regret, as it is conceptualized by the Supreme Court and these women, is only a possible consequence of having had the agency to make choices.

4.5 Rationalizing Motherhood

This is what makes the "abortion regret" discourse so powerful and palatable. Unlike PAS, which pathologizes abortion patients and renders them dependent on specialized recovery care, the "abortion regret" discourse centers women as decision makers and produces them as rationally choosing motherhood, even if retroactively. In this following section, I will argue that, much like the larger "choice paradigm" under which the "abortion regret" discourse emerged, "abortion regret" erased the conditions under which women make their abortion decisions, thus individualizing responsibility. This thus produces women as independent decision makers. Regret further produces abortion patients as *temporary* bad decision makers, whereby their regret rehabilitates them as good decision makers who ultimately choose motherhood, despite their abortions.

Returning to the *Gonzalez v. Carhart* (2007), the Court simply assumed that "some women come to regret their choice to abort the infant life they once created and sustained" (p. 29). There is no indication that the justices account for the circumstances under which women made their abortion decision. The Court thus overlooked pregnant women's relationships with loved ones and how these may circumscribe their decision to terminate the pregnancy (Madeira, 2014). Instead, it relied on a narrow understanding of decision-making in which the atomistic agent is artificially insulated from relational and social influences. Nor did the Court account for the ways in which social disapproval, the loss of a romantic relationship, or pragmatic concerns over financial resources often contribute to post-abortion emotional difficulties (Kimport, 2012; Rocca et al., 2020). The Court further collapses entire decisional processes and moments into a singular form of regret: the yearning for fetal life. Patients could regret a whole myriad of decisions that led them to the abortion without regretting the actual procedure and the loss of fetal life (Watson, 2014). It effectively uses "regret" as an umbrella and abstract term that erases the conditions under which women make reproductive decisions and the factors that contribute to their emotional experiences.

Additionally, the Court presumes a relatively monolithic emotional experiences for all abortion patients without considering the specific circumstances of women pursuing later-term abortions. It is important to remember that the *Gonzalez* Court was not dealing with abortion rights, generally, but was considering the proscription of D&X procedures, which are performed throughout the second and third trimester. Later-term abortions are a minority of all performed abortions in the United States. Ninety-one percent of abortions occur throughout the first trimester, before the end of the thirteenth gestational week. Seven percent are performed between the 14th and 20th week, while only 1% of all abortions occur after the 21st gestational week (Greene Foster & Kimport, 2013). While little is known about the profiles of women who obtain later-term abortions, research has shown that logistical barriers overwhelmingly explain why women obtain later-term abortions. The procedure is often postponed because of women's difficulties in finding a provider or in procuring the necessary funds to cover the procedure and/or travel. Women may additionally pursue later-term abortions because of recently acquired knowledge of fetal anomalies (Guttmacher Institute, 2017). Women seeking later-term abortions are more likely to experience a variety of emotional turmoil due to the stress of navigating logistical barriers or because they are mourning the termination of a desired pregnancy.

Centering regret thus enabled the Court to erase these material circumstances and thereby naturalizes motherhood as women's rational, even if delayed, choice. Under the "abortion regret" discourse, abortion patients are likely to regret their abortion decision because of their retrospective realization that they did, in fact, desire motherhood. By erasing why women chose abortion, women's abortion decisions are removed from the reality of their lives, from the financial pressures they may face, from the reality of raising other children while having to work. As such, regretting one's abortion works to reify the assumption that pregnant women are inherently and already mothers who share a loving bond with their pregnancy. Indeed, Justice Kennedy refers to the pregnant woman as a mother and the fetus as a child who share a "bond of love". What is so powerful about the regret discourse, as opposed to PAS and even compared to similar emotions like shame, is that the retrospective evaluation of women's choice is done by abortion patients themselves. This further legitimizes motherhood as the ultimate choice because it is women themselves, not psychiatrists, legislators, or taxpayers, who come to realize that motherhood is their ultimate desired choice, even as they previously chose abortion. Many of the women from the Justice Foundation's *amicus* brief seem to conceptualize of themselves as mothers and the aborted pregnancy as their child. Many imagine what their child would have been like. The imagined child is thus an important character in compounding women's regret, while simultaneously enabling regretful women to understand themselves as (imagined) mothers.

Indeed, an important strategy of the WPAA was to reconcile the threatened maternal-fetal bond. As I discussed in Chapter 1, an important anti-choice strategy was to either erase the pregnant woman and/or constitute her as distinctly separate from, and in conflict with, the fetus. Medicine, science, and visual culture constructed a free-floating, almost agentive, and autonomous fetus who deserved separate legal protection and recognition and medical care. David C. Reardon (1996) called for reconciling maternal-fetal interests: "It is noteworthy that abortion was legalized only after pro-abortionists succeeded in promoting their argument that when there is a conflict between the rights of a woman and the rights of her unborn child, the rights of the woman must prevail" (39). He further denounced the anti-choice movement's hitherto exclusive fetal-centric focus and calls, instead, for a strategy that understands the deep and inextricable shared interests of the mother and her fetus: "If there is a single principle, then, which lies at the heart of the pro-woman/pro-life agenda, it would have to be this: *the best interests of the child and the mother are always joined*" (Reardon, 1996, p. 5).

"Abortion regret" not only works to reify motherhood as women's ultimate reproductive choice, but it also casts motherhood as the rational choice. The Justice Foundation's collection of testimonies was also used in the Report of the South Dakota Task Force to Study Abortion, which was submitted to the Governor and Legislature of South Dakota in December 2005. One of its conclusions was that:

> (…) abortion related reasoning in young women is significantly lower than their general reasoning abilities. There can be no doubt that a pregnant mother considering an abortion is under stress, in crisis, and is vulnerable to the suggestions of others. However, after the stressfulness of the decision and the procedure has ended, women's cognitive abilities return to natural, often ushering in feelings of pronounced guilt, sadness, and regret (South Dakota Task Force to Study Abortion, 2005).

The very decision to undergo an abortion "significantly" lowers pregnant women's "reasoning abilities". The very process entails stress and vulnerability, which renders pregnant women more prone to persuasion and influence. Once women overcome the procedure, and its related stressors, her "cognitive abilities return to natural". And it is upon this return to normal "cognitive abilities" that women realize the depth of their mistake and experience "guilt, sadness, and regret". In other words, women's abortion decision is an irrational reaction to a stressful event, and regret is a rational reaction. Regretting one's abortion, or the yearning to have become a mother, is thus a rational emotion that restores motherhood as women's choice and rehabilitates women as rational decision makers.

Much like PAS, the "abortion regret" discourse frames the abortion decision as a deviant, abnormal, and irrational. Regret, like PAS, thus becomes the redeeming emotion that restores abortion patients as mothers, despite their abortion decision. However, PAS is a deeply therapeutic, and hence pathologizing, discourse. PAS is "an adaptive response to a maladaptive decision to have an abortion" (Speckhard & Rue, 1992, p. 113). The "abortion regret" discourse similarly frames the abortion procedure as maladaptive and ensuing painful feelings as appropriate, but it eschews the pathologizing framing and language and replaces it with the language of rationality, cognitive abilities, and choice. "Abortion regret" thus produces abortion patients as mothers and simultaneously as rational decision markers. The very experience of regret casts the abortion decision as a temporarily irrational one, whereby women retroactively realize the depth of their mistake. Under the "abortion regret" discourse, women are still rational agents with access to reproductive choices, but they are the agents who ultimately choose motherhood by regretting their abortion.

Interestingly, separate behavioral economists simultaneously developed regret theory in the late 1980s as an alternative to expected utility theory to explain people's decisions (Bell, 1982; Loomes & Sugden, 1982). Economists were confounded by the fact that individuals did not always act rationally and made choices that violated "conventional expected utility axioms" (Loomes & Sugden, 1982). They identified the fear of experiencing regret as a significant factor in individual's decisional processes. People were not just concerned with the consequences of their decision, but with the possibility that an alternative to their choice may ultimately be more desirable. And this fear of regret factored into individuals' decisional processes as they sought to minimize the chances of experiencing regret, hence the chances of yearning for the jettisoned alternative (Diecidue & Somasundaram, 2017). Importantly, this process of preemptively seeking to avoid regret thus transformed regret from a mere emotion to a rational choice behavior for behavioral economists. The threat of regret rehabilitated rational choice and utility theory even as it threatened their very premises.

This is important for our purposes because it speaks to the ways in which regret, more broadly, is conceptualized as productive, potentially positive, enriching, and ultimately rational emotion. It is not just an emotion, but it is a decisional consideration that both redeems regretful subjects as rational agents and it helps people's cost-benefit analysis as they consider their future choices. Mobilizing regret specifically, in addition to emotions such as shame and sadness, thus enables the anti-choice movement to (re)naturalize motherhood. Shame is productive in similarly naturalizing motherhood but it does so by emphasizing abortion patients' failure to abide by societal and relational norms (Millar, 2015). But motherhood, under the "abortion regret" discourse, is not a product of externally imposed and then internalized gendered roles. Instead, motherhood is framed as women's rational choice that they came to after making an abortion decision. The "abortion regret" discourse thus produces and rehabilitates abortion patients as rational decision makers, who were temporarily irrational, made a bad choice, and ultimately chose motherhood. It reconciles and juxtaposes neoliberal discourses of choice with conservative refrains about women's inherent role as mothers.

4.6 From Regret to Relief

Given the "abortion regret" discourse's reliance on the availability of choice, its emphasis on personal responsibility, self-evaluation, agency, and rationality, it was easily integrated into pro-choice texts. In this following section, I will examine social scientific research that attempts to disrupt and complicate the "abortion regret" discourse. Studies have repeatedly concluded that a vast majority of abortion patients do not experience regret and, in fact, overwhelmingly experience relief. I will argue that this research simultaneously complicates and perpetuates the "abortion regret" discourse. Not only are relief and regret mutually constitutive, claims about either abortion regret or relief are perpetually engaged in the practice of evaluating women's decisional processes and attempting to produce women a good decision-makers. "Abortion relief" simultaneously complicates the "abortion regret" discourse, while paradoxically reaffirming its perpetual threat.

The Turnaway Study, housed at the University of California, San Francisco, is the only methodologically rigorous longitudinal study examining the impact of unwanted pregnancies. It spans dozens of articles that compare the effects of undergoing an abortion as opposed to the effects of carrying an unwanted pregnancy to term. The researchers have repeatedly concluded that women denied an abortion are more likely to remain in abusive relationships, to experience higher-risk pregnancies, and to suffer from anxiety, chronic pain, and gestational hypertension. But it is the study's findings about post abortion emotions and "decision rightness" that have garnered wide news coverage (Burbank & Kwong, 2022; Burns, 2020; Chiu, 2022; Christensen, 2020; Jenkins, 2015; Rapaport, 2020; Schiller, 2015). These news articles all report the catchphrase that 95% of women do not regret their abortions and that, in fact, most experience post-abortion relief. This, unsurprisingly, misses much of the nuance of the studies' actual findings that distinguish post-abortion emotions from women's sense of "decisional rightness". What seems noteworthy about the Turnaway Study is that most women's feelings about their abortion decrease throughout the years: "Over time, the percentage of women expressing feeling none/few negative emotions increased sharply, to 45% at one year and 63% at three years, plateauing thereafter" (Rocca et al., 2020, p. 4). By the fifth post-abortion year, 64% had "low emotions", while 19% experienced primarily positive emotions (Steinberg, 2020). The fact that most women ultimately feel neutral or feel little, whether positive or negative, about their abortion throughout the years, while "the intensity of relief declined significantly among all groups" (Rocca et al., 2020, p. 4) seems significant in disrupting claims that abortions cause emotional reactions that warrant stringent regulations. It's not that abortion patients actively avoid thinking about their abortions and thus may feel latent and repressed emotions, as threatened by the PAS diagnosis. Most women feel little to nothing. Their abortion is no more noteworthy or disruptive than the many quotidian life-decisions we all encounter.

And yet, despite this neutrality, journalists and researchers focus on the studies' findings that a vast majority of abortion patients feel that their abortion decision was the right decision because this most effectively counters anti-choice claims about abortion regret. And the fact that 95% of women, immediately post-abortion and in the years following their procedure, consider the abortion decision to have been the right one is important information (Rocca et al., 2020). It counters claims that women may, eventually, come to regret their abortion by demonstrating that only relatively few women come to experience their abortion. It substantiates the fact that women make weighted and informed decisions that consider the complexities of their lived circumstances.

And yet, the fact that this research has been repeated in 2013, 2015, and again in 2020 speaks to the perpetual practice of evaluating women's "decision rightness" about their abortions and their lives (Rocca et al., 2013; Rocca et al., 2015; Rocca et al, 2020). It falls into the very dichotomy framed by anti-choice researchers, legislators, and activists that erases the nuances and complexities of women's reproductive decisions and lives and instead produces a "relief/regret polemic" (Weitz et al., 2008). Relief is offered as an oversimplified and similarly decontextualized counterweight to regret, whereby relief and regret are "antitheses that depend on each other for meaning" (Solinger, 1998). And, it perpetually begs the question of what policy interventions should be implemented *if* research found that women actually did regret their abortion. In other words, this research, while having important, immediate policy potential, also upholds practices of evaluating women's choices in ways that are not replicated across medical decisions more generally.

