Writing the History of Legal Abortion

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I started to research the history of legal abortion in the early 2000s, when the papers of a North Carolina abortion provider, Dr. Takey Crist, fell into my lap. Crist had wanted to donate his papers to an archive, and I volunteered to help him. Indeed, I ended up organizing his entire collection and, following that, the collections of a number of other abortion providers.[1] When I began this work, I could not conceive of a world in which the U.S. Supreme Court might overturn *Roe v. Wade*. The providers I met, by that time all in their sixties and seventies, were full of passion and fervor about the 1970s, when they had taken the political moment to open the first legal abortion clinics. They were strong believers in a woman's right to choose, to control her body, to determine her future.

In addition, politics looked different twenty years ago. One of the first abortion providers Crist introduced me to was his friend Susan Hill, who owned the National Women's Health Organization (NWHO), the largest group of free-standing abortion clinics after Planned Parenthood. As a twenty-four-year-old social worker, Susan had helped to open an abortion clinic in Florida two weeks after the *Roe* decision. Even the judges appointed by Republican presidents, she told me in the early 2000s, tended to be fair when she met them in court. By the late 1970s, she had founded the NWHO and was opening clinics in some of the most underserved areas in this country, including, in the early 1990s, the "Pink Clinic" in Jackson, Mississippi, which became the defendant in the *Dobbs* case.[2] To open her clinics and to keep them open and services unobstructed, she had spent her life in court.[3]

I could not imagine a Republican Party interested in alienating a large voting block and losing abortion as the easy political rallying point

1. The papers of Dr. Takey Crist and a number of other abortion providers are deposited at the Sally Bingham Center for Women's History and Culture (SBC) at Duke University Libraries.

2. *Dobbs v. Jackson Women's Health Organization*, no. 19–1392, 597 U.S. (2022).

3. For the experience and challenges opening abortion clinics, see Johanna Schoen, *Abortion After Roe* (Chapel Hill: University of North Carolina Press, 2015), chap. 1.

it had been since the 1980s. Clearly, I was wrong—which just shows that you should never ask a historian to predict the future. By the time the U.S. Supreme Court did overturn Roe with its decision in *Dobbs v. Jackson Women's Health*, I was no longer surprised. I was also twenty years older and more cynical.

When I first began to research legal abortion, I was fascinated with the stories of young feminists who, in the early 1970s, had had no doubt about their ability to open abortion clinics and offer health care to women across the country. Their political commitment and compassion were deeply moving; they believed that their actions could change the world. Of course, sometimes their political convictions were also didactic and funny. For a few years, while I taught at the University of Iowa, I sat on the board of the Emma Goldman Clinic in Iowa City, the longest running feminist health collective in the country. When I confessed to one of the directors that I had never seen my cervix—in the world of women's health clinics this was seen as a prerequisite on the path to a feminist consciousness—she assured me that I could call on their services any time. I never took her up on this offer.

As a historian, I was interested in the fault lines that existed in the world of abortion care. I wanted to tell the heroic stories of young women activists who had overcome sexism and patriarchy to establish women's health clinics and the stories of young male doctors committed to legal abortion care who had dared their colleagues to integrate abortion into their OB-GYN clinics. I also wanted to know what decades of harassment had done to the abortion provider community and how members coped with it. Had the relentless antiabortion propaganda changed their feelings about their work? And if so, how had they responded to these changes?

Learning about antiabortion politics and harassment was easy. The papers of Takey Crist and Susan Hill were full of antiabortion materials—pamphlets and leaflets handed out on picket lines, letters by antiabortion activists to convert or threaten them and their staff, audiotapes and notes from antiabortion meetings that Crist's supporters had infiltrated, legal depositions in which antiabortion activists bragged about their actions to lawyers, and public testimonials on antiabortion websites. I analyzed how antiabortion activists fetishized the fetus and used the fetal body as a political tool when they displayed fetuses on picket lines and stole fetal remains from pathology labs to give them ceremonial burials. I also pointed out how they used the fetal body metaphorically, attributing consciousness and intent to it as they described the experience of an abortion from the perspective of the fetus.[4]

4. See, for instance, Schoen, *Abortion After Roe* (n. 3), 140–50, 155–86.

It was much more difficult to find out what abortion providers and women seeking abortion care thought. It was clear to me that I would be able to tell the story of legal abortion from the perspective of abortion providers only if I were able to interview them and convince them to donate their papers to archives. In the early 2000s, I joined the National Abortion Federation (NAF), the professional organization of abortion providers, at a time when NAF was haunted by the harassment and violence surrounding abortion care. Security at meetings was high. People feared for their lives—and rightly so. Over the previous decade, seven abortion providers and clinic staff had been murdered at their home or places of work. Others had escaped attempted assassinations. Clinics were sites of frequent bomb threats, and a number of them had been firebombed and destroyed.[5]

