

April 2008

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Recommended Citation

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Sometimes, It's a Child *and* a Choice: Toward an Embodied Abortion Praxis¹

JEANNIE LUDLOW

Feminist analyses of recent abortion politics in the United States note that the “abortion debate” has settled into a system of dichotomies, such as the dichotomy between women’s autonomy on the abortion rights side and the value of unborn life on the anti-abortion side. This article posits that these dichotomizations contribute to the erosion of women’s access and rights to abortion through loss of credibility for abortion rights discourse and loss of access to abortion praxis that can handle more complex situations. Maintenance of the dichotomies requires denial or erasure of more complicated situations, like late-second-trimester abortion and situations in which women grieve their aborted fetuses. Drawing on her experiences working in an abortion clinic, the author argues that a more complete consideration of these more complex abortion experiences could interrupt the erosion of our reproductive rights.

Keywords: abortion rights / Partial Birth Abortion Ban / fetus / late-term abortion / abortion praxis / United States

It was my first D&X (dilation and extraction) procedure. I had been working as a patient advocate at an abortion clinic for about three weeks; the patient was about 22 weeks LMP—that is, it had been about 22 weeks since the first day of her last menstrual period, the point from which doctors measure gestation, for purposes of consistency. The abortion was elective. There was no fetal anomaly, no threat being posed to the woman by her pregnancy. She simply could not afford to have a baby, and it took her several months to save up the money for her abortion. According to the Allan Guttmacher Institute, this woman is typical of second trimester abortion patients. The top four reasons women cite for having abortions after 16 weeks LMP are (in order): lack of knowledge that they are pregnant; difficulty in making arrangements for the procedure (including finances, transportation, and childcare); fear of telling their parents or partners about the pregnancy or abortion; and need for more time to come to a decision about the pregnancy. Almost half of women having second trimester abortions cite financial or logistical reasons for waiting until after sixteen weeks of pregnancy to abort (Allan Guttmacher Institute 2005). Of course, as historian Rickie Solinger demonstrates in *Beggars and Choosers*, “choice” is complicated by these difficulties. Solinger explains how in the United States, “choice” to abort is always already circumscribed by race, class, access, and resources (2001, 6–7). In addition, Dorothy

Roberts' *Killing the Black Body* (1997) and Loretta J. Ross' (1998) work on African American women's reproductive rights activism provide some of the best analyses of the complexities of reproductive rights and activism for Black women. As a scholar, I respect and agree with these interrogations into the limitations and circumscriptions of "choice." As a provider, however, I also recognize that circumscribed choices are still choices; to suggest that only a full range of options equals "choice" not only detracts from women's attempts to empower themselves as much as possible but also buys into the commodification of pregnancy and childbearing. Poor women, women of color, young women, and women in very difficult living situations make decisions based on the choices available to them, decisions made often with full awareness of the systems of power, privilege, and oppression that circumscribe those choices, as Ross demonstrates in her work (1998).

The D&X procedure I observed that day seemed interminable compared to the first-trimester procedures to which I had already become accustomed. First-trimester procedures usually last less than five minutes; the 22-week D&X procedure took more than twenty minutes. The woman was awake and alert during her abortion (we did not have the technology at that time to offer sedation) as her advocate talked her through it: "I want you to take a slow deep breath, and as I count, breathe out completely. As we do this, you will feel a lot of pressure." After the procedure was over, I went into the surgery lab, where each surgery's fetal tissue is checked to insure completion of the procedure. The advocate trainer was checking tissue that day, and the fully intact fetus, looking like a tiny baby, lay in a glass dish, lighted from beneath. I drew my breath sharply. The trainer took my hand and said, "Sometimes, I see these little ones and I am sad for them. I don't believe it's just 'tissue' at this stage." She reminded me that the woman who chose this abortion had really good reasons for not trying to parent this child, and it would be better for her entire family if this little one were not a part of their lives right now. Then she said, "Sometimes, patients ask me to baptize their fetuses, so I do. I sprinkle them with just a little water and wish them safely into the next world." I was surprised and asked if she were religious. "Not like that," she said, "but I am spiritual and I believe I am doing spiritual work at the clinic." Then, she gave me some rubber gloves and left me alone with the fetal body for a couple of minutes. On November 5, 2003, President George W. Bush signed the "Partial-Birth Abortion Ban" into law, making illegal the D&X procedure that I witnessed that day. Now, by law, 22-week abortion procedures either put women through prolonged labor and delivery or result in dismembered fetal bodies. Since the majority of late-second-trimester abortions involve women living in poverty, young women, and women in difficult living situations, this law disproportionately affects the most vulnerable of our patients.