Research on “medical regret” is comparatively scarce (McQueen, 2017). Medical ethicists debate acceptable levels of regret and whether physicians’ refusal to provide a procedure because of the possibility of regret hinders patients’ autonomy (Djulbegovic, 1999; McQueen, 2017; Watson, 2014). Post-treatment regret has primarily been studied in prostate and breast cancer patients (Christie et al., 2015; Davison & Goldenberg, 2003; Fernandes-Taylor & Bloom, 2010; Hu et al., 2003), in patients seeking gender confirmation treatment (MacKinnon et al., 2021; Olsson & Möller, 2016), in patients seeking voluntary sterilization (Curtis et al., 2006; Hillis et al., 1999) and in abortion patients. In other words, the experience and threat of regret has primarily been considered when medical procedures destabilize conventional gendered and sexual norms. Even so, research on “medical regret” largely acknowledges the inevitability that some patients will regret their procedure and some ethicists resign themselves to this (McQueen, 2017; Watson, 2014). The uncertainty surrounding all (medical) decisions means that the threat of regret always looms large. Patients do not know how painful, long, or isolating a procedure may be. They cannot forecast the support they will receive. Nor can they anticipate the extent to which their lives will resume normally. The very process of making decisions, of having choices and agency, entails that some will wish they had chosen differently. That is the very risk inherent in having choices: the perpetual threat of regret.

To scrutinize abortion patients’ “decision rightness” and feelings of relief and regret upholds and materializes the practice of evaluating women’s decisional capacity rather than simply accepting abortions as just another medical and life decision that may, for some, engender complex and sometimes conflicting and painful emotions. It perpetuates practices that distinguish women as good decision makers from those who make poor decisions. And, despite attempts to complicate and refute the “abortion regret” discourse, it ultimately reifies the very threat it seeks to eliminate. Indeed, the scholarly practice of focusing "on positive representations of abortion may, therefore, help amplify their normative effects" (Baird & Miller, 2019, p. 1118) by upholding abortion procedures as atypical ones that warrant a level of scrutiny and oversight rarely found with other medical interventions.

4.7 Conclusion

The "abortion regret" discourse was just one particular iteration of the larger Woman-Protective Antiabortion Argument that emerged in the late 1990s and early 2000s. Previous fetal-centric efforts had proved largely ineffective and prominent activists called for the popularization of a strategy that had previously been localized in Crisis Pregnancy Centers. By claiming that abortion harmed women, anti-choice leaders hoped to simultaneously tap into the discourses of feminism and public health to appeal to the "middle majority" who valued fetal life *and* women's decisional freedom. The "abortion regret" discourse, while finding its antecedent in Post-Abortion Syndrome, was free of the pathologizing and therapeutic language of PAS. The availability of choice and processes of self-evaluation that engender self-blame are regret's idiosyncratic features that distinguish it from similar emotions such as shame or disappointment. Indeed, the "abortion regret" discourse emerged in a larger political context in which women had more reproductive choices than they ever had, and these choices were vulnerable to constant scrutiny and evaluation. This process of evaluation distinguished good, hence responsible and resourceful, decision makers from bad, hence irresponsible and impoverished, decision makers. Unlike feminists' previous arguments that abortion was a fundamental right necessary for materializing women's emancipation and equality, the "choice paradigm" absolved taxpayers and the State of the responsibility to materialize these choices. The "abortion regret" discourse is particularly powerful and productive because it produced women as the decision makers and, simultaneously, as the evaluators of their own decisions. Abortion patients came to choose (imaginary) motherhood, despite their choice to terminate their pregnancy. Being regretful thus rehabilitated them as rational decision makers *and* as mothers. Motherhood was the rational choice and abortion was the irrational choice, made in a moment of stress and decreased cognitive abilities. Regretful abortion patients chose motherhood not because of internalized traditional gender norms but because they came to the realization that they wanted to be mothers.

In the next chapter, I turn my attention to informed consent statutes in abortion regulation. In some instances, these explicitly mention the possibility of regret. But, more generally, these two strategies are mutually constitutive because both are concerned with the content and quality of women's abortion decisions. While the "abortion regret" discourse warns of the alleged consequences of a bad reproductive decision, the informed consent statutes seek to improve pregnant women's decisional processes.

CHAPTER 5

“Safe Abortion is an Oxymoron”: Curtailing Reproductive Freedom through Patient Autonomy and Positive Rights

Before *Roe v. Wade* (1973) was overturned under *Dobbs v. Jackson Women’s Health Organization* (2022), Texas Senate Bill 8 (SB8), otherwise known as the “Texas Heartbeat Act”, went into effect on September 1st, 2021. The statute banned abortions after the detection of “fetal heartbeat”, which usually occurs around the sixth gestational week – when most people are unaware of their pregnancy. What made SB8 so notable was not just that it effectively sought to criminalize all abortions. It was more widely denounced as draconian because it deputized citizens, thereby seeking to bypass judicial oversight since there was no governmental official to sue. Any private citizen who wanted could file a civil suit against anyone who “aids or abets” the procurement of an abortion, in hopes of collecting $10,000 (Ziegler, 2021). The bill’s language was so expansive and comprehensive as to render Uber or Lyft drivers culpable if, unbeknownst to them, they dropped off an abortion patient at a clinic where this patient would go on to receive a criminalized procedure (Goodwin, 2021; White et al., 2021).

Much like the *Dobbs* decision, SB8 was largely void of the Woman Protective Anti-Abortion (WPAA) rhetoric. The bill did not attempt to appeal to larger discourses around the alleged physiological and psychological dangers of abortion. Nor did the legislature reference pregnant women’s bodily integrity or “right to know”. Before *Dobbs*, SB8 was one of the (most publicly visible) canaries in the coal mine: the anti-choice movement no longer needed to mobilize the discourses of science and feminism in its quest to curtail abortion access. Donald Trump’s Supreme Court nominations would finally make the dream of overturning *Roe* in the near future a tangible and realistic goal. Indeed, this novel legal strategy did not rely on changing public perception about fetal personhood, nor did it attempt to pass incremental restrictions, as the movement had been forced to do in the years since 1973 (Schmidt, 2021). And yet, it nonetheless alluded to the strategy of mobilizing the informed consent doctrine.

SB8 criminalized abortions after the detection of "fetal heartbeat", thereby centering this physiological process as a "key medical predictor that an unborn child will reach live birth". In light of this, "to make an informed choice about whether to continue her pregnancy, the pregnant woman has a compelling interest in knowing the likelihood of her unborn child surviving to full-term birth based on the presence of cardiac activity" (Texas Heartbeat Act, 2021).[39] Even if just fleetingly, SB8 alludes to the remnants of the strategy of mobilizing the informed consent doctrine. Pregnant women still figure as individuals who can make an "informed choice" and who have "compelling interests". However, the decision whether to terminate a pregnancy is entirely contingent upon the "the likelihood of her unborn child surviving to full-term birth". Following this line of reasoning, irrespective of abortion's legal status, the legislature seems to presume that abortion patients will only terminate their pregnancies when no cardiac activity is detected. The choice, here, is not whether to terminate a pregnancy irrespective of fetal development or stage, as *Roe*'s first-trimester privacy right protected. Instead, the choice is whether to bring to term a healthy pregnancy or to terminate an unviable pregnancy. What would likely be considered medical necessity by many – to abort an unviable pregnancy – is framed here as a woman's "informed choice". Abortions before this moment remained legal, while those thereafter were not only proscribed but also presumably unwanted by the patient. The ultrasound, and the detection of cardiac activity, thus worked as a sort of modern quickening, whereby

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[39] The American College of Obstetricians and Gynecologists (ACOG) has denounced the term "fetal heartbeat" as medically inaccurate and ideologically laden. The sound heard during an ultrasound in very early pregnancies is "the ultrasound machine translating electronic impulses that signify fetal cardiac activity" (n.d.). At those stages, there are "no chambers of the heart developed" that would render a "heartbeat" recognizable.

certain physiological processes become associated with markers of humanity that are then used to legitimize some abortions and criminalize others.[40]

SB8 illustrated the protean and versatile nature of the informed consent doctrine and its foundational notions of consent, autonomy, and by extension, of refusal and coercion. While the "information" produced by the ultrasound in SB8 is the same information that abortion patients had been encouraged, if not compelled, to listen to for years, the terms of the abortion decision are different. SB8 uses "fetal heartbeat" as an indication of a healthy pregnancy that will "reach live birth". Previous statutes use ultrasounds in an attempt to personify the fetus and produce the patient as its mother, irrespective of her willingness to understand herself as such.[41] By SB8, the patients are already written into legislation as *willing* mothers. The ultrasound is no longer a desperate, last attempt to sway the woman's perception of the fetus' humanity, in hopes of "overwhelming the decision to abort by triggering something like a primitive maternal instinct" (Sanger, 2008, p. 396). The abortion patient is already presumed to have "primitive maternal instinct" and her decision becomes almost exclusively a medical one: whether to terminate an unviable pregnancy. In some ways, SB8 seems to restore the ultrasound's original "diagnostic purpose" (Sanger, 2008, p. 373).

Mobilizing the informed consent doctrine and reconceptualizing its foundational terms has been a popular and effective mechanism of what Reva Siegel (2008) identified as the Woman Protective Anti-Abortion Argument strategy while the anti-choice movement awaited

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[40] As I discussed in Chapter 2, following British Common Law, at the beginning of the nineteenth century, abortion in the Unites States was only proscribed after quickening (Luker, 1984; Mohr, 1978; Saurette & Gordon, 2015; Smith-Rosenberg, 1985). As understood at the time, quickening was when the pregnant woman first experienced fetal movement, usually between the fourth to sixth gestational month (Luker, 1984; Mohr, 1978).

[41] Rosalind Petchesky (1987) argues that an article published in the *New England Journal of Medicine* is at the basis of the practices of viewing ultrasound that attempt to deter women from undergoing an abortion. According to the authors, early ultrasounds translated into "maternal bonding" since the pregnant woman will "experience a shock of recognition that the fetus belongs to them" (Fletcher & Evans, 1983, as cited in Petchesky, 1987, p. 265).

Roe's reversal. Since the early 2010s, we have witnessed a series of abortion legislation, often titled "Women's Right to Know", that structure and detail the informed consent process for abortion procedures (Daniels, et al., 2016). As indicated by their name, this legislation is meant to ensure that women's abortion decision is well-informed and voluntary. Political scientist Amanda Roberti (2021) analyzed 1,706 abortion bills between 2008 and 2017. She found that 70% of them used a "pro-woman" framing, while the remaining 30% were concerned with fetal personhood. These laws compel women to either 1) undergo counseling, 2) wait 24-hours between the counseling session and the actual procedure, 3) view the ultrasounds, 4) be informed of fetal gestational age, fetal developmental stages, fetal pain, and/or the unsubstantiated link between abortion and breast cancer, future infertility, and possible psychological trauma, and/or 5) refer patients to public and private agencies that can help them through their pregnancy, childbirth, and childrearing (Vanderwalker, 2012).[42]

This regulation does not help abortion patients, in practice. A vast majority of abortion patients are not swayed by compulsory waiting-periods, ultrasounds, or the onslaught of information that may, or may not, be relevant and helpful to them (Gould et al., 2013; Roberts et al., 2017; Upadhyay et al., 2017). Most proceed with their abortions as planned. This legislation delays time-sensitive care, burdens some patients with additional housing and/or childcare costs, and can, at worst, render abortions inaccessible to some (Rowlands & Thomas, 2020). Patients denied a desired abortion are then more likely to experience physical complications, depression,

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[42] 32 states compelled pre-abortion counseling and 28 of those detailed the information providers needed to disclose (Guttmacher Institute, 2016a). 27 of those state implemented waiting periods, which mandated between 24 to 72 hour waiting periods between a consultation and the procedure. 26 states included information about fetal development, while 12 states included information about fetal pain. Five states compelled physicians to inform patients that personhood begins at conception. 27 states inform patients about the risks of abortion, some of which discuss the alleged possibility of abortion reversals, potential infertility, the unsubstantiated link between abortion and breast cancer, and possible negative emotional consequences. 36 states mandate parental involvement, with the possibility of judicial bypass, by requiring either parental consent or notification (Guttmacher Institute, 2016b).

anxiety, and to remain impoverished and in an abusive relationship (Biggs et al., 2017; Gerdts et al., 2016; Miller et al., 2020; Roberts et al., 2014). In other words, these statutes have deeply curtailed women's (reproductive) freedom and threatened their emotional, physical, and material wellbeing.

The majority of the literature that examine informational requirements in abortion regulation explores the issue of informed consent within the limits of legal theory by comparing abortion restrictions to other legislation grappling more generally with informed consent in medical decisions. Some scholars have compared *Gonzalez v. Carhart* (2007) and ensuing abortion statutes to other legislative or ethical cases in which patients' decisional autonomy has similarly been overruled or preemptively prohibited (Manian, 2009; Tobin, 2008; Vanderwalker, 2012). These studies all conclude that abortion bans misuse the informed consent doctrine and deviate from general informed consent laws, thereby undermining pregnant women's decisional capacity. Other research explores the issue of professional speech to argue that abortion statutes infringe on physicians' First Amendment right by compelling them to disclose often inaccurate and/or misleading information, which deviates from professional recommendations that advocate for a reciprocal, open-ended, and adaptive communicative process (Daniels et al., 2016; Post, 2007; Shaw & Stein, 2016; Vanderwalker, 2012). These studies are important to 1) elucidate how medical findings are manufactured and distorted in order to personify the fetus, 2) demonstrate how these bans overlook legal precedent and impose atypically stringent informed consent regulations, and 3) demonstrate how these statutes ignore professional recommendations for improving the informed consent process in order to promote patient autonomy. This is important foundational work that demonstrates how these statutes are used to promote ideologically driven, often scientifically dubious and unreliable information that promotes fetal personhood and traditional gender norms.