The political controversies surrounding abortion also meant that NAF members worried about any negative publicity—so much so that a senior colleague warned me that if I were to betray the trust placed in me as a new NAF member, they would make sure to quickly end my research in the world of abortion care. In fact, no one ever questioned my research, opinions, and writings. And members eventually came to trust that I was a researcher with integrity. But the sense of fear and secrecy that surrounded the meetings was palpable.

I discovered that when abortion providers articulated their thoughts and feelings about their work, they entered a minefield. Antiabortion activists exploited the words of abortion providers to prove that providers were immoral profiteers who did not care about women, callously murdered fetuses, and were at best mentally deranged, at worst cold-blooded.[6] Worries in the abortion provider community that members' words and deeds might provide fodder for antiabortion propaganda stretched back to the 1970s and the development of Dilation and Evacuation (D&E) procedures, in which the fetus is removed in parts through the cervix. Early pioneers of the use of laminaria and the development of D&E were met with hostility by their own colleagues who worried that women might be infected or even die under the hands of inexperienced providers, thereby confirming the worst stereotypes—that abortionists were really butchers.[7]

5. See Schoen, *Abortion After Roe* (n. 3), 199–201, 210–19.

6. For a detailed discussion about antiabortion activists' exploitation of abortion providers' thoughts, see Schoen, *Abortion After Roe* (n. 3), 131–40.

7. D&E replaced the saline procedure as the predominant abortion practice after the first trimester. A saline procedure required that a physician withdraw amniotic fluid and replace it with a concentrated salt solution, leading to miscarriage within twenty-four to thirty-six hours. Saline procedures could be performed only after the sixteenth week of pregnancy,

By the early 1980s, researchers had established the safety record of D&E and urged all abortion providers offering procedures after the first trimester to adopt the practice.[8] But since D&E involved the extraction of recognizable fetal parts, the procedure took an emotional toll on the doctors and the staff who assisted.[9] While NAF offered continuing education seminars and supportive services for abortion providers and staff, exploring the philosophical underpinnings of fetal development and personhood, the organization balked at any discussion that might address the violence inherent in performing D&E procedures. Struggling with the implications of the procedures they performed, but committed to a prochoice position, providers had no space to voice their thoughts without the risk that such discussion would be exploited for antiabortion purposes.[10]

In the early 1990s, newly adopted intact D&E procedures attracted the attention of antiabortion activists who launched a nationwide campaign to discredit the procedures and the clinicians who provided them. Physicians developed intact D&E, in which the fetus is removed in one piece without dismemberment in utero, to address some of the technical difficulties they encountered with D&E procedures at more advanced pregnancies. NAF leadership was unprepared to publicly defend an abortion procedure now dubbed "partial birth abortion" in which the death of the fetus could be depicted in such gruesome terms. Leaders argued that intact D&Es were rare procedures that were performed only in hardship cases—statements that were far removed from clinical practice. Frustrated with the official response and feeling poorly represented, some members left NAF. Feminist providers and owners of independent clinics who had always been at the forefront of honest discussions of abortion care told me about their frustrations with the conservative positions of abortion rights organizations which failed to counter the antiabortion propaganda. Some of them mounted a discussion inside NAF about the perceived failures to address issues hitherto considered taboo: the violence inherent in abortion and the fact that abortion ended a developing life.[11]

when the uterine cavity contained enough amniotic fluid to allow for the procedure. In the 1970s, this left a window of four weeks during which women were unable to terminate unwanted pregnancies. For more on the switch from saline to D&E procedures, see Schoen, *Abortion After Roe* (n. 3), chap. 4.

8. See Schoen, *Abortion After Roe* (n. 3), chap. 4.

9. Judith Bourne Rooks and Willard Cates, "Emotional Impact of D&Es vs. Instillation," *Fam. Planning Perspect.* 9, no. 6 (November/December 1977): 276–77.