Mine is a story of the fetus that is not a part of the current public discourse of U.S. abortion politics, although its telling is inspired by the powerful history of abortion-related consciousness-raising in U.S. feminist politics. I offer this story as a contribution to the ongoing feminist conversation about what happens in abortion politics when the fetus and the pregnant woman are separated from one another in a process of discursive rupture, and women's embodied experiences are excised from the public discussion of abortion. Feminist analyses of abortion politics in the past twenty years note that they break down into a dichotomization of "fetus" from "woman" or, from an anti-abortion perspective, "mother" from "child," at best, a reductive way to think about a very complex issue (Petchesky 1987, Hartouni 1992, Stabile 1992, Taylor 1992, Balsamo 1996, Berlant 1997, Michaels 1999, and Stabile 1999). As many of these scholars demonstrate, this reductive approach has played a role in the gradual diminishment of support for and access to abortion in the United States. My own point of entry into this conversation is located at the intersection of my ten years' experience as an abortion clinic employee and my work as a feminist academic, a location that provides me with a perspective from which to analyze the discourse of abortion and its relationship both to women's lived experiences with abortion and to the political limits on abortion.

In this paper, I begin with the unbridgeable discursive gap that characterizes the U.S. abortion debate. Within the context of this debate, women are losing—not only through changes in Supreme Court membership and recent legislation (including the complete ban on all abortions passed in South Dakota and pending in my own state of Ohio in 2006), but also through the gradual decrease of the number of doctors trained or willing to perform abortions and the more rapid loss of public support for abortion rights. I argue that a more accurate understanding of abortion, which includes a full range of women's relationships to their fetuses and how these various relationships shape individual abortion experiences, has been elided by the dichotomization of abortion politics. As a 2005 *New York Times* article explains, "While public conversation about abortion is dominated by advocates with all-or-nothing positions . . . most patients at [abortion] clinic[s], like most Americans, f[i]nd themselves on rockier ground" (Leland 2005). This rockier ground is epitomized by the situations that I examine in this paper: later-term second-trimester abortions and the "Partial Birth Abortion Ban," and women's experiences of connection to fetuses they choose to abort.

Cultural attention to these situations has been superseded by attention to the strategies used by abortion rights activists to counter anti-abortion contentions, strategies that have actually served to strengthen the dichotomizations central to abortion politics rather than to complicate our understanding of abortion in the United States. In the current cultural context,

what is at stake in my analysis is nothing less than the maintenance and reclamation of women's access to a range of abortion options, via a fuller, more complete representation of our lived experiences with abortion. This more complete representation will challenge the absolutism of "the abortion debate," showing abortion experiences to be more complex and more nuanced than generally acknowledged by those on either side of that debate. If this more complex understanding of abortion experiences were to become an element of our public abortion debate, I assert, it would be much more difficult for anti-abortion activists to proffer simplistic solutions to what they sometimes call "the abortion problem." This more complex understanding of abortion experiences also complicates, and in some ways challenges, the strategies that feminists have developed to counter anti-abortion discourse; for this reason, my contribution to the discourse is risky.² This is, however, a risk that must be taken, and one that has already been broached in the movement.

In the Winter 2004/2005 issue of *Conscience*, Frances Kissling, founder of Catholics for a Free Choice, made waves in the abortion rights movement by calling for activists to attend to questions and concerns related to the fetus. In "Is There Life after *Roe*? How to Think About the Fetus," Kissling argues "that the pro-choice movement must acknowledge the moral value of a fetus—and the potentially painful reality of its loss" (Traister 2005). She acknowledges the historical context of the dichotomization of fetuses and women in U.S. abortion discourse: "It has long been a truism of the abortion debate that those who are prochoice have rights and those who are against legal abortion have morality; that those who support abortion rights concentrate on women and those opposed focus on the fetus" (Kissling 2004/2005, 8). But now, Kissling argues, we need to work toward "the development of an abortion praxis that combine[s] respect for the fundamental right of women to choose abortion with an ethical discourse that include[s] the exploration of how other values might also be respected, including the value of developing human life," thus moving beyond the rather simplistic dichotomies that have characterized U.S. abortion discourse (2004/2005, 2).