And yet, this research treats the informed consent doctrine as a stagnant, inflexible, and unchanging document that statutes perpetually fail to uphold. This presumes that abortion patients' autonomy could be materialized, if only statutes did not encroach upon the patient-physician relationship. In this framing, the doctrine is not the issue, but its implementation is. An entire body of ameliorative literature has undertaken the task of bridging the gap between the doctrine's theoretical aspirations and its practical limitations (Grady, 2015; Manson & O'Neill, 2007). But, as historian Pamela Haag (1999) described of her methodological framework in regard to sexual consent: "But casting consent as a nonexistent ideal (…) because it has yet to be developed according to feminist values seems to erase the rich and perhaps illustrative history of the idea as a social and not a philosophical artifact" (p. vx). In the same way, it is not because the informed consent doctrine has failed its emancipatory promise, in general, and particularly in the context of abortion politics, that there is no value in examining how it has been mobilized, negotiated, and ultimately reconceptualized. In fact, doing so can help unpack how it has come to be used in such counter-intuitive ways that stray from its theoretical aspirations and legal implementation.

As I attempted to demonstrate in Chapter 3, the Supreme Court was concerned with the doctrine, and its role in mitigating the patient-physician relationship and the abortion decision, before *Planned Parenthood v. Casey* (1992). For almost 20 years before *Casey*, the Supreme Court gestured to seemingly shifting conceptualizations of the doctrine, all while repeatedly tasking the pregnant woman to make a quality, weighted, informed decision in light of her health and well-being. It was a mechanism, under *Roe*, that protected physicians from simply “acquiescing” to patients’ demands. It later became a means of assuring the state’s “desirable and imperative” interest that the abortion decision “be made with full knowledge of its nature and consequences” (*Planned Parenthood of Central Missouri v. Danforth*, 1976). Most of the literature examining the doctrine’s use in abortion cases and statutes identify *Casey* as the watershed moment that legitimized and engendered biased “measures to ensure that the choice is informed” considering “the State’s interest in potential life” (Ehrlich & Doan, 2019; Manian, 2009; Post, 2007; Tobin, 2008). And *Casey* has an undeniable role in legitimizing the use of the informed consent doctrine in ways that attempt to sway women’s decisions in favor of motherhood. But the doctrine had already been used by the Supreme Court as a mechanism of decisional paternalism over abortion patients. What had shifted was whether physicians, or legislators and the judiciary, ought to supervise women’s reproductive decisions. This has meant, in turn, that courts and legislatures have negotiated and reconceptualized the doctrine’s foundational terms.

My purpose, in this chapter, is twofold. First, I explore how anti-choice activists and legislators espoused early abortion jurisprudence’s medical framing to then reconceptualize the informed consent doctrine. Rather than assume that legislators are disingenuously weaponizing the informed consent doctrine, I seek to explore how abortion statutes reconceptualize the very terms of the doctrine. In other words, how does consent, choice, coercion, and autonomy get reconfigured in ways that simultaneously expand the doctrine’s purview and yet restrict women’s decisional freedom and abortion access? What notions of freedom are at play that can simultaneously and paradoxically work to nominally expand women’s freedom while effectively encouraging a form of self-regulation that promotes narrow understandings of fetal life, pregnancy, and motherhood. My second goal is to examine how the informed consent doctrine's inherent presumptions and limitations made it a perfect vehicle for anti-choice efforts.

This chapter will argue that informed consent statutes in abortion regulation often juxtapose neoliberal notions of choice with a conditional understanding of positive freedom. In other words, the neoliberal prescription to make rational, preventative medical choices is compounded by (limited) attempts to rectify the material conditions that circumscribe women's reproductive decisions. This juxtaposition ultimately works to frame motherhood as women's preferred and voluntary choice and abortion as a desperate, yet rational, choice in the face of the oppressive circumstances some abortion patients face. I will first argue that early WPAA efforts that advocated for informational requirements espoused *Roe*'s conceptualization of abortions as medical procedures and pregnant women as abortion patients. However, by contesting and refuting *Roe*'s reliance upon a "good" physician, anti-choice leaders could mobilize the informed consent doctrine precisely as it had been originated: to protect patients from medical paternalism and utilitarianism, thereby replacing medical oversight with the state's interest in "normal childbirth". My second section will echo arguments made by political scientists Jennifer Denbow (2015) and Amanda Roberti (2021) that informed consent statutes presume and produce neoliberal patients who navigate a biomedicalized environment, in which they are tasked with making the "right" choice to preventatively ensure their future health. However, informed consent statutes seem to acknowledge the limitations of negative freedom and its associated "choice paradigm" discussed in Chapter 4. This regulation does not espouse an exclusively neoliberal understanding of choice that individualizes responsibility and abandons individuals to their own devices. Most of these statutes insert detailed informational resources directing women to the "many public and private agencies willing and able to help you carry your child to term, and to assist you and your child after your child is born" (Louisiana Department of Health, n.d., p. 4). As such, legislators simultaneously acknowledge, yet mobilize, the material conditions that circumscribe women's reproductive decisions. By referring them to these resources, these statutes can nominally increase women's decisional freedom by providing them with (certain) resources that would expand the scope of their reproductive choice, while, in practice referring them to resources that reify the nuclear family and traditional gender roles.

I engage primarily with three different sets of primary documents. As I did in my fourth chapter, I rely heavily on David C. Reardon's (1996) text since it was so pivotal in first articulating the WPAA strategy (Doan & Ehrlich, 2019; Siegel, 2008). I put his work in conversation with the *Report of the South Dakota Task Force to Study Abortion* (2005), which was published after the South Dakota legislature enacted House Bill 1233 that authorized the Task Force's creation (Ehrlich & Doan, 2019). This report is important because it acts as a sort of amalgamation of anti-choice evidence from the early 2000s. Not only did it reference, in detail, the first-hand testimonies gathered by Operation Outcry that Justice Kennedy later cited in *Gonzalez v. Carhart* (2007), but it also relied on testimonies made by prominent anti-choice leaders and advocates. It thus provides insight into the ways in which different movement factions converged around the WPAA strategy and its use of the informed consent doctrine.[43] Finally, I analyze informed consent statutes and the resulting informational booklets that must be distributed to abortion patients. While I focus primarily on Louisiana's "Women's Right to Know Act" and its correlated informational booklet, these statutes are all based on the

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[43] David C. Reardon appeared in front of the Task Force, as did Dr. John C. Willke, former obstetrician and president of the National Right to Life Committee (NRLC) and author of *Handbook on Abortion* discussed in Chapter 1; Dr. Vincent Rue, originator of Post-Abortion Syndrome (PAS) introduced in Chapter 4; and Dr. Bernard Nathanson, also encountered in Chapter 1, an obstetrician-gynecologist who helped found the National Association for the Repeal of Abortion Laws (now known as NARAL Pro-Choice America) who later became the anti-choice activist who famously narrated *The Silent Scream.*

Americans United for Life's (AUL) model legislation and resemble each other greatly.[44] As I mentioned in Chapter 1, the AUL is a nonprofit law firm that was founded in 1971 by a group of academics and lawyers and is often recognized as the "law firm of the pro-life movement" constituted of the "legal elite" (Becker, 2022). It developed the "Women's Right to Know Act" in 2013, as a part of its *Defending life* "'pro-life playbook' that includes model legislation" (Americans United for Life, 2013; Ehrlich & Doan, 2019; Khazan, 2015).

5.1 (Re)Producing Consumer Patients

Efforts to curtail abortion access through stringent informed consent statutes espoused and reified *Roe*'s assumption that pregnant women were, first and foremost, patients. To briefly recapitulate, I argued in Chapter 3 that the Supreme Court decisions that instituted and protected the abortion right established the medicolegal framework the anti-choice movement would later mobilize. I first argued that the *Roe v. Wade* (1973) Court produced abortions as medical procedures necessary to treat the physical and psychological consequences of an unwanted pregnancy, thereby eclipsing feminist claims that abortions were emancipatory technologies necessary for women's equality. Pregnant women's first-trimester privacy right was thus circumscribed by the physician's authority and beneficent commitments. The *Doe v. Bolton* (1973) decision further imagined an almost therapeutic patient-physician relationship in which the patient, in consultation with her "conscientious" and "good" physician, considered the circumstances of her life to determine the procedure's necessity. This rendered women's reproductive choices perpetually vulnerable to a particular form of medical scrutiny and

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[44] I focus on Louisiana for two reasons. First, according to the AUL, Louisiana was the "best" pro-life state as of 2015 (Khazan, 2015). In other words, its legislation was most stringent and detailed. Second, Louisiana was the second state with the highest rate of maternal mortality rates in the nation before the pandemic (Leins, 2019) and the second state with the highest child poverty rates (U.S. Census Bureau, 2022). This will be important considering the Act's encouragement to consider agencies that can help with pregnancy, childbirth, and childrearing, which I will discuss in the third section of this chapter.

paternalism, which presumed that women were never quite capable of making their own abortion decisions. Quickly, the *Planned Parenthood of Central Missouri v. Danforth* (1976) Court imagined the abortion procedure as a distinct one that warranted atypical requirements, such as written consent, since it presumed that the "decision to abort (…) is an important, and often stressful one". It was no longer compulsory motherhood that threatened women's wellbeing. Abortions became the threat. And the *Roe*'s Court imagined and prescribed consultative patient-physician relationship had not materialized. The State thus had a "desirable and imperative" interest in assuring that the abortion decision "be made with full knowledge of its nature and consequences" (*Planned Parenthood of Central Missouri v. Danforth*, 1976). Written consent was meant to ensure and formalize the quality of women's decisional processes. While the *Danforth* Court did espouse the informed consent doctrine as it was then conceptualized to insure that "the pregnant woman retains control over the discretions of her consulting physician", it replaced medical paternalism with a new State interest in the quality of women's decisional processes. In all these moments, the Courts distinguished good and (medically) necessary abortions from "abortion on demand" that presumably did not meet the criteria of medical necessity.

This reasoning culminated decades later when the anti-choice movement instituted atypically stringent informed consent requirements.[45] And prominent movement leaders looked to *Roe*, *Doe*, and *Danforth* to develop this women-centric strategy. David C. Reardon (1996),

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[45] As I traced in Chapter 1, the anti-choice movement turned to direct action throughout the 1980s as its evangelical Christian constituency grew. Most Supreme Court cases during that period were reflective of that strategy and thus concerned with weighing patients' right to safety and medical treatment as opposed to protestors' first-amendment rights. The Court repeatedly grappled with the applicability of federal anti-racketeering statutes (RICO) and whether these could be used against clinic protestors (Doan, 2009). It was not until the 1990s that movement leadership appropriated and popularized the women-centric focus and strategy that mobilized the informed consent doctrine in its quest to incrementally restrict abortion access (Siegel, 2008).

one of the leading strategists behind the Woman-Protective Anti-abortion Argument analyzed in Chapter 4, argued that the movement was:

> better served by looking at *Roe* and the subsequent abortion decisions more carefully to see how their nuances can be turned to our advantage. By working with these precedents, rather than against them, we can pass laws which are within the bounds allowed by *Roe* for protecting women from dangerous abortions (p. 37).

An important key in doing so was to pit physicians against pregnant women, thereby attacking the trusting, almost therapeutic, patient-physician relationship as imagined under *Roe*. Since the woman's privacy right was qualified and largely one shared with her consulting physician, attacking this relationship would work towards eroding the abortion right. Doing so entailed simultaneously re-naturalizing the maternal-fetal bond and instead reconfiguring physicians' interests as being inherently at odds with their patients' best interests:

> Unlike the co-dependent interests of a woman and her child, the abortion liberty's entwining of a woman's rights with her physician's rights is an unnatural one. While the best interests of the woman and child are always the same, the best interests of a woman and her abortionist are not. The key, then, to unraveling the 'abortion liberty' is to expand the legitimate rights of women so that they are clearly superior to the imputed rights of abortionists (Reardon, 1996, p. 39).

These "legitimate rights" included the right to receive the best "choice of care options", the right to "be protected from contraindicated procedures", the right to be fully involved in the medical decisional process, and the right to "receive full financial compensation for any injuries" resulting from an "abortionist's failure to respect their rights" (Reardon, 1996, p. 39). Women's rights were first and foremost, here, conceptualized as patients' rights to medical decisional freedom and safe medical practice. Even as he decried *Roe*'s conceptualization of the patient-physician relationship, Reardon espoused its framing of abortion as a medical procedure and, by extension, pregnant women as patients. In this framing, "abortion is best described as a medical procedure which women have a protected liberty to seek because of their unique health needs" (Reardon, 1996, p. 40). The abortion was thus not an "arbitrary" one, but an individualized medical one that necessitated tailored consideration of women's idiosyncratic life circumstances and health.