10. For more details, see Schoen, *Abortion After Roe* (n. 3), 121–31.

11. In the mid-1990s, antiabortion activists mounted a concerted campaign to pass legislation to ban intact D&Es. Both houses passed the ban in 1995 and 1997, and although President Clinton vetoed the bill twice, in 2003 President Bush finally signed it into law. In

In 2006, feminist scholar and abortion provider Lisa Harris and her colleagues at the University of Michigan launched a research project to analyze the types of stories about which abortion providers routinely remained silent. As a member of NAF and herself an abortion provider who trained colleagues in second-trimester abortion care, Harris acknowledged that talking frankly about abortion was threatening to abortion rights and frequently caused a rift with feminist movements.[12] But, she cautioned, abortion providers' self-censorship came with personal and social costs that allowed inaccurate and toxic representations of abortion providers and their patients to occupy the public sphere. Thus, embracing such discussions was essential. Showing respect for the fetus while performing the abortion, she argued, were not simultaneously exclusive emotions, for providers could express discomfort with aborted fetuses while affirming that women should have full access to abortion.[13] Between 2013 and 2017, my colleague Kim Mutcherson, law professor at the Rutgers School of Law, and I began to organize annual meetings for abortion providers, lawyers, bioethicists, and historians to discuss sensitive issues in abortion care, conversations that led to a number of publications asserting that health care providers were motivated by their moral convictions to provide reproductive health care services, including abortion. Abortion care, these providers concluded, *is* moral work.[14]

2007, the U.S. Supreme Court, in *Gonzales v. Carhart*, upheld the 2003 ban of intact D&E. For more details on the development of intact D&E, the debate surrounding it, and the events leading up to the ban of the procedure, see Schoen, *Abortion After Roe* (n. 3), chap. 6.

12. Lisa H. Harris, "Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse," *Reprod. Health Matters* 16, no. 31 Supplement (2008): 74–81.

13. Ibid., 78. Indeed, Harris was not the only one making this argument. James McMahon, one of the first physicians to develop intact D&E, was "caring and gentle and ultimately life-affirming in his approach to the abortion procedure." Dru Elaine Carlson to Patricia Schroeder, June 27, 1995, 104th Cong., 1st sess., House of Representatives Report 104–267, Partial Birth Abortion Ban Act of 1995, Report with Dissenting Views. See also Schoen, *Abortion After Roe* (n. 3), 219–31.

14. Johanna Schoen, ed., *Abortion Care as Moral Work: Ethical Considerations of Maternal and Fetal Bodies* (New Brunswick, N.J.: Rutgers University Press, 2022); Lisa H. Harris, "Recognizing Conscience in Abortion Provision," *New Engl. J. Med.* 376, no. 11 (2012): 981–83. Indeed, the argument that abortion provision is "conscientious" was first supported by sociologist Carole Joffe, who showed that skilled mainstream physicians offered safe and compassionate abortion care before *Roe*. Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion before and after* Roe v. Wade (Boston: Beacon, 1995). See also Willie Parker, *Life's Work: A Moral Argument for Choice* (New York: Atria, 2017); Katie Watson, *Scarlet A: The Ethics, Law, & Politics of Ordinary Abortion* (Oxford: Oxford University Press, 2018). More recently, as providers are retiring, a number of them are writing their memoirs, which will in coming years offer more open reflections on the world of abortion care. Among them

Hidden, and hence most challenging to research, were the thoughts of women who had chosen to end a pregnancy. With the exception of one publication from the late 1970s, such voices could be found only inside abortion clinics where staff offered women an opportunity to articulate their thoughts—most frequently in notebooks laid out in recovery rooms. After the publication of *Abortion After Roe* in 2015, the people who had generously offered their papers, recollections, and opinions now saw how I had reconstructed and interpreted their past. Most commented on the accuracy of the descriptions and the memories that came flooding back as they read *Abortion After Roe,* although a couple took umbrage at my description of their actions. An abortion provider friend, upon learning that I had never seen an abortion procedure, invited me to her clinic to shadow her for several days. The invitation provided a post-book reflection while also opening yet another cache of sources: sixteen recovery room notebooks dating from 2010 to 2016 in which women reflected on their abortions. Integrating the 1978 collection and recovery room notebooks from two clinics allowed me to reflect further on women's motivations and experiences. Most women seeking abortions, I realized, had high expectations of themselves as mothers. Unable to provide their future children with the life they wanted, women framed their abortion decisions as a moral choice.[15] "I felt that I did not want to bear a child without a father," one young woman explained. "I did not love the father, did not want to marry him, and, as a matter of fact, never even told him that I was pregnant. . . . I did not feel my abortion was immoral. . . . On the contrary, I felt it would be immoral to bring a child into the world under my circumstances."[16]