The responses to Kissling's article have been strong and swift. Anti-abortion responses predictably charge inconsistency: a *Free Republic* commentary is titled "The New Line of Pro-Choice: 'Saying it's wrong makes it right'" (Vanderleun 2005), clearly reinscribing the dichotomy, while John Mallon (2005), contributing editor to *Inside the Vatican*, posits that Kissling's article was evidence of "Cracks in the Wall." Less predictable, perhaps, have been the responses of some abortion rights activist leaders. In *The Village Voice*, Ellie Smeal of the Feminist Majority Foundation accuses Kissling of diverting the abortion debate to issues that are less important than "putting the right wing on the defensive" and of simplifying the issue of abortion by talking only about potential sadness. "I don't

hear her saying that there's joy sometimes," Smeal is quoted as saying. "I think if an 11-year-old is pregnant, it's a great relief for her to have an abortion" (Lerner 2004). Smeal's example is problematically simplistic; my own abortion at age 23 was a great relief, and I have worked with many very young patients who, although they were strong in their determination that abortion was the best choice for them, felt sad or ambivalent about making that choice. Smeal's charge that Kissling ignores the "joy" in turn ignores the fact that much feminist discourse around abortion emphasizes its benefits to the exclusion of its complexities. Later, in *Salon.com*, Smeal denies that Kissling's argument is new. "Frances is not changing the discussion . . . we are focused on keeping women's fundamental rights for reasons of her survival. Of course we are moral, feeling people" (Traister 2005). In fact, Smeal argues that the focus on what is perceived to be "new" in Kissling's argument may be the result of an attempt by "the press" "to start infighting on the liberal side" (Traister 2005).

Like Smeal, Susan Hill, president of the National Women's Health Organization, accuses Kissling of diverting attention away from where the movement needs to be focused—on women. She says, "It's so frustrating to hear people discussing the fetus but not discussing the woman" (Traister 2005). Hill's response, like Smeal's, is reductive and reinscribes the dichotomy of fetus/woman that Kissling is clearly trying to challenge. Surely, in Kissling's call for "combin[ing] respect" for women's right to choose with "exploration[s]" of the "value of developing human life" is an explicit consideration of both fetus and woman, not fetus at the expense of woman. And Rosalind Petchesky, one of the most respected and prolific scholars on abortion rights, has reportedly sent Kissling an e-mail response. "If and when those who dominate anti-abortion politics could for a minute take seriously the rights to a decent life and health of born children," the e-mail says, "maybe then we could start to talk about advancing respect for fetal life, early or late" (Lerner 2004). Petchesky's response demonstrates the challenge to the abortion rights movement posed by deconstructing the dichotomies that characterize the abortion debate in the United States.

At the same time, it is very possible that Smeal's concerns about attempts to portray the movement as conflicted are correct. I could find only one prominent activist organization leader quoted in the media speaking positively of Kissling's argument. Lerner briefly quotes Joan Malin, CEO of Planned Parenthood of New York City, as acknowledging that the consideration Kissling asks for is already happening on the private level for most women. She says, "I have never seen a woman take the decision lightly" (Lerner 2004). More recently, I have found a consonant message on the website of the National Coalition of Abortion Providers (NCAP), which is constructing a linked page call "heartssite.com" whose purpose is "to make the American public more tolerant and comfortable

with abortion, with the ultimate goal being the elimination of the abortion stigma" (NCAP 2005), by collecting individuals' stories about their experiences—joyful and fraught—with abortion. The abortion rights activists' responses to Kissling's article, although surprising, are hardly inconsistent with the history of abortion discourse in the United States. As Smeal says, "The polls have been the same for 30 years . . . And in reality, so is the debate" (Traister 2005).

In this paper, I argue that Frances Kissling is on to something: hidden in the gap of the U.S. abortion debate is the relationship between woman and fetus, a relationship that many women consider seriously when they choose abortion, a relationship that is not honored by a legal mandate that late second-trimester procedures dismember the fetal body. Based on my experiences as an abortion clinic employee, I claim a role of witness to this relationship—sometimes characterized by connection and sometimes by distance—in order to demonstrate that Kissling's challenge that we attend to the fetus is correct, and also that, in the clinic where I work (and in many other abortion clinics), this attention is already a powerful force. In my role as witness, I can be accountable to Smeal's request for the stories of joy and Petchesky's call to take seriously the rights to life and health of the already-born—I see and work toward both on a regular basis, both in the clinic and in my other activist work. As I integrate an examination of my own experiences working in the clinic with an analysis of the language of and responses to the "Partial Birth Abortion Ban," I will show that the discourses surrounding the ban are illustrative of the larger conversation around U.S. abortion politics. Finally, I will explain why the ban demonstrates not the concern for the fetus that its proponents claim but, rather, a clear disdain for any connection that a woman choosing abortion might feel for her fetus.