But abortion providers could not be trusted in the ways the *Roe* and *Doe* Courts had postulated, according to Reardon. Instead, decades of legal and accessible abortion services had corroborated what had previously been impossible to study: abortion providers were, overwhelmingly, "incompetent, compassionless, unethical technicians dispensing abortion on request without review of risks or consideration for better treatment options" (Reardon, 1996, p. 48).[46] In Reardon's view, abortion providers were greedily motivated to turn "a quick buck (…) into an extra hundred thousand" (p. 44). Physicians were not incentivized to counsel ambivalent women who may have preferred adoption or motherhood since this threatened their bottom line. Instead, clinics did everything possible to maximize their revenue. This effectively created "abortion mills" where patients were compelled to pay, in cash, "the full amount of the abortion prior to rendering any services" (p. 45). Clinics recognized women's ambivalence and used upfront payment as a type of coercion on "women who want to change their mind" (p. 45). Since

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[46] In the same vein, the South Dakota Task Force (2005) similarly took as its starting point what it deemed to be *Roe*'s false assumptions. It postulated that: "*Roe*, and many of the subsequent cases following *Roe*, were based on a number of assumptions about the nature of the abortion procedure, the physician-patient relationship, the decisions women seeking abortions made, the safety of the abortion procedure (…). It is clear that the most essential assumptions made by the *Roe* Court are incorrect" (p. 8).

clinics were conceived as financially driven factories, and not places of care and healing, patients were partially produced as clients who deserved consumer-protections. There were two mechanisms that could protect abortion patients from "abortion mills". Consumer-protections would remove any possibility of economic coercion, while a strengthened and rigorous informed consent process could protect women's decisional processes from uncaring and rushed providers. To mitigate any economic coercion, some states later compelled physicians to inform their patients that they were "not required to pay any amount for performance or inducement of the abortion until at least 24 hours have elapsed" after the consultation (Wis. Stat. § 253.10, 2011/2014). Additionally, statutes frame extensive informational requirements as necessary because of providers' unforthcoming and transactional relationship with their patients:

> The vast majority of elective abortions in this state are performed in clinics that are devoted solely to providing abortions and family planning services. Women who seek elective abortions at these facilities do not have a prior patient-physician relationship with the physician who is to perform or induce the abortion, normally do not return to the facility (…). In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive personal counseling (…) Because of this, certain safeguards are necessary to protect a woman's right to know (Wis. Stat. § 253.10, 2011/2014).

The legislature imagines clinics as factories, in which physicians only briefly encounter patients *as* they provide the abortion. This does not give patients the opportunity to receive the compassionate guidance and individualized attention the *Roe* and *Doe* Court imagined. It thus becomes the legislature's responsibility to implement these "safeguards" to promote women's knowledge about the procedure they are about to undergo. And, as I discussed in Chapter 2, the informed consent doctrine is a well-suited mechanism to inject the State's paternalism and ideological preferences into women's decisional processes.

5.1.1 Centering Abortion Patients' Rights through the Informed Consent Doctrine

The anti-choice movement mobilized some of the doctrine's foundational definitions and legal mechanisms to center patients as the ultimate decision makers whose rights needed to be prioritized and protected from physicians' interest. In ways that are never explicitly (or even implicitly) articulated in the analyzed Supreme Court cases, the South Dakota Task Force report (2005) identifies the consent process, and the woman's signature in particular, as a legally transformative moment that changes what would otherwise be medical battery into a voluntary procedure: "the authority for the physician to terminate the life of his or her patient rests exclusively upon the written consent of the pregnant mother, which, at the time it is signed, terminates the doctor's duty to her child" (South Dakota Task Force, 2005, p. 13). Indeed, the entire premise of consent, more broadly, is that it acts as a mitigating communicative, moral, and legal act between multiple parties (Dougherty; 2014; Fischel, 2020; Greenblatt & Valens, 2018; Haag, 1999; Hurd, 1996; McDonagh, 1996; O'Neill et al., 2008; O'Regan, 2019; Pateman, 1980; Weinberg, 2016). It seeks to adjudicate what are generally potentially contentious circumstances since one of the parties cedes over their property, body, or freedom to the other party. Without explicit agreement, the act would otherwise be illegal and immoral. Consent thus distinguishes rape from sex, lending from stealing, and medical battery from treatment. At the same time, the very process of giving consent is understood as an enactement of the individual's inherent self-determination right. It is because people can consider the circumstances of their lives and willingly and freely decide to forego some of their freedom or bodily integrity that the act of consent is understood as an embodied of autonomy. Accordingly, the pregnant woman's consent absolves the abortion provider of the legal responsibility towards the fetus. Only the woman's consent can transform what would otherwise be a murderous act into a legal (even if immoral) one. This indicates a different understanding of the informed consent doctrine from the one developed and reconceptualized by the Supreme Court. Here, the woman's consent gives meaning to the physician's actions. Her decisional process is centralized as most meaningful and powerful, in ways that attempt to redistribute decisional power and authority from the physician to the patient. Her consent is, arguably, an extension and enactment of her autonomy. This contrasts with the Supreme Court's conceptualization of consent where it acts either as protective barrier against abortion on demand or as the materialization and proof of the State's interest in ensuring a particular decisional process. Of course, in this instance, the Task Force is similarly vested in ensuring an even more restricted decisional process that, ideally, translates into the decision to bring a pregnancy to term. But the Supreme Court relied primarily on physicians to advise their patients, while the Task Force centers abortion patients as the agents whose decisions gives legal meaning to the physicians' actions and responsibilities. It is the State, not physicians, who can reliably guide women as they consider their reproductive choices.

Consent cannot be a materialization of autonomy without the correlated right of refusal (McDonagh, 1996; Pateman, 1980). Consent without the ability to refuse is coercion. And, indeed, the informed consent doctrine emphasized patients' right to refuse, even if doing so was contraindicated. The right to refusal was direly necessary given the medical abuses, in the name of medical utilitarianism and paternalism, that had engendered the doctrine's popularization and institutionalization. Informed consent abortion statutes mobilized this originating conceptualization of the doctrine as the right to refuse medical encroachment. Legislation states that: "No abortion shall be performed on any woman unless prior to the abortion she shall have been advised (…) that she is not required to submit to the abortion and that she may refuse any abortion for any reason and without explanation (…)" (Louisiana's A Woman's Right to Know Act, R.S. 40:1061.4). Here, abortion is framed as something potentially compelled upon women and that her outright refusal, irrespective of the "reason" and "explanation" is completely valid. Reaffirming women's right of refusal, in a larger context that presumes that "unethical technicians dispense abortion on request" (Reardon, 1996, p. 48) is quite striking, unless women's abortion decision is perpetually viewed as temporary and unreflective of her true desires. This presumes that women seek out abortions, and then find themselves compelled to undergo the procedure irrespective of any emerging ambivalence and uncertainty. This requirement thus appropriated the informed consent doctrine as it was first conceptualized by producing undecided abortion patients who needed a protective mechanism against greedy, and hence coercive, abortion providers.

Not only do these documents mobilize a distinct understanding of consent, with an emphasis on the corollary right to refuse, they further seek to accentuate abortion patients' decisional authority and freedom by advocating for the use of the "reasonable patient" standard of disclosure. The Supreme Court, in the analyzed cases, perpetually deferred to physicians in ensuring that the abortion decision be well-informed and considered. The Court repeatedly refused to explicitly and definitively define terms such as "health" or "viability" since doing so would infringe on the physicians' discretion and judgement, thereby limiting physicians' ability to practice tailored medicine as they deemed necessary and safe.[47] In other words, physicians were responsible, because of their expertise and knowledge, to advise and treat patients according to their best medical judgement. Effectively, the Court seemed more inclined to espouse a "community standard" of informational disclosure, which instructs physicians to

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[47] In *Doe v. Bolton* (1973), *Planned Parenthood of Central Missouri* (1976), and *Colautti v. Franklin* (1979), the Courts were tasked with defining what constituted women's health and with identifying normative, physical markers and/or stages of viability. In all instances, the Court refused to do so and ruled that, given the ambiguity of determining health and viability, imposing judicial definitions thereof would "not afford broad discretion to the physician. Instead, it conditions potential criminal liability on confusing and ambiguous criteria" (*Colautti v. Franklin*, 1979).

disclose what another specialist would impart under similar circumstances. This centers physicians' discretion and evaluation of the communicative process.[48] In contrast, Reardon (1996) and the South Dakota Task Force (2005) advocated that informed consent requirements espouse the "reasonable patient" patient standard, which was instituted under *Canterbury v. Spence* (1972) as I discussed in Chapter 2. It is patient-centric standard that compels physicians to disclose what a "reasonable" patient may find relevant. Reardon argues that abortions are elective procedures, and rarely urgent life-saving ones, and physicians have all the more duty to reveal all relevant information, even if this information is scientifically unsubstantiated and ideological in nature. An abundance of information, out of an abundance of caution, promises to best serve women's medical self-determination. By defining consent as the act whereby physicians' responsibility and legitimacy acquires meaning, by emphasizing abortion patients' refusal right, and by advocating for the "reasonable patient" standard, both Reardon and the South Dakota Task Force sought to center and prioritize patients as medical decision makers. Patients were not making their reproductive decision in consultation with a "good" physician. Instead, they were encouraged to make these decisions despite their abortion provider.

One strategy of the WPAA was to (re)produce pregnant women as patients and as consumers who deserved the protections and rights usually attributed to them. Under this framing, the anti-choice movement could thus mobilize the discourse of patient autonomy, while escaping larger questions around women's equality and emancipation. It simply needed to turn to *Roe*, and ensuing abortion cases, to appropriate its deference to medical paternalism and, instead, replace it with state paternalism. Abortion patients had always been subjected to some level of

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[48] The "community standard" was overwhelmingly used prior to 1972. The "reasonable patient" standard partially replaced it after *Canterbury v. Spence* (1972), when the Court ruled that the "community standard" allowed physicians to insulate and protect themselves by communally agreeing on limited informational standards without oversight or collaboration from external entities (Murray, 2012).

scrutiny and oversight while making their abortion decisions. They had always been instructed to make quality *medical* decisions in light of their well-being. However, early WPAA efforts rejected the Court's conceptualization of a good and compassionate physician and instead infiltrated the patient-physician relationship by compelling physicians to disclose what anti-choice activists, researchers, and legislatures had deemed necessary information for an "informed and voluntary" decision. Ensuing statutes thus emphasized patients' consent as the mitigating moment that legitimized and legalized physicians' act, centered patients' right of refusal, and underscored the importance of disclosing information according to the "reasonable patient" standard. All of this worked to produce the anti-choice movement as legitimately and exclusively protecting women's rights as patients against nefarious, unforthcoming, and greedy abortion providers and clinics. I will conclude the chapter by further examining how some of the informed consent doctrine's very terms and legal mechanisms were perfectly poised for the movement's incremental goals since, in its conceptualization and institutionalization, the doctrine's commitment to patient autonomy is always circumscribed by the medical profession's commitment to beneficence. The anti-choice movement reached for the doctrine precisely as it was first imagined.

5.2 The Neoliberal Patient

Even as early WPAA documents relied upon the informed consent doctrine's original conceptualization and goals, these simultaneously deployed another iteration of the doctrine that redefined patient autonomy in economics terms with an "empowered consumer" at its center (Gere, 2017). The doctrine started morphing into a neoliberal artifact throughout the 1980s, in light of the AIDS epidemic. Activists in the early 1980s, in a desperate collaboration with libertarians, fought for research participants' right to willingly shoulder and internalize the risks of experimental treatment, free from paternalistic and burdensome FDA protocols that had rendered potentially life-saving treatment inaccessible (Epstein, 1995). Patients, who had previously been rights-bearing autonomous agents, were increasingly reconceived as risk-bearing “educated consumers” (Gere, 2017, p. 210).

Simultaneously, as I discussed in Chapter 4, the pro-abortion movement replaced feminist calls for abortion as a fundamental right with the “choice paradigm” as it attempted to appeal to a broader, more conservative libertarian constituency that feared big government. Reproductive justice scholars quickly denounced the notion of “choice” as one that confounded reproductive choices with consumer choices, whereby women were free to make their reproductive decisions if they had the means to access them (Solinger, 2001). The emergence of assisted reproductive technologies (ARTs) and the popularization of prenatal testing further compounded this. Indeed, scholars have argued that ARTs are portrayed as expanding infertile women’s autonomy and reproductive choices by providing them the much-desired opportunity to bring a pregnancy to term. Of course, given the technology’ exorbitant cost, IVF is only accessible to a wealthy minority with the means to materialize their dreams of genetically related offspring (Roberts, 2009). More importantly for our purposes, bioethicist and legal scholar Lisa C. Ikemoto (2009) argues that the lack of governmental oversight and regulation “increases the weight born by informed consent” as the only protective mechanism offered to individuals as they navigate an onslaught of information and statistical risks. In other words, the informed consent, in an unregulated, consumer-based market, nominally expands women’s autonomy by offering them more choices, all while individualizing responsibility. Similarly, Dorothy Roberts (2009) further argues that prenatal testing nominally increases autonomy by providing individuals the opportunity to terminate a pregnancy with a fetal anomaly. This, in turn, individualizes a decision that cannot be decontextualized from the larger cultural, social, and economic conditions under which people raise disabled children. Prenatal testing without correlated social support systems that help raise children with disabilities effectively ignores the social conditions of disability. The choice prospective parents face is to either terminate a desired pregnancy or navigate the challenging reality of singlehandedly raising a disabled child. Parents are tasked with understanding complex and largely inaccessible questions of risk and statistical significance that cannot account for the complex, embodied reality of raising a disabled child (Samerski, 2009). Parents must "deliberately accept or guard against" the possibility of raising a disabled child, effectively rendering a previously uncontrollable pregnancy into a carefully optimized equation of acceptable risk.