A number of women seeking abortions tried to protect their children from abusive relationships or to escape such relationships altogether. "I knew this guy since high school," one mother of two explained her decision to have an abortion:

> He was my best friend until we took our relationship further. I became pregnant. My first [pregnancy] was complicated. He had changed. We would fight and I'd be blocked or shoved into walls. How I didn't lose my daughter is a mystery. When I had my last daughter, things turned for the worse. I was forced to have sex. If I said no, it would be a fight and forced sex. When I found out

are Curtis Boyd and Glenna Halverson Boyd, Marc Heller, and Shelley Sella, all of whom have essays in *Abortion Care as Moral Work.*

15. For a more detailed discussion of women's thoughts about abortion, see Johanna Schoen, "Abortion Care as Moral Work," *J. Mod. Eur. Hist.* 17, no. 3 (2019): 262–79.

16. R. Soma, *Women Speak Out about Abortion. By Women, for Women in Their Own Words* (no publisher given, 1978), 48.

> I was pregnant, I wanted to be happy. But I felt rage and hate. After I felt sad and alone. My parents aren't supportive. . . . I won't lie, I still feel like shit. But I know this was for the best. I will miss my daughter, but I know she will be safe.[17]

Women also argued that they had a moral obligation to their potential children. Parents seeking to end wanted pregnancies after their fetus had been diagnosed with fetal anomalies saw their decision as protecting the fetus from unnecessary suffering. "We found out he had a severe heart defect that meant he would die slowly within a few days or weeks of being born," the husband of one patient wrote. "We couldn't bear the thought of watching a baby slowly suffocate and die just so we could see him and hold him. That would be selfish. We chose to terminate so that he would die painlessly inside his mother where he wouldn't ever know pain or suffering."[18] "If you know that this child will suffer more on earth than you will by having an abortion," one woman concluded, "then that is a decision for you to make and only you to make."[19]

Women also framed their abortions in religious terms, relying on God for guidance in their decision-making process. "I prayed about this situation," one woman wrote, "and I believe God is really listening and working through me."[20] Some gained solace in the belief that their experience was preordained. "I know you must feel like it's a sin, but actually, it's not," one patient noted. "God does things for a reason and he chose this for us because it was better."[21] Others felt that their finding and getting to the clinic itself was a sign that God had guided them to the clinic. "I have been praying and praying and we went over so many options to have the baby," one woman wrote. "Thank you Lord for giving me the team of doctors and nurses that you did. They were so kind and gentle. Thank you Lord for helping me find this facility."[22] Instead of being an obstacle to a good abortion experience, women's religious beliefs gave them the strength to make the abortion decision.

The *Dobbs* decision illustrates that five decades of antiabortion campaigns have—at least in the political arena—triumphed over the voices of those who defend the morality of abortion care. While abortion pro-viders and women seeking abortion care have eloquently articulated why access to abortion is necessary and moral, the stigma that surrounds

17. 2013 Brown Notebook, 20, Mountain County Women's Clinic, Susan Wicklund Papers (hereafter SWP), SBC.

18. 2015 Brown Notebook 3, SWP, 10.

19. Ibid.

20. 2010 Purple Notebook, Southwest Women's Options (SWWO), 25.

21. 2014 Brown Notebook, SWWO, 14.

22. 2015 Brown Notebook 2, SWWO, 24.

abortion care has continued to keep these voices hidden inside abortion clinics. Indeed, although abortion is a health care procedure central to the lives of women, the *Dobbs* decision did not mention women as individuals with a stake in the legal status of abortion. Instead, the decision denies women the ability to make their own reproductive decisions. The struggle over abortion has now returned to the states, many of which have already recriminalized abortion. The impact of this change will be most significant for young and poor women who lack the resources to travel to a state where abortion is legal. But it will also be felt by all women in need of medical treatments that have implications for women's reproduction: from the management of miscarriages and ectopic pregnancies to the treatment provided by rheumatologists and oncologists whose patients need access to abortion since treatments are often harmful to a developing fetus. In Texas, for instance, oncologists say they now wait for pregnant women with cancer to get sicker before they treat them because the standard of care would be to abort the fetus rather than allow treatments that damage it. But a state law allows abortion only "at risk of death."[23] The *Dobbs* decision not only limits women's control over their lives but also illustrates that to opponents of legal abortion women's health care needs, like their lives, are of no importance.

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23. Kate Zernike, "Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say," *New York Times*, September 10, 2022, https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html.