Descriptions of my work with patients serve to reinsert women's experiences into abortion discourse and challenge the notion that in abortion politics we are forced to choose between pregnant women and their potential babies. I offer this analysis in response to the recent exhortations not only of Frances Kissling but also of several feminist scholars that we in the abortion rights movement seriously consider the fetus (Duden 1993, Franklin 1999, Oaks 1999, Hartouni 1999, and Shrage 2003). Like Laurie Shrage, I strive to introduce into abortion discourse representations of the fetus that serve to "appropriat[e] the 'managed fetus' for subversive purposes" (2003, 127); however, unlike Shrage, I am interested in the images and discussions that already circulate in U.S. abortion practice in the clinic.³ Like Kissling, I think we should consider the fetus' place in women's abortion experiences, not iconicize it. I will focus on second trimester abortion, to demonstrate the correlation between the power of the woman/fetus dichotomy and the political and social success of the "Partial Birth Abortion Ban." My analysis is organized around activist slogans in order to illustrate, simultaneously,

how those slogans relates to and extends the popular discourse around abortion and how reductive that popular discourse ultimately is. It is my intention to show that the real and complex abortion experiences of women extend beyond the limits of the debate and thus simultaneously embody “pro-life” and “pro-choice” values.

It’s a Child, Not a Choice

One of the most popular anti-abortion bumper stickers in my region of the Midwest features a line drawing of a fetus surrounded by an amniotic sac next to the phrase, “It’s a Child, not a Choice.” This sentiment, which illustrates perfectly the fetus/woman dichotomy, effectively defines fetal personhood and claims the fetus as a symbol of anti-choice politics. Because the assignation of personhood to the fetus is a common trope in mainstream anti-abortion discourse, Kissling’s assertion that “those opposed (to abortion) focus on the fetus” may actually be an understatement. I have found that, in activist discourse, the figure of the fetus belongs to anti-abortionists, for whom it has been a source of considerable strength. The anti-abortion movement began utilizing images of the fetal body in 1973, immediately after *Roe v. Wade*. The abortion rights movement’s response to these images has primarily been to divert attention away from the fetus and onto women’s rights, as in “woman’s right to choose” or a woman’s right to her own bodily integrity. Of course these are important considerations, particularly within the context of a society that romanticizes motherhood but does not honor mothering, especially mothering by poor women, women of color, and young women. However, the inevitable result of this diversion has been an almost complete excision of the fetus from abortion rights discourse and the simultaneous association of representations of the fetus with anti-abortion discourses.

This association reaches its ultimate expression in the language of the “Partial Birth Abortion Ban,” which George W. Bush signed into law on November 5, 2003, setting historical precedent by outlawing an elective medical procedure not because it was scientifically proven to be unsafe, but because it was deemed by politicians to be disturbing. Although the ban was put under appeal by several state and local actions immediately upon its passage, and remains under appeal as I revise this article, it was celebrated as a victory for anti-abortion politics. Sen. George Voinovich (R., Ohio) is quoted as claiming triumphantly, “[t]oday is a glorious day . . . We can now begin to save human lives” (McFeatters 2003). “Partial birth abortion” is a label chosen by politicians that serves to increase people’s discomfort with a procedure that is more appropriately known as “Intact Dilation and Evacuation” (Intact D&E) or more commonly “Dilation and Extraction” (D&X). Descriptions of this procedure have become part of our

cultural discourse of abortion. Carol Mason demonstrates that the phrase “partial birth” is intended to counter the statement in *Roe* “that a fetus is not a person.” Although unborn fetuses may not be persons, those in the process of being born are not unborn and, therefore, are not designated by *Roe* as not-persons (2002, 81). I have found this fine distinction to be reflected in the language of the 2003 congressional findings of the Partial Birth Abortion Ban Act.