Similarly, political scientists Jennifer Denbow (2015) and Amanda Roberti (2021) have argued that informed consent statutes are a product of neoliberal, biomedicalized discourses of choice and autonomy that produce self-regulating, yet increasingly surveilled, abortion patients. Abortion patients are tasked with weighing the costs and benefits of abortion, as opposed to motherhood, in an attempt to make the "best" and "right" choice. Autonomy and choice, in this framing, are restricted iterations thereof that normatively compel women to engage in cost-benefit analysis. Autonomy becomes confounded with a prescriptive understanding of making the "right" choice that entail rationally considering all variables. To be sure, these bills are imbued with the prescriptive, individualizing discourses of biomedicalization and neoliberalism. Adele E Clarke, et al. (2010) argue that biomedicalization compels patients to be healthy and to preventatively avoid the lingering and ultimately unavoidable threat of illness. Health does not happen by chance or luck but is instead patients' moral duty to actively pursue. Patients thus "inhabit a tenuous and liminal space between illness and health (…)" whereby "it is impossible not to be considered ‘at risk’” (Clarke et al., 2010, p. 64). Indeed, abortion patients are interpellated by informed consent statutes and their informational booklets as potentially sick, despite their presumed current health. The threat of future illness is used to further circumscribe and direct women’s abortion decisions.

According to the Guttmacher Institute (2016a) two states compel physicians to inform patients that there is a link between abortions and increased risk of breast cancer; a claim that has been widely disproven (Bryant & Levi, 2012; Huff, 2014; Pateve & Hood, 2021; Rowlands, 2011). Both the American Cancer Society (ACS) (n.d.) and the American College of Obstetricians and Gynecologists (ACOG) (2021) denounce research linking abortion and breast cancer as methodologically flawed. Another seven states gesture to the ACS’ report that full-term pregnancies in younger patients can decrease the likelihood of certain cancers:

> Women who have had a first full-term pregnancy at an early age have reduced risk of breast, ovarian and endometrial cancer. Furthermore, the risks of these cancers decline with each additional full-term pregnancy. Pregnancies that are terminated afford no protection; thus, a woman who chooses abortion over continuing her pregnancy would lose the protective benefit. If you have a family history of breast cancer or clinical findings of breast disease, you should seek medical advice from your physician before deciding whether to remain pregnant or have an abortion” (Louisiana Department of Health, 2019, p. 23-34).

Full-term pregnancies in younger patients are thus framed as a protective measure against certain forms of cancer. Multiple full-term pregnancies offer even more “protective benefit”. And this protection is lost when terminating the pregnancy. While these statements do not explicitly link abortion and breast cancer, they nonetheless imply that there is a higher chance of getting breast, ovarian, or endometrial cancer because of one’s abortion. This calls upon patients to make sense of their pregnancy as a preventative measure, especially for those with a genetic predisposition to these cancers. Indeed, Clarke et al. (2010) argue that risk and surveillance are important elements of biomedicalization, whereby individualizes are categorized into “risk groups” and called upon to actively minimize these risks. Women are thus compelled to consider the abortion, and really the pregnancy, as it relates to their future physical health. They are encouraged to bring the pregnancy to term as a protective and preventative measure against cancer, without considering the physical consequences of pregnancy.

These informational requirements further interpellate a "'free' subject who rationally deliberates about alternative courses of action (…)" (Brown, 2005, p. 43). Since greedy providers and clinics cannot be trusted to act in their patients' interest, it falls entirely on the patient to make an "informed" and weighted decision, not in consultation with their physician but despite him:

> Rather than making informed medical recommendations based on case-by-case benefit analyses, abortionists have tended to provide abortions simply on request. Since abortionists cannot be trusted to do a complete risk-benefit analysis, especially if the patient is withholding relevant information, the importance of each patient doing her own risk-benefit analysis is much further amplified. In order to do this evaluation, the patient needs *all* the relevant information which is available (Reardon, 1996, p. 75).

Women's reproductive autonomy is thus a rational and calculating process of engaging in cost-benefit analysis, during which "(…) in neoliberal fashion, the self is called on to engage in rational self-regulation by assessing risk and conducting oneself in a manner that minimizes risk" (Denbow, 2015, p. 126). Abortion patients do not have the right to make wrong decisions, to make decisions irrespective of information; instead, their choice, hence their autonomy, is best materialized after careful, rational, weighted consideration of the variety of risk factors they may have after terminating a pregnancy. In all these moments, women are called upon to make the right decision by choosing motherhood, or a full-term pregnancy at the very least, as a preventative health measure.

Importantly, a notable characteristic of neoliberalism is the processes of privatization and the erosion of state support (Brown, 2005; Denbow, 2015; Roberts, 2009). Since individuals are portrayed as rational, calculating agents with the freedom to choose the trajectory of their lives, they become exclusively responsible for the consequences of their bad decisions. The State is neither responsible for mitigating these consequences nor for financing social support networks that attempt to rectify conditions of oppression that minimize individuals' choices and freedom.

5.3 Mobilizing and Reconfiguring Positive Rights

And yet, informational abortion requirements present a much more complex understanding of freedom than an overly simplified neoliberal one under which rational individuals bear the full consequences of their choices, abandoned by systems of governmental support. Instead, an important component of these statutes is the emphasis on resource disclosure. These requirements often compel physicians to disclose four distinct categories of information: physical risks; psychological consequences; fetal development and, at times, fetal pain; and resources (Richardson & Nash, 2006). The first three categories have received the most scholarly attention for often being scientifically unsubstantiated and/or misleading. But the fourth category has largely been overlooked.

According to the American Medical Association's (AMA) Code of Medical Ethics (n.d.), physicians ought to disclose: "(i) the diagnosis (when known); (ii) the nature and purpose of recommended interventions; (iii) the burdens, risks, and expected benefits of all options, including foregoing treatment". In some circumstances, physicians are required to disclose their expertise performing a particular procedure, if it may be deemed necessary for a patient's decision (Murray, 2012). Physicians are rarely (if ever) compelled to disclose available resources that would aid patients, either materially or emotionally, when undergoing either the proposed treatment plan or its alternative(s).[49] By and large, physicians are not required to act in any referential capacity; a responsibility that often falls upon social workers or counselors. In contrast, Louisiana's *A Woman's Right to Know* informational booklet, developed by the Louisiana Department of Health (n.d.), states:

> There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The State of Louisiana strongly urges you to consult an independent physician about the risks of abortion to your physical and psychological wellbeing and to contact the resources provided on our website before making a final decision about abortion (p. 4).

This passage mobilizes many traditional anti-choice discursive strategies. The fetus is already presumed to be a child and abortion is portrayed as both psychologically and physically deleterious. What is more important for our purposes, here, is that the State further attempts to sway women's reproductive decision by referring them to a rather exhaustive list of agencies that can help pregnant women throughout their pregnancies, through childbirth, and while the child is still dependent. These agencies are both "willing and able to help you carry your child to term", thereby implying that the abortion patient may find herself isolated and incapable of doing so on her own but has legitimate recourse to resources with the will and capability to help her. The booklet further urges women to contact these various resources "before making a final decision

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[49] The Prenatally and Postnatally Diagnosed Conditions Awareness Act was enacted in 2008 with broad bipartisan support. It requires "the federal government to arrange for the collection and dissemination of up-to-date, evidence-based information about the conditions subject to prenatal and early postnatal diagnosis" (Asch & Wasserman, 2009). In an attempt to help prospective parents grapple through a confusing array of statistical information that does not reflect the lived realities of raising a disabled child, the Act compels information about "the range of outcomes for individuals living with the diagnosed condition". And it further refers patients to a variety of services. However, these resources are, by and large, informational and counseling services and hotlines that either help parents make sense of a positive test or gives them access to community-based support centers and groups (The Prenatally and Postnatally Diagnosed Conditions Awareness Act, 2008). The Act does not compel the explicit disclosure of private or public agencies that provide financial and material support. It does, nonetheless, require increased funding towards these agencies.

about abortion" in hopes that the possibility of governmental or private aid may deter women from undergoing an abortion.

Abortion patients get referred to two distinct types of material support. One the one hand, informed consent statutes refer women to state and private agencies that provide medical, financial, and material resources for pregnant women and mothers. On the other hand, both statutes and their associated informational booklets inform abortion patients that: "the father of the unborn child is liable to assist in support of her child, even in instances where he has offered to pay for the abortion" (A Woman's Right to Know Act, R.S. 1061.17). More specifically, the informational booklets list, under a section titled "A Father's Duty", that "The father of a child has a legal responsibility to provide for the support, educational, medical, and other needs of that child. That duty can include child support payments to the child's mother" (Louisiana Department of Health, 2019, p. 24). It then proceeds to inform abortion patients how to demonstrate paternity. Louisiana further mandates under the "Forced Abortion Prevention Sign Act" (2011) that signs "conspicuously posted in each patient administration area, waiting room, and patient consultation room" inform patients that they cannot be forced into undergoing an abortion, that the "father of the child must provide support of the child", that adoptive parents may pay costs of prenatal care, and that "many agencies are willing to help you carry your child to term and to assist after your child's birth". Abortion patients are repeatedly told that they are not alone if they wish to bring the pregnancy to term. The burdens of pregnancy and motherhood can be shared among the state, nonprofits, the father, or adoptive parents.

Similarly, the Louisiana Department of Health "Women's Right to Know" website gives abortion patients different options. They can either visit the "Abortion: A Woman's Right to Know" tab, or they can get information on "Adoption: A Loving Option", "Genetic

Abnormalities – Resources for pregnant women, infants and child", "Medical care and assistance", "Pregnancy Resource Centers", or "Human Trafficking: How to Get help". The very mention of "a woman's right to know", as it relates to abortion services, mobilizes the language of rights to give women an onslaught of information they may, or may not, find relevant. The other tabs speak to some of the material and relational obstacles pregnant women may find themselves in. These different options acknowledge the reality that some abortion patients may choose to terminate a fetus with a diagnosed anomaly, some may do so because of lack of medical insurance, and others still may be victims of human trafficking.[50] Many states with "A Woman's Right to Know Act" have separate resource directories still titled "A Woman's Right to Know" geared towards abortion patients. These booklets refer abortion patients to public and private agencies that provide mental health and substance addiction resources; adoption agencies; birthing and health services; Women, Infant, Children (WIC) services that offer nutrition assistance; maternity homes; Medicaid eligibility resources; and Crisis Pregnancy Centers (CPCs).

The emphasis on these resource referrals, and their multimodal representation, seems to speak to a more nuanced understanding of choice and autonomy than a purely neoliberal one that individualizes responsibility. Encouraging abortion patients to reach out to these services acknowledges the complex and material realities that many abortion patients navigate when making their reproductive decisions. It acknowledges that many pregnant women seeking abortions exist under conditions of poverty while lacking reliable access to safe and reliable medical care. Already in 1990, Angela Davis warned of the consequences of providing abortion

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[50] Of course, as I will discuss later, this entirely ignores the fact that women are exponentially more likely to be the victims of intimate partner violence (IPV) than to be victims of human trafficking.

access without simultaneously giving women access to the social networks that would enable them to make reproductive choices free from economic coercion:

> When Black and Latina women resort to abortions in such large numbers, the stories they tell are not so much about the desire to be free of their pregnancy, but rather about the miserable social conditions which dissuade them from bringing new lives into the world (…). As if having fewer children could create more jobs, higher wages, better scholars, etc. (Davis, 1990, p. 17).

Abortion and birth control, which are otherwise emancipatory technologies, become mechanisms of population control without concomitant state support networks, such as universal childcare, healthcare, paid parental leave. Rather than address these "miserable social conditions", access to reproductive technologies can become technologies that marginalized women are compelled to consider when they cannot raise their children safely and comfortably. Research has consistently shown that a majority of abortion patients are living on the margins of society and are unable to provide for (additional) children. Between 2008 and 2014, research by the Guttmacher Institute reported that 75% of abortion patients lived at, or below, the federal poverty level and 73% of patients reported being unable to afford a(nother) child (Finer et al., 2005; Jerman et al., 2016). Abortion decisions cannot be removed from the economic and material pressures that these pregnant women face.

Anti-choice activists and legislators seem to have understood and mobilized this reality much more rapidly than the mainstream, liberal pro-abortion movement has.[51] Informing patients

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[51] Reproductive justice scholars and activists have been criticizing the mainstream pro-abortion movement for perpetually focusing on abortion rights without addressing other oppressive mechanisms that have, for decades, curtailed Black and Brown women's reproductive freedom (Davis, 1990; Goodwin, 2020; Roberts, 1997; Ross, 2016).

that these resources exist thus seems to posit a more complex understanding of reproductive choice than simply weaponizing the discourse of choice and autonomy while entirely abandoning women to their own devices. It seems to echo critiques of the privacy right as being insufficient in materializing women's reproductive autonomy. Privacy, or negative liberty, guarantees a sphere of individual action that the government cannot encroach upon, thereby enabling individuals to act in accordance with their preferences and desires free from governmental impositions. This necessitates governmental neutrality. However, the designation of something as being private, as opposed to public, simultaneously enable systems of oppression to go unchecked, unless these cause flagrant, tangible, or physical harm (Fraser, 1990; Roberts, 1997). And, importantly, the privacy right does not guarantee individuals' access to rights. People have decisional freedom to make one reproductive choice as opposed to another but without the concomitant resources to materialize either choice (Robertson, 1994). The informed consent statutes, by emphasizing that women be informed of the "many public and private agencies willing and able to help you to carry your child to term" acknowledge that *Roe*'s privacy right, and the "choice paradigm" it engendered, cannot effectuate impoverished women's reproductive freedom. It acknowledges that some women turn to abortion because they cannot afford a(nother) child.