The congressional findings—a record of the congressional hearings and fact-finding that inform the debates around an act that may eventually become a law—emphasize that in this procedure, the fetus is “inches from being born” and deemphasize the number of weeks between the procedure and the fetus’ possible viability. For example, following the language of the findings, even a 20-week fetus with no chance of surviving outside of the womb for at least six more weeks, even with extensive technomedical intervention, is “only inches from being” a child, a sentiment that reinforces the public discourse that the fetuses being aborted in D&X procedures are “almost children.” For instance, in an opinion piece in the *National Law Journal*, Jay Sekulow, chief counsel to the American Center for Law and Justice, characterizes the procedure as on the border between the born and the unborn: “Partial-birth procedures represent the beachhead of abortion’s assault on postnatal life, the bridge between abortion and infanticide. Partial-birth procedures open the way to legal infanticide.” Sekulow notes that the next incarnation of the Supreme Court “could conclude that a human being who is partially outside the mother’s body is a person entitled to the equal protection of the law” (2004, 26). Sekulow does not examine the extent to which the law should—or could—protect a 20-week fetus, without functioning lungs or nervous system, who is “partially outside the mother’s body.”

Both the ban itself, as signed into law, and the congressional findings in the initial act begin with short descriptions of the procedure that is banned. Because the two descriptions are not identical, a comparative examination of their language can expose the underlying assumptions behind the ban. For example, in the language of the law, when “the person performing the abortion” (who is not named as a physician or health care professional) is invoked, the object of the sentence is a “living fetus,” implying that the abortion is performed on the fetus, that the fetus is the patient rather than the woman having the abortion. In addition, when the woman on whom the abortion actually is being performed is invoked, she is referred to as “the body of the mother.” This is a clear example not only of a discursive separation of a fetus from the body that must sustain it, but also an inversion of personhood status, so that the fetus becomes the person (patient) and the pregnant woman becomes a “body,” relegated to the status of vessel. Thus, according to the language of the ban that President Bush signed into law, a “partial-birth abortion” is one in which

(A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus. (“Partial-Birth Abortion Ban Act,” SEC. 3, Chapter 74, Sec. 1531, b1AB, 2003)⁴

In comparison to the language of the ban as signed into law, that of the congressional findings describes the procedure as

an abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child’s body until either the entire baby’s head is outside the body of the mother, or any part of the baby’s trunk past the navel is outside the body of the mother and only the head remains in the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child’s skull and removing the baby’s brains) that the person knows will kill the partially delivered living infant, performs this act, and then completes delivery of the dead infant— . . . a gruesome and inhumane procedure that is never medically necessary and should be prohibited. (“Partial-Birth Abortion Ban Act,” Congressional Findings SEC. 2, (1), 2003)

Most notable in this description, which presumably informed congressional debates surrounding the passage of the bill, is the language used to name the fetus. Although the ban consistently refers to “the fetus,” the congressional findings uses language that most U.S. citizens associate with either the successful completion of a pregnancy or with anti-abortion discourse—“unborn child,” “baby,” “child,” and “infant”—to refer to the fetus. The connotative difference between the two descriptions is obvious when we read them together; “fetus” is a less emotionally-charged term than “baby,” “child” or “infant,” all of which confer personhood on the fetus. The phrase “dead infant” serves to “mobilize a desire to protect” the fetus—to personalize the abortion procedure and the fetus, in a manner similar to anti-abortion photos of fetuses *in utero*, as Lauren Berlant has argued (1997, 110).

At the same time, the language of the findings designates the “person performing the abortion” to be a “physician,” while the language of the law uses the longer descriptor; it is important to note that the language of the findings preceded the language of the law. Therefore, the shift from “physician” in the act and findings to “person performing the abortion” in the actual law would make the ban applicable to abortions performed by physicians’ assistants (and by non-medical personnel) as well as by physicians. In addition, the findings describes in some detail (and in evocative language) what the ban names more generally the “overt act that the person knows will kill” the fetus. The detailed and evocative description in the findings could limit the scope of the ban, while the more

general description in the ban would insure that the law is applicable to a broader range of abortion procedures. If, for example, a physician were able to determine that another act (besides intrauterine cranial decompression) could lead to a successful intact removal of the fetal body through a woman's partially-dilated cervix, the intact abortion procedure which utilized that act might not be covered by the description in the congressional findings, but it could be covered by the law as it was passed. And, of course, the findings' phrase, "gruesome and inhumane procedure," is inappropriate for inclusion in a law, although its strategic utility in the congressional findings cannot be overstated.