Instead, these statutes seem to presume a positive understanding of freedom. While scholars largely agree that negative freedom protects individuals from governmental intrusion, they have more difficulties reaching a consensus on positive freedom (Chistmas, 2021). However, when I mention positive freedom, I am primarily echoing definitions thereof that center the "facilitating conditions that allow actions to proceed as intended" (Christman, 2021, p. 4). Proponents of positive freedom, while recognizing that negative freedom is necessary to protect individuals from totalitarian governments, argue that providing individuals with material resources and support enables the individualism and pluralism envisioned by John Stuart Mill and Isiah Berlin (Denbow, 2015; Hirschmann, 2021; Knight, 2017; Roberts, 1997). These informed consent statutes seek to inform women that there are not alone if they pursue motherhood, that there is a plethora of resources at their availability that will help them through pregnancy, childbirth, and childrearing. They can receive medical, financial, nutritional, emotional, housing support. These statutes recognize that women's reproductive decisions are not made in isolation, irrespective of the circumstances of their lives and of their relationships. Instead, once freed from these material concerns and constraints, women can choose what they truly desire: motherhood.

5.4 From the Margins to Policy: Helping Women Become Mothers

Historian Sara Matthiesen (2021) argues that under decades of what she terms "state neglect", whereby the state has abandoned marginalized families to their own devices while upholding the discourse of choice that individualizes all responsibility, families have found themselves obliged to make do with a patchwork of social services. Often times, Crisis Pregnancy Centers (CPCs) are an important resource for these families. While CPCs (rightfully) receive attention for misinforming prospective abortion patients in attempt to deter them from undergoing the procedure, Matthiesen (2021) argues that these organizations have remained relevant because they provide much needed material support to families in need who have limited alternative recourses. From their inception, CPCs have always focused on helping pregnant women, rather than exclusively focus on the fetus as the rest of the anti-choice movement did, under the conviction that addressing women's material and emotional needs would curb abortion rates.

Indeed, one of the Women Protective Antiabortion Argument's strategies was to frame abortions as a constrained, yet rational, reaction to an *unplanned* pregnancy. The issue was not that women did not want children but that they were navigating the crisis of an unplanned pregnancy. Under this framing, unplanned and unwanted are not synonymous and addressing the former transforms an otherwise seemingly unwanted pregnancy into a wanted one. Indeed, the Report by the South Dakota Task Force to Study Abortion (2005) stated that: "The pregnant mother, in virtually every instance, considers having an abortion because she, or others in her life, believes that her circumstances render the *timing* of motherhood – *not motherhood itself* – inconvenient or undesirable" (p. 34). The pro-abortion discourse of choice further obscures the fact that many women turn to abortion out of desperation and not out of genuine desire to be free from their pregnancy:

> These women are seeking abortions not because they believe it is the right thing to do, but because, given the pressures they face, they feel it is the *only* thing they can do. Indeed, all the pro-abortion rhetoric about "freedom of choice" has actually only served to conceal the truth that most aborting women feel they have *no* choice. They are choosing abortion not in accordance with their own conscience, but *against* their own conscience (Reardon, 1996, p. ix).

In thus foregrounding the material and lived conditions that circumscribe women's abortion decision, the anti-choice movement can frame abortions as a desperate choice engendered by economic or relational coercion. Most of these informed consent statutes seek to curb "explicit" coercion, whereby abortion patients find themselves, sometimes violently, coerced by family members, partners, or providers into undergoing an abortion (Denbow, 2015; Siegel, 2008). Legislation addresses this by repeatedly telling patients, through different modalities, that they cannot be pressured to undergo the procedure and that they have the right to refuse it without retaliation. This traditional definition of coercion echoes Isaiah Berlin's (1958) definition thereof in his seminal "Two Concepts of Liberty" presentation: "Coercion implies the deliberate interference of other human beings within the area in which I could otherwise act" (3). But these informational requirements additionally, even if implicitly, develop another definition of coercion. Patients' reproductive choices are understood as mitigated and curtailed by "the pressures they face", which compels them to act "against their own conscience" and resort to abortion out of desperation and lack of choice. The very use of the term "pressure" speaks to an external form of coercion that constraints patients' available options, effectively portraying abortion as the only option when there is, in truth, "no choice".

In this framing, abortions are not one option amongst others but are the only available option given the circumstances of one's life. Motherhood would be women's genuine choice, if only they existed under conditions that enabled them to raise a child safely and comfortably. The reasoning that first emerged within CPCs, which sought to combat abortion rates by addressing the material circumstances that compelled some women to terminate their pregnancies, ultimately made its way into informed consent legislation.

And, once again, this particular strategy that attempts to account for the variables that circumscribe women's abortion decision is a reaction to pro-abortion efforts. In Chapter 4, I described the emergence of the neoliberal motto "right to choose" that individualized responsibility while simultaneously rendering women's reproductive choices more vulnerable to surveillance and oversight. Another pro-abortion strategy developed relatively concomitantly in reaction to anti-choice accusations that women were frivolously and selfishly using abortion as birth control to avoid the consequences of liberalized, non-monogamous, and nonreproductive heterosexual sex (Roberti, 2021; Tonn, 1996). The abortion rights movement disseminated (unrepresentative) personal narratives that described women’s moral agony and anguish as they wrestled with their abortion decision in hopes that these stories would appeal to a public increasingly swayed by fetal-centric arguments. Many were already mothers whose abortions paradoxically reified their maternal status. Terminating their pregnancy enabled these women to provide better care for their children, especially in situations of divorce or financial hardship. Abortion was the ultimate sacrifice, in this view. Other stories spoke to women’s devastation and heartbreak upon learning about a fetal anomaly, thereby portraying abortion as the most caring and loving act towards a future child that would be incapable of surviving more than a few, torturous hours outside the womb. In other words, these personal narrative of moral anguish and ambivalence served to absolve only certain abortion patients whose decision was done selflessly in light of her responsibilities.

This strategy was precisely what Reardon (1996) sought to mobilize: “Because pro-abortionists have long wanted to diffuse the notion that women abort for selfish or casual reasons. They want the public to sympathize with the desperation of women seeking abortions because they want to convert sympathy for women into support for abortion” (p. 105). Echoing previous anti-choice strategies in the years immediately after *Roe*, Reardon compares abortion patients to Jews under Nazi Germany to develop a particular definition of choice under circumstances of coercion. He argues that Nazis, given their comparatively low numbers, were forced to rely on mechanisms of control other than sheer force and violence. They thus gave Jews the illusion of choice, or a restricted choice, which was perpetually contingent on hope, to compel them to act against their values and safety. As long as there was something to save, people were willing to comply with atrocities and conditions they would otherwise never live under. And doing so was a rational, not ideological or moral, decision:

> The similarity between Nazi manipulations of the Jews and the abortionists' manipulation of women faced with crisis pregnancies is striking. Just as the Jews were forced to choose between losing everything or just a little, so abortion counselors encourage the victim-woman to view 'this pregnancy' as a threat to everything she has – her relationships, her family, her career, her entire future. She is assured that by sacrificing this one thing (a tiny unborn child), she can save the rest. During this process, the victim-woman is urged to view the abortion decision not as a moral choice, but as a rational choice of 'saving what you can' (Reardon, 1996, p. 108).

This passage is important for three reasons. First, women's abortion decisions are here framed as rational, even if immoral and selfish. Second, the fact that women's available alternatives – "sacrifice" the "tiny unborn child" or loose "everything she has" – appear irreconcilable is a false dichotomy manufactured by "abortionists" is their attempts to persuade pregnant women to undergo an abortion. Without this false dichotomy, whereby women were "forced to choose" between their life as is and the "tiny unborn child", abortion patients would choose motherhood. Finally, Reardon articulates a particular understanding of choice. The comparison between abortion patients and Jews under Nazi Germany presumes that both are operating under circumstances of incredible coercion and pressure, whereby a choice can never be a genuine choice. Indeed, the oxymoronic juxtaposition of being "forced" to "choose" works to absolve the latter of any substance, effectively indicating that people operating under conditions of despair cannot make genuine choices. To choose between the lesser of two evils is inherently a restricted choice because it does not allow an individual to choose according to their true desires and preferences. Or, to put it in the words of Frederica Mathewes-Green of Feminist for Life: "No woman wants an abortion as she wants an ice cream cone or Porsche. She wants an abortion as an animal caught in a trap wants to gnaw off its own leg" (as cited in Reardon, 1996, p. 105).[52]

5.5 Materializing the Nuclear Family

While these statutes seem to capture a more nuanced understanding of choice and autonomy that accounts for one's lived circumstances, they simultaneously espouse a narrow, heteronormative, Christian understanding of family relations. These bills all compel that physicians refer patients to CPCs to receive abortion counseling or ultrasounds. By thus advertising these free services to abortion patients, which primarily target impoverished patients who may not have the funds to cover an ultrasound, legislators are encouraging abortion patients to receive treatment and counseling from places that provide explicitly religious counseling.

Additionally, the statutes' focus on helping victims of human trafficking, while laudable, is also concerning when considering the glaring lack of referenced resources for victims of intimate partner violence (IPV). Between 3 to 9% of all pregnant women experience abuse but poor women are at even higher risk (Alhusen et al., 2015). By some estimates, up to 50% of impoverished, single pregnant women experience IPV. In fact, up to 22% of abortion patients reported recently experiencing violence from an intimate partner. These women explained that they opted for an abortion because they do not want to be tethered to their abuser and they wanted to shield their future child from violence (Roberts et al., 2014). Unsurprisingly, victims of IPV who were denied an abortion continued to face abuse at similar rates, while those who underwent an abortion were faster to end their relationships and therefore less likely to continue

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[52] Mathewes-Green was Feminists for Life's vice-president for communications in 1989, after she rejected her previous beliefs that abortions were necessary for women's liberation (Siegel, 2008). For years, she understood abortion as a symptom of social decay that women turned to out of desperation. However, she eventually renounced her role as vice president and her identity as a feminist when she espoused the belief that women could find redemption through marriage and motherhood and by renouncing their careers and extramarital sex.

experiencing violence by the abuser. While it is virtually impossible to accurately gauge rates of human trafficking, the National Human Trafficking Hotline (n.d.) estimates that there have been approximately 73,946 cases of human trafficking between 2007 and 2020. Put differently, pregnant women are much more likely to be the victims of IPV than victims of human trafficking. This makes the legislatures' ongoing insistence about the "father's duty" all the more concerning.

All informational booklets provide information and resources on the legal mechanism to demonstrate paternity, even in circumstances when the biological father offered to pay for the termination. In other words, this targets a very particular demographic of abortion patients: those living in financial precarity who are unable to afford a child – the very population most at risk of experiencing IPV – and/or those who have sexual partners who are unwilling to parent a child. The State is nonetheless willing to refer abortion patients to services that circumvent this and encourages them to establish a years-long, if not decades-long, financial and legal relationship of dependency with an unwilling, and potentially abusive, biological parent. These statutes thus acknowledge a particular form of coercion, when partners seek to compel or influence someone to undergo an abortion, without acknowledging the much higher emotional, physical, and financial risks of raising a child with an unwilling partner. This works to perpetuate the nuclear family as the ultimate, desired family formation, irrespective of the safety or willingness to coparent.

Similarly, these bills encourage women to receive particular forms of state and private support. None of these informational booklets, or their attendant statutes, encouraged referrals to educational or professional services for pregnant. This is not surprising since the Reagan administration slashed many of these services throughout the 1980s, castigating impoverished mothers of color on welfare for their dependency while simultaneously robbing them of educational and professional opportunities that would help raise them out of poverty (Solinger, 2001). As such, the informational booklets refer women to services, agencies, and legal options that produce them as dependent upon the state, non-profits, or the men that impregnated them. These referrals further overlook how the welfare system has increasingly become a "system of behavior modification that attempts to regulate the sexual, marital, and childbearing decisions of poor unmarried mothers by placing conditions on the receipt of state assistance" (Roberts, 2009).

A conditional iteration of positive freedom thus emerges. Pregnant women are given access to necessary material resources, *if* they bring their pregnancy to term or if they come to regret their abortions. By providing post-abortion emotional support, which targets women who have difficulties coming to terms with their abortion decision, these statutes are willing to counsel and support women who regret their termination and who retroactively yearn for motherhood. But these statutes do not provide resources for funding abortions and most states with stringent informed consent requirements criminalized state funding for abortions. In fact, many statutes actively emphasize that referrals must direct patients to pregnancy centers that do not provide any abortion services. Impoverished mothers can receive support, but this means subjecting themselves to pervasive governmental oversight that perpetually constraints their choices and freedom. Abortion patients are given the opportunity to exercise seemingly unobstructed decisional freedom, which is not constrained by economic coercion, if they choose motherhood. Women's true choices, and hence decisional freedom, are only (marginally) materialized and promoted when women ultimately choose motherhood.

And this is where it is important to consider the informed consent statutes comprehensively. I have paid particular attention to the resource referrals, but these exist in conjunction, both legislatively and visually in information booklets, with the other three types of informational requirements. Resource directories are listed after pages showing images of fetal development in two-week increments. Some of these images are drawn, but most are copies of Leonard Nilsson's fetal photographs. Each image is accompanied by a description of the fetus' developing organs. The booklets then warn patients of the physical and emotional risks of abortion procedures. Physical risks are mostly framed statistically, compelling patients to consider their risk-tolerance when faced with a procedure that causes blood clots in approximately 1% of patients, a cut or torn cervix in less than 1% of first trimester abortions, or perforation of the uterus wall in approximately 0.002% of abortions. In South Dakota, abortion patients must receive a statement in writing describing "all known medical risks (…) and statistically significant risk factors", such as the risk of "depression and related psychological distress; increased risk of suicide ideation and suicide". Otherwise, these booklets, by and large, simply inform patients that:

> (…) women experience different emotions after an abortion. Some may feel guilty, sad or empty, while others may feel relief that the procedure is over. Some women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks and substance abuse. These emotions may appear immediately after an abortion or gradually over a longer period of time. These feelings may recur or be felt stronger at the time of another abortion, or a normal birth, or on the anniversary of the abortion (Louisiana Department of Health, 2019).

These disclosures are not quite the obviously dubious ones that have often received attention that alleged that abortion causes breast cancer or that the fetus is already a human being (Denbow, 2015; Huff, 2014; Post, 2007). There is no talk of statistical significance but simply that "some women have reported". And while the description overwhelmingly lists what are effectively some of the symptoms that Dr. Vincent Rue (1992) identified when describing Post-Abortion

Syndrome, there is the more nuanced, even if elusive, acknowledgment that abortion patients experience a variety of feelings, including relief. Other informational booklets additionally address how patients come to make sense of their decision as being either the right one, the wrong one, or one they would have preferred to entirely avoid. In many ways, this disclosure seems somewhat reflective of scholarship that has repeatedly concluded that women experience a vast array of post-abortion emotions that are no more traumatic or pathological than the feelings we experience after any life event (Adler et al., 1992; Major et al., 2009). These disclosures border bureaucratized platitudes that simply warn patients that they will experience (painful) feelings after a medical decision.

And yet, this language, which is washed of explicitly medicalized and statistical references, departs from more traditional informational requirements that compel the disclosure of scientifically recognized risks (Post, 2007).[53] Indeed, the South Dakota Task Force to Study Abortion (2005) argued that abortions, although rarely necessitated as medical treatment, remain nonetheless a medical procedure, thereby blurring a(n often artificial) line between medical risks and nonmedical ones. The alternatives, adoption or raising the child, are thus “nonmedical in nature” and necessarily entail “the right of the pregnant mother in her relationship with her child, her right to protect the child’s welfare” (p. 36). This enables the legislatures to use the informed consent doctrine in explicitly nonmedical ways that imbue the informational process with biased and ideological disclosures. If the alternatives, and even abortion, are nonmedical in that they are mostly unnecessary to treat illness, the informed consent process is necessarily, in this framing,

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[53] Legal scholar Robert Post (2007) examines First Amendment principles that ought to apply to South Dakota’s H.B. 1166 (2005) that compelled physicians to disclose to abortion patients that: “the abortion will terminate the life of a whole, separate, unique, living human being”. He distinguishes “professional speech” from “speech by a professional”, whereby the former is prone to regulation since it is part of medical care while the latter occurs when a professional speaks to the public but does not provide tailored medical recommendations. While professional speech is regulated, “the doctrine of informed consent compels physician speech only insofar as the content of that speech is consistent with the knowledge of the medical community” (Post, 2007, p. 970).

going to cover “nonmedical”, and hence unsubstantiated and moral, information. The legislatures can imbue the decisional process with biased and ideological information about their views of fetal personhood, abortion, and motherhood. And, importantly, this compels patients to pause and reflect on the possibility of their future emotions as part of their medical decisional process, thereby attempting to weaponize women’s future emotions against their current choice.

Finally, the informed consent requirements are disclosed while abortion patients, in most of these states, are further compelled to undergo ultrasounds during which they are informed that it is their right to view, hear, and get a print of the ultrasound. Carol Sanger (2008) argues that mandatory ultrasounds are deeply coercive by compelling abortion patients to use their bodies in the production of information thereafter meant to dissuade them from undergoing the termination they already chose. Since mandatory ultrasound exists in a larger visual context in which the fetus is a “familiar presence”, the technology’s original diagnostic purposes have been erased and replaced as a nonmedical mechanism that produces pregnant women as mothers. The abortion patient’s very body is used in producing individualized and personalized information meant to ignite innate maternal instinct that will override her abortion decision, thereby using her body against her “deliberative path taken to the abortion decision” (Sanger, 2008, p. 396). A diagnostic and medical technology is thus rendered into a nonmedical one that produces abortion patients as mothers despite themselves. Ultimately, these informational requirements concerning the patient and the fetus effectively use medicolegal mechanisms that legitimize nonmedical, ideological, and moral information as necessary information for someone undergoing a procedure, or considering its alternatives, that are nonmedical in nature. Abortion patients are repeatedly produced as prospective mothers, whose decisional process is forcibly disrupted by information produced by and about themselves (or their potential future selves) that is meant to use women's decisional processes and feelings against themselves.

5.6 Mobilizing the Doctrine's Inherent Presumptions

And even as the anti-choice movement expands the scope of the informed consent doctrine, turning it into an ideological vehicle protected by the legitimacy of medical discourses, it also taps into some of the doctrine's inherent assumptions and limitations. Consent is generally a mitigating legal and moral process that transforms the otherwise illegal, impermissible, and immoral into a moral and legal act since the consenting party necessarily foregoes, to some degree, their bodily integrity, autonomy, or property (Dougherty; 2014; Fischel, 2020; Greenblatt & Valens, 2018; Haag, 1999; Hurd, 1996; McDonagh, 1996; O'Neill et al., 2008; O'Regan, 2019; Pateman, 1980; Weinberg, 2016). Its very nature renders it most necessary under conditions of risk, uncertainty, and ambiguity (Butler, 2012). In these moments, consent is tasked with the momentous responsibility of simultaneously upholding individual autonomy and ensuring social cohesion. The individual's decision to voluntary and rationally abandon some of their freedom is what simultaneously absolves the other party from any (legal) responsibility while enacting the consenting subject's originating freedom that enabled them to make a decision in the first place (Simmons, 1993). Consent is a preemptive act whereby someone agrees to something in the future, thereby collapsing time and compelling the individual to forecast, to the best of their ability, how they will come to feel. As such, consent is an inherently speculative act that can never be entirely informed since the very process of experiencing the thing one consented to may change our originating feelings and agreement (Butler, 2012; Greenblate & Valens, 2018). This is precisely why sexual consent has morphed from a binary "yes" or "no" into something that must be affirmative and revocable. Anti-choice activists have accounted for this by compelling physicians in some states to disclose that "research has indicated that the first pill provided (…) is not always effective in ending a pregnancy" (Bhatti et al., 2018). If after taking the first pill you regret your decision, please consult a physician (…) immediately to determine if there are options available to assist you in continuing your pregnancy" (Public Health and Safety Act, 2021).[54]

This elucidates the relationship between regret and the informed consent doctrine. The latter is meant to ensure and protect medical decisional processes. Even as it upholds patient's autonomy, and the right to refuse or go against medical advice, the very notion of consent presumes a rational and calculating agent who calmly weighs the circumstances of their lives against the medical information divulged by the physician (Donnelly, 2010; Fischel, 2020; Greenblatt & Valens, 2018; O'Regan, 2020; Phillips, 2008; Weinberg, 2016). As I discussed in Chapter 2, the doctrine's capacity requirement is deeply normative in what constitutes decisional capacity. Informed consent abortion statutes simultaneously acknowledge the impossibility of the atomized, calculating, and rational agent while nonetheless normatively (re)producing her as such. The combination of informed consent anti-abortion statutes along with the "abortion regret" discourse calls upon women to consider that they may come to regret their abortion decision. Infiltrating allusions to regret throughout informational disclosures thus recognizes that patients can never be entirely certain of their post-operative feelings, while nonetheless tasking them with considering how they may feel in the future. Since regret presumes having chosen incorrectly, patients need to further reconsider how their current abortion decision, which they

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[54] "Abortion reversals" entail the repeated administration of progesterone after taking the first abortion medication, mifepristone, which blocks the production of progesterone necessary for the pregnancy's development (Grossman & White, 2018; Planned Parenthood, n.d.). The American College of Obstetricians and Gynecologists (ACOG) issued a statement denouncing these claims as "not based on science", not meeting clinical standards, and thereby interfering in the physician-patient relationship.

presumably perceive as the right and necessary one, may eventually be recast as the wrong decision. Their future, potential emotions are pitted against their current selves.

And, ultimately, the informed consent doctrine cannot escape the very power differentials that engender its necessity. Consent, much like the “choice paradigm”, is a proxy for individual’s autonomy and decisional freedom. It thereby eclipses the larger conditions under which people agree to something, while nominally upholding their freedom (Angel, 2021). Political theorists Wendy Brown (2005) and Judith Butler (2012) further argue that consent necessitates and presupposes the inequality it is tasked with remedying. Consent is inherently a response to power, a way of legitimizing subordination and oppression. The consenting individual legitimizes these originating conditions without ever escaping them: “Consent is thus a response to power – it adds or withdraws legitimacy – but it is not a mode of enacting or sharing in power” (Brown, 2005, p. 163).

Indeed, the informed consent was a response to an asymmetrical relationship between the physician and the patient. And, as I discussed in Chapter 2, its emphasis on patient autonomy was always circumscribed, both legally and theoretically, by the medical profession’s commitment to beneficence. The doctrine instituted the right of refusal, even if contraindicated, but it was never able to materialize and protect patients’ self-determination. The very notion of autonomy is inextricably linked with notions of capacity and rationality. Someone is deemed autonomous when having cognitive capabilities, which, in turn, protects them from governmental oversight and encroachment. But the informed consent doctrine further delineates and qualifies autonomy. The noun “patient” acts as a qualifier, indicating the type of self-determination available to individuals. They can make decisions so long as these are aligned with a larger, often normative, quest for health and well-being. The profession’s commitment to beneficence thus supersedes and circumscribes the choices made available to patients. Or, as Brown (2005) and Butler (2012) argue, the patient's consent is a legitimization of an agreement whereby the patient renounces some of their bodily integrity. Their consent cannot escape the circumscribing conditions of the exchange.

The informed consent's emphasis on rationality, which is materialized through its capacity requirement, and its restricted and qualified conceptualization of autonomy make it an effective medicolegal mechanism for the anti-choice movement. Patient autonomy, under the informed consent doctrine, is only ever a marginal and restricted form of self-determination that cannot escape the prescriptive call to rationally make one's medical decisions in line with normative understandings of health. And this is precisely what makes it such a powerful artifact for the anti-choice movement. Informed consent statutes can seek to promote patient's decisional freedom, even if nominally or conditionally, not despite the doctrine but because of its inherent difficulties and presumptions.

5.7 Conclusion

Ultimately, these informed consent statutes and the discourses upon which they rest conjure and reconcile multiple, largely conflicting understanding of autonomy and decisional freedom. First and foremost, pregnant women are (re)produced as patients, which warrants the mobilization of the informed consent doctrine as it was first instituted and conceptualized: to protect patients from medical encroachment. Since the procedure remains, nonetheless, a medical one and women are patients, the anti-choice movement effectively replaced medical paternalism with state paternalism in its quest to nominally promote women's reproductive choices. In practice, these informed consent statutes then merge and juxtapose neoliberal notions of "choice" with, paradoxically, a conditional understanding of positive freedom. Women are compelled to rationally weigh the alleged physical and emotional risks of abortion against the possibility of bringing the pregnancy to term. They are perpetually tasked with preemptively considering their future lack of health, which produces their pregnancy as a preventative measure against cancer and mental illness. And, simultaneously, women are informed that “many” agencies are willing to help them with their pregnancy, childbirth, and childrearing.

These informed consent statutes thus acknowledge, and critique, a reproductive landscape in which some women turn to abortions out of desperation while existing under “state neglect” without having to actually work towards combatting these systems of oppression. These bills, and their informational booklets, thus tap into the reality that a significant percentage of abortion patients report terminating their pregnancies because they cannot afford a(nother) child. This exists in a larger context that has, for decades, used women’s morally ambivalent and anguished abortion stories to demonstrate that most abortions are undergone after thoughtful, deliberate, selfless, and rational reasons. In these narratives, women are compelled into abortion out of desperation for reasons beyond their control. And the anti-choice movement have harnessed this reality, and its associated pro-abortion strategy, to further naturalize motherhood. If only women had access to resources that enabled them to bring an unplanned, but desired, pregnancy to term, they would almost always choose motherhood over abortion.

The anti-choice movement thus developed notions of choice, coercion, and ultimately freedom that move beyond restricted, neoliberal iterations thereof. In fact, the movement seems to simultaneously acknowledge and mobilize the critiques of neoliberalized conceptualization of freedom that individualizes responsibility by framing individuals as having unlimited autonomy in choosing the trajectories of their lives. And yet, the resource lists, which direct women to agencies and to seek child support from potentially resistant sexual partners, reify a narrow understanding of family arrangements that underscore the nuclear family with heterosexual parents irrespective of the conditions and circumstances of this relationship. These statutes thus acknowledge the (rare) fact that some women may be coerced to undergo an abortion by family members or partners. And yet, it only seeks to protect women from these coercive relationships when these threaten fetal life. When these relationships could provide material support to raise the child, the State is willing to direct pregnant women to these, irrespective of the nature of the relationship and the form of dependency or abuse this could engender. In the same vein, the resources are almost exclusively ones that provide (marginal) material support but do not give pregnant women the opportunity to escape poverty through professional or educational trainings and opportunities. Women are given the resources to materialize their choices, and seemingly make genuine, unconstrained decisions, if they choose motherhood.

As such, the neoliberal imposition of being an informed, risk-adverse patient who makes the “right”, weighted and considered decision is compounded by this contingent and conditional form of positive freedom only available to (future) mothers. The anti-choice movement simultaneously acknowledges, decries, yet nonetheless mobilizes women’s marginalization in attempting to impose motherhood upon them.