The shifts from the language used in the act's congressional findings to the language used in the ban—from specific to general descriptions and from emotion-laden names for the fetus to more neutral medical terminology—are evidence that the law contains traces of anti-abortion discourse. In addition, the language of the ban indicates a shift in anti-abortion discourse, from a pornography of images of dismemberment to a pornography of descriptive discourse. The language of the ban both relies on and perpetuates the assignation of personhood to the fetus in service to the ultimate goal of ending all abortions. In fact, Matt Trehwella, of Missionaries to the Preborn, explains in *Life Advocate* how the Partial Birth Abortion Ban could lead to the prohibition of abortion, by revealing "pro-abortion legislators" to be "brutes," thereby "causing them to be unseated" (NARAL 2005). Even Randall Terry, founder of Operation Rescue, admits in a news release in September 2003 (only two months before the ban was signed into law), that the ban was "a political scam" that "may not save one child's life" but, because of the public debate surrounding the bill, it is "a public relations goldmine" (NARAL 2005).

These activists, whose efforts to sway public opinion about this particular procedure began almost ten years before the bill was signed into law, clearly perceive the ban to be a political victory for anti-abortion forces. The response from abortion rights activists has been less emphatic. Many decry the ban's prohibition against a medical procedure, but few, if any, have taken up the cause of defending the D&X procedure from charges that it is "gruesome and inhumane." In addition, the lukewarm responses of abortion rights activists, organizations, and scholars to the ban have served not to deconstruct the woman/fetus dichotomy but, rather, to broaden the discursive gap that characterizes U.S. abortion discourse.

"My Body, My Choice"

A popular slogan among abortion rights advocates in my region is "My Body, My Choice," a slogan that serves as an illustration of what Kissling critiques as the "prochoice movement's" unwavering focus on women's

legal—and sometimes abstract—right to choose. She notes, “This often means a reluctance to even consider whether or not fetal life has value, or . . . attempt to define that value or to see how it can be promoted with restricting access to legal abortion” (2). In the slogan “My Body, My Choice,” as in much abortion rights discourse, the fetus is invisible, excised by fears that discussions of the fetus and of women’s varied relationships to their fetuses will lead inevitably to anti-abortion sentiment. If, as Kissling argues, the “prochoice movement” has been too focused on women’s right to choose (perhaps to its own detriment), our reasons were certainly understandable.

The abortion rights movement’s early responses to the issue of fetal personhood were diversionary: countering images of “dead fetuses” with images of “dead women.” The most famous of these were Gerri Twerdy Santoro in the early 1970s (died from illegal abortion induced by her boyfriend, in 1964), Rosie Jiménez in the late 1970s (died in 1977 of an illegal abortion after passage of the Hyde Amendment made it impossible for her to afford a legal abortion), and Becky Bell in the late 1980s (died from an illegal abortion in 1988 after Indiana’s parental consent laws led her to choose illegal abortion over disappointing her parents). These women’s tragic stories served to balance the mangled fetal bodies that increasingly became a staple of anti-abortion discourse. In the 1990s, in order to palliate its message for a backlash-educated audience that was increasingly wary of feminism, abortion rights discourse became a more abstract discourse of “choice,” rights, and policies rather than an embodied discourse.

When I began working at the clinic in 1996, activist discourse named women “private citizens,” not mothers, lovers, or daughters, and the fetus was called a “pregnancy,” if it was invoked at all. While this approach served to divert attention away from anti-abortion images of dismembered fetuses, it also diverted abortion rights activism and theory away from women’s lived experiences of pregnancy and abortion and, in many ways, failed to provide real women with accurate representations of our experiences.

More recently, some abortion rights activists have argued that anti-abortion images of the fetus are all inaccurate, a denial response that actually solidifies the dichotomization of woman/fetus. Based on my work in the clinic, I can witness to the fact that some anti-abortion fetal images and descriptions are indeed inaccurate and often racist. For instance, our state-mandated “informed consent” information includes a full-color booklet on fetal development whose images resemble Lennart Nilsson’s fetal photographs, famously published on the cover of *Life* magazine in 1965. These *Life*-like fetal images have been computer-enhanced to resemble white babies, including eyebuds colorized to look blue, and skin colorized to look light pink. The famous anti-abortion film *Silent Scream* constructs an incredible story of a nine-week fetus with consciousness and

ability to experience pain during abortion, even though researchers who are convinced that fetal pain is possible estimate that the earliest gestational stage at which this is a risk is 20 weeks and a *JAMA* clinical review article, "Fetal Pain: A Systemic Multidisciplinary Review of the Evidence" finds that the more plausible stage is 29–30 weeks LMP (Anand 2004, Lee, et al, 2005). Other representations of the fetus are just plain silly, such as those ubiquitous on-line poems, written in the "voice" of a fetus, ending with statements like "today, my mommy killed me."