This is precisely why reproductive justice scholars have long argued that women’s (reproductive) self-determination can only be materialized when women’s negative freedom is upheld, *and* the responsibilities of motherhood are evenly distributed throughout society. Women’s negative freedom, or privacy rights, without concomitant systems of support effectively transforms birth control and abortion into technologies of population control. State support mechanisms without a concomitant respect and protection of women’s right to make their reproductive choices in accordance with their ideology, beliefs, morals, and preferences is compelling women to become mothers. As Dorothy Roberts was already calling for in 1997, we need a concept of liberty that "includes not only the negative proscription against government coercion, but also the affirmative duty of government to protect the individual's personhood from degradation and to facilitate the processes of choice and self-determination" (p. 309). Or, as Rosalind P. Petchesky (1990) was inquiring:

> How do we transform the social relations of reproduction to bring men, as potential fathers, into those relations on an equal basis? How would such a transformation affect the principle of "control over our bodies"? The two ideas of reproductive freedom discussed here must be incorporated into a revolutionary feminist and socialist politics. Despite the real tensions between these ideas – stressing changes in the social relations of reproduction and stressing women's control over their bodies – neither is dispensable for feminists (p. 14).

That feminists were already calling for this decades earlier is quite discouraging. The anti-choice movement seems to have both recognized and weaponized their calls for positive and negative freedom. Indeed, as I have attempted to demonstrate, the necessity of distributing the responsibilities of motherhood across society seem to have made their way into informed consent statutes, but in ways that ultimately encourage, if not compel, women to "choose" motherhood. And the direction of the anti-choice movement post-*Dobbs* brings renewed urgency to Roberts' and Petchesky's pleas for reconceptualizing and expanding, in practice, (reproductive) freedom. Americans United for Life (n.d.) recently published its post-*Dobbs* strategy and goal: the "abolition of abortion", which entails reconceptualizing the "culture of life". In the AUL's vision of the future "mothers will receive care from a constellation of pro-life pregnancy centers; states will ensure that alternatives to abortion are well-funded and promoted; and infants will be welcomed and cherished in life, as they should be" (Americans United for Life, n.d.). Similarly, the organization Feminists for Life's mission "recognizes that abortion is a reflection that our society has failed to meet the needs of women. We are dedicated to systematically eliminating the root causes that drive women to abortion" (Feminists for Life, n.d.). In other words, some factions of the anti-choice movement seem well-poised to weaponize the language of abolition and reproductive justice movements in their next quest to federally criminalize abortion. These organizations recognize the political power of addressing the material conditions that circumscribe women's reproductive decisions. It becomes all the more important to fight for an environment in which access to state resources with which to raise children are not used as a coercive mechanism to compel women into motherhood but, instead, materializes women's genuine ability to choose the trajectories of their lives in accordance with their desires and beliefs.

CONCLUSION

The abortion procedure embodies a liminal space within medical procedures. It is, even if increasingly rarely, a medical *treatment* against potentially debilitating and sometimes fatal ailments. And, as of now, healthcare workers must be the ones to prescribe and provide them. At the same time, it is a procedure with tremendous emancipatory potential that allows people to live their lives in accordance with their authentic desires and goals, unencumbered by the pervasive and inescapable consequences of an unwanted pregnancy and of compulsory motherhood. It enables women to live their lives without being tethered to their reproductive capacities. My project traces how *Roe*'s enshrinement of the abortion right in a medical framework was easily appropriated by later anti-choice efforts that nominally valued abortion patients' autonomy while practically working to curtail abortion access.

I argue that current informed consent statutes in abortion regulation are, in many ways, manifestations and culminations of early abortion jurisprudence in which abortion was primarily configured as a medical treatment and the pregnant woman as an abortion patient. The privacy right delineated by the *Roe* Court was always a qualified one, even during the first trimester, as physicians and patients collaboratively determined whether the procedure was a necessary one. As I traced in my third chapter, early abortion jurisprudence continually tasked pregnant women with making the "right", considerate, and informed decision in light of their well-being and health and in consultation with their physician. The discrepancy between abortion practices and the Court's imagined consultative relationship enabled the anti-choice movement to seek informed consent requirements as a way to formalize this relationship and decisional process. The informed consent doctrine was well-aligned with this first-trimester privacy right as imagined by the *Roe* Court: it shared similar goals and presumptions. The doctrine was conceptualized in attempts to redistribute and equalize decisional power between physician and patient. Medical paternalism was to be replaced, or at least complemented, by patient autonomy. And yet, as I argue in Chapter 2, the very term "patient autonomy" betrays its inherent constraints. The noun "patient" acts as a qualifier, thereby circumscribing someone's autonomy according to their status as a patient. Patients acquired the right to make their medical decisions, rather than simply comply with their physicians' prescriptions. And yet, a patient's choices are always circumscribed by available medical treatments meant to promote or restore their health and well-being.

I am not decrying this form of autonomy. It was revolutionary, necessary, and seemingly unavoidable given the inherent power asymmetry between patient and physician. But it can constrain pregnant people's (reproductive) freedom, as this project has attempted to demonstrate. Once the procedure is overly medicalized, pregnant women's self-determination right to make their (reproductive) choices unencumbered by any external constraints or normative impositions, is confused and collapsed with their rights as a patient. Self-determination and patient autonomy are rendered synonymous, thereby obscuring the ways in which patient autonomy can never materialize a broader, more robust self-determination right. Abortion patients have always been tasked, through *Roe*'s first-trimester privacy right and then through informed consent requirements, to make good, responsible medical decisions. The threat of "abortion regret", and its mutually constitutive alternative of "abortion relief", is a complementary discursive practice that paternalistically warns abortion patients of the consequences of a wrong choice, thereby producing motherhood as the rational, retrospective choice despite women's abortion decision. What has changed throughout the decades, as the Supreme Court's composition leaned Right and anti-choice legislators gained traction, is the degree to which the State entrusted physicians to oversee the abortion decision. I argued in my fifth chapter that the anti-choice movement thus mobilized the doctrine precisely as it had been conceptualized: as a vehicle that simultaneously protects patients from excessive medical paternalism while promoting *patient* autonomy. Notions of health, well-being, choice, coercion, and refusal changed accordingly as these came to internalize religious and conservative views on motherhood, pregnancy, and fetal life.

Ultimately, the use of the informed consent doctrine and its concomitant "abortion regret" discourse were both acknowledgements, by the anti-choice movement, and weaponizations of liberalism's presumptions and limitations. The informed consent doctrine embodies liberalism's commitments: it presumes a rational, self-knowing, coherent, atomistic subject whose resulting autonomy warrants protection from medical paternalism. These statutes acknowledge this fictional character. The "abortion regret" discourse is entirely contingent on the view that abortion patients cannot ever quite understand the depth of their decision until it is too late. At the same, the very admonishment to consider the possibility of regret (re)produces and interpellates abortion patients to embody the fictional liberal subject who makes responsible decisions. And the informed consent doctrine is a perfect vehicle through which to nominally espouse and protect pregnant women's autonomy, while perpetually curtailing it in view of a normative understanding of well-being that confuses motherhood with health.

C.1 A Post-*Roe* Era

Working on this dissertation has been an ongoing process of reassessment. In retrospect, my starting presumption that I would primarily focus on shifting notions of choice seems shortsighted. My expectations deeply reflected and echoed critiques by reproductive justice scholars and legal theorists who have condemned individualizing liberal notions of choice and privacy (Denbow, 2015; Goodwin, 2020; Roberts, 1997; Solinger, 2001; West, 2009). I was expecting to find discourses about the atomized, rational liberal subject baked into the Supreme Court cases that originated or protected abortion access. My hypothesis was that these notions of choice and privacy, which promote freedom all while abandoning individuals to their own devices, would be easily appropriated by ensuing anti-choice efforts.

To my surprise, women's self-determination right was largely, if not entirely, absent from these decisions. To the extent that it was alluded to was to in discussions of the privacy right in earlier cases. But early abortion jurisprudence did not articulate the sort of privacy right as delineated under *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972), which instituted the right to birth control, first for married couples and then individuals. These cases, much more explicitly, acknowledged the relationship between privacy and self-determination and why it was important to let individuals make such intimate decisions unencumbered by governmental surveillance and oversight. Instead, early abortion jurisprudence was much concerned with questions around physicians' discretion and authority.

I am somewhat ashamed to admit that it took me until the last weeks of writing to finally realize and be able to articulate something I was long bothered with: patient autonomy can never materialize the more robust form of self-determination I not only presumed abortion jurisprudence instituted (even if only marginally), but which I also take to be an integral part of the abortion procedure. The discrepancy between my expectations and what I read likely explain some of the project's shortcomings, especially in the third chapter. My first analysis was deeply framed and shaped by this surprise and it took me some time to articulate, I hope, a more nuanced analysis of the Court's decisions and how these adjudicate competing claims around medical authority. Put differently, I did not anticipate this project being so concerned with medicalization and medical authority, even as I always knew it would be an important factor given my focus on the informed consent doctrine.

And the project, at this juncture, has largely confirmed two instincts and deep frustrations I experienced in the days following the *Dobbs v. Jackson* (2022) decision. I do not know of a single abortion scholar who did not anticipate this moment. But what struck me in the days and weeks following both the Politico leak and the official decision was how much people resorted, once again, to these medicalized framings to legitimize abortion access. Social media was replete with posts, memes, and tweets of people decrying the criminalization, in some states, of a potentially life-saving procedure. As I discussed in Chapter 2, we have already started to witness the violent consequences of the decision, despite medical exemptions. I understand why people resort to medical rationalizations since it renders a procedure most people still feel ambivalent and uncomfortable about more palatable, respectable, and understandable. Abortion patients are more sympathetic and relatable figures than the irresponsible pregnant person.

I hope that if this project has shown anything it is that there is a cost in enshrining the abortion right in medical terms. We need to tread carefully when resorting to abortion's value as medical treatment as both the pro and anti-abortion movements look to the future. As long there is not a superseding, or at least complementary, emphasis on the procedure's emancipatory potentially, I fear that we will continue to cede the discursive terrain to anti-choice efforts. The abortion decision will always, to some degree, be relegated to some external entity who can infuse religious and conservative values into what constitutes a necessary as opposed to an unnecessary procedure. There will always be a process of categorization, and hence legitimization, around abortion procedures and by extension around abortion patients. I am not arguing anything new. I am simply recycling and echoing claims that started in the 1960s and have since been reiterated throughout the decades by feminists, feminist legal scholars, and reproductive justice scholars and activists.

The fact that pro-abortion organizations, such as Plan C (2021), are dedicated to “normalizing the modern option of a self-managed or at-home abortion and laying the groundwork for over-the-counter access to abortion pills” is quite encouraging and reflect a broader attempt to de-medicalize abortion access. Advancing New Standards in Reproductive Health (ANSRH), housed at the University of California, San Francisco whose research on “abortion relief” and “decision rightness” I am critical of in Chapter 4, has started exploring the viability of over-the-counter abortions. ANSRH (n.d.) argues that mifepristone and misoprostol, the medication abortion pills, “meet many of the FDA’s criteria for being available over the counter. They are safe, have no risk of overdose, are not addictive and people are already using them safely on their own in many parts of the world”. A research team has started preliminary studies examining some of the logistical concerns around over-the-counter medication abortions, such as determining whether individuals can “understand a drug facts label”, whether people could accurately assess gestational age, and whether individuals could identify complications that necessitate medical care. At the time of writing, they have found that ultrasound assessments may not be necessary for medication abortion patients who used expanded screening questionnaires to determine gestational age (Ralph et al., 2022).

While these endeavors are ground for restrained optimism, de-medicalization efforts need to be complemented by a re-emphasis on the procedure’s emancipatory potential. This brings me to my second frustration. I have been so enmeshed, over the last few years, in examining anti-choice efforts and critics thereof that I have developed a relatively robust vocabulary to describe how and why these efforts are problematic, concerning, insidious, and ultimately oppressive. But

I have continually encountered difficulties when attempting to articulate the alternative. I see the limitations of confusing patient autonomy and self-determination, but I always stumble when trying to define and describe what this form of self-determination could look like. I am acutely aware of the ways in which the focus of my project has structured and confined both my dissertation and my ability to imagine and utter alternatives. Reproductive justice scholars have been central in articulating more robust, expansive, and inclusive notions of (reproductive) freedom. Loretta J. Ross (2017), the reproductive justice activist, public intellectual, and scholar who co-founded SisterSong, identifies three interconnected values of reproductive justice: "the right *not* to have children by using safe birth control, abortion, or abstinence; the right to *have* children under the conditions we choose; and the right to *parent* the children we have in safe and health environments" (p. 171).

As I argued in my fifth chapter, the younger generations of the anti-choice movement are particularly focused on remedying the material conditions that prompt women to choose abortion. Generation Z activists decry the circumstances that force pregnant people to terminate an otherwise desired, even if unplanned, pregnancy. Their purpose is to work towards eliminating those oppressive conditions so that pregnant people have the support and resources to bring a pregnancy to term and raise their child in a safe environment. The resurgence and popularization of this anti-choice focus calls for, all the more urgently, a system of material support that is not contingent upon the quality of people's decisional processes. Irrespective of what they decide and *why* they decide it, people deserve access to rights and (reproductive) healthcare with which to effectuate the trajectories of their lives as they envision and desire it. Financial support exists but in extremely conditional ways that facilitate state surveillance and deeply curtail people's self-determination. It needs to be separated from people's decisional processes. Reproductive decisions need to be relegated to a sphere of privacy, free from any form of oversight or evaluation, while still being materialized irrespective of the rationale. The material conditions that circumscribe people's reproductive decisions need to be eradicated to allow them to make their reproductive choices according to their desires, proclivities, motivations, and beliefs. And this necessitates not only the right to make choices, but the material and genuine ability to make potentially wrong, bad, ill-informed, immature, irresponsible, and hasty decisions.

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