Just as often, however, anti-abortion fetal images are not inherently inaccurate. One of the earliest anti-abortion images I can remember seeing was the "tiny feet" poster, which shows two tiny feet with toes, looking almost fully-developed; in the clinic where I work, a technician measures the fully-formed feet from each fetal body over 9 weeks LMP, confirming fetal age and development in the context of ascertaining the successful completion of the procedure. And anti-abortion advertising often uses photos that resemble Nilsson's to draw attention to fetal development in addition to their popular photos of dismembered fetuses. What I have found is that these photos do look like fetuses we see in our clinic, although the gestational ages of the fetuses in the photos are often understated by two-to-four weeks, giving the impression, for example, that the photo of a ten-week fetus is instead a photo of a seven- or eight-week fetus. In fact, a fetus as young as 9 weeks LMP can have tiny, fully-formed feet, and a fetus at sixteen weeks can indeed (as a particular anti-abortion ad says) "make a fist, get hiccups and suck her thumb." Accuracy of an image should not, however, be read as indication of the image's political innocence. Ultimately, I agree with feminist scholars who argue that there are no "innocent" images of the fetus (Stabile 1999, Taylor 1992, Petchesky 1987, Berlant 1997, Hartouni 1992, 1999 and Balsamo 1996). As Stabile reminds us, we ignore the politics behind images to our own disadvantage. Even seemingly innocuous images of the fetus, she notes, are implicated in "the massive infrastructure behind the anti-abortion movement's propaganda" (1999, 135). I argue that the abortion rights activist movement's reticence to engage in discussions of the fetal body has left the door open for all uses of fetal imagery to be read as anti-abortion.

Just as abortion rights activists' responses to anti-abortion imagery tend either to divert or deny—to divert attention away from the unpleasant claims associated with those images or to deny the anti-abortion images that are representational of the fetus—so have our responses to the Partial Birth Abortion Ban. When the ban was first introduced to the U.S. public in 1993, anti-abortion activists began with a media blitz of misinformation and disgust-mongering. The now-famous images of the procedure (particularly of the intrauterine cranial decompression) were placed in newspaper ads, in brochures and on-line. Under a headline asking, "Do these drawings shock you?" the ad warns, "We are sorry, but we think you should know

the truth." Beneath this declaration is a column of line-drawn images juxtaposed with exaggerated and inflammatory textual descriptions of the D&X abortion procedure (Gianelli 1993, 3). As these ads were more widely distributed, leaders of the abortion rights movement were asked to comment on the procedure. Almost immediately, the responses became denials. The National Abortion Federation (NAF) first said that the procedure was only performed on women whose fetuses were already dead (Gianelli 1993, 21); Barbara Radford, then-head of NAF, retracted this claim almost immediately. The next response was that the procedure was rare; NAF claimed that late-second trimester and third-trimester abortions were very rare and that only "a handful of doctors" used the D&X procedure (Gianelli 1993, 21). Although the Allan Guttmacher Institute estimates that fewer than two percent of abortions in the United States are performed after the twentieth week of pregnancy, anti-abortion activists argue that, with an annual abortion rate of nearly 1.3 million per year, two percent equals approximately 26,000 abortions performed after 20 weeks LMP, when D&X would most likely be used (2005). Gianelli reports that in the 1990s "doctors who use the (D&X) technique acknowledged doing thousands of such procedures a year . . . the majority . . . on healthy fetuses and healthy women," and that at one facility alone, almost 1500 D&X procedures were performed in one year. Another physician, in Nebraska, reported that he performed about 500 D&X procedures a year (1997, 54-5).

Both of the claims made by abortion rights activists, that D&X was used rarely and largely in cases of fetal anomaly or death, entered public discourse before they were effectively retracted. In 1995, Ron Fitzsimmons, head of NCAP, said on *Nightline* that "the procedure was used rarely and only on women whose lives were in danger or whose fetuses were damaged" (Stout 1997, A11). Two years later in a statement that made headlines, Fitzsimmons admitted he "lied through [his] teeth" in that interview. But the damage was done; while vetoing an early version of the ban in 1996, President Clinton invoked the information that the procedure was rare and only performed in extreme circumstances. He vetoed the law on behalf of "a few hundred women every year who have personally agonizing situations where their children are . . . about to be born with terrible deformities" (Stout 1997, A11). This campaign of misinformation, of denial, has been embarrassing for abortion rights activists. Although Ron Fitzsimmons is quoted in the *New York Times* article as saying that he "continue[s] to support the procedure and abortion rights in general" (Stout 1997, A11), a mere week later, he is quoted in *American Medical News* as saying that the abortion rights movement should "roll over and play dead" regarding the ban, rather than trying to fight it. He says, "We're fighting a bill that has the support of, what, 78% of the public? That tells me that we have a PR problem" (Gianelli 1997, 55). Fitzsimmons is right, there is a public relations problem regarding

D&X, and his initial denial responses—as well as those of other pro-choice activists—have played a significant role in creating that problem. If these activists had not made statements about the procedure that were judged untrue, and instead explained why the procedure was safer than the late-term dismemberment procedures that have now replaced it, then anti-abortion claims about the procedure would not have been strengthened by a loss of credibility in the abortion rights movement. In fact, when Fitzsimmons' admission came to light, President Clinton backpedaled on his veto, saying he was opposed to “using the procedure on healthy women with healthy fetuses”: a White House spokesperson is quoted as saying, “if this procedure is being used on an elective basis, where there's another procedure available, the president would be happy to sign legislation that would ban it” (Padawer 1997).

Although anti-abortion organizations continued to target D&X in their activism and imagery and several state-level laws banning D&X were in courts in the late 1990s, the national public discourse around the procedure died down in 1997, until 2002 when it became clear that President Bush was poised to sign a ban into law. At that time, the major abortion rights organizations and their leaders reverted to diversion, a familiar tactic within the movement, historically. Even now, when the ban is invoked, the standard response from the Planned Parenthood Federation of America, NARAL/Pro-Choice America, the National Abortion Federation, and other national abortion rights organizations is to focus on privacy and, still, on stories of extreme cases. The federal government, they assert, should not be making medical decisions for women.

This, of course, is true, but it does not address the claims, now common in public discourse, that D&X is cruel and inhumane, nor does it explain why D&X became such a widely-used procedure in the first place. The reason these two issues are not addressed by abortion rights advocates is directly related to the movement's reticence, as recognized by Kissling, to engage in discourse about the fetus. The ban clearly increases limitations on women's rights to control fertility and choose parenthood; it sets a dangerous precedent by making illegal a safe, effective, elective medical procedure; and it represents a reassertion of patriarchal power over, particularly, the most vulnerable women's bodies. Of course, the abortion rights response is not inaccurate; it is merely incomplete and thus ineffective in the public arena.

The U.S. attorney who is defending the ban in a New York appeal has argued that “this procedure is never in the best interest of the mother” (Edwards 2003). This statement is baldly incorrect; there are reasons why D&X is sometimes in the best interest of the patient, but presenting these reasons requires abortion rights activists to speak honestly about pregnant women's varied relationships to their fetuses as well as about the fetal body. The D&X procedure was developed by Dr. Martin Haskell, an Ohio

physician, and first presented at a 1992 meeting of the National Abortion Federation, a trade association of abortion providers (Haskell 1992, see also Gianelli 1993).

The procedure was promoted to solve a problem common to late second-trimester suction abortions. In standard suction abortions, the fetal body falls apart, is dismembered. During the second trimester of pregnancy, the fetus' bone tissue begins to harden from a cartilage-like state into bone. One of the most dangerous complications of a late second-trimester suction abortion for the patient is that the uterine wall might be lacerated or perforated by fetal bone tissue, in severe cases potentially necessitating hysterectomy. If the fetus is removed intact, no sharp bony edges are exposed, and perforation is thus avoided. One way to accomplish intact removal is via induction abortion—basically induced labor—a procedure almost like childbirth, much longer in duration and often more expensive and more painful than suction procedures. The D&X procedure is a compromise that combines the relatively quick (usually less than thirty minutes) duration of a suction procedure with the decreased risk of perforation provided by intact removal.⁵

I have attended women having these procedures; the woman has typically been under a very light anesthesia (often called “twilight sleep”—awake and responsive, but woozy and relaxed), is able to walk with support immediately after the procedure, and is often fully alert and comfortable within an hour or a little more. In the mid-1990s, before we had the equipment necessary for anesthetization, all our D&X patients underwent the procedure with local anesthesia and the assistance of a patient advocate trained in relaxation techniques. These patients were able to drive themselves home from the clinic after their recovery time. Therefore, one benefit of the D&X procedure is that it provides a level of patient safety and comfort for late second-trimester abortions that is not available with most other methods—methods that involve either surgery on the uterus, protracted contractions and delivery, or the dismemberment of the fetus and an increased risk of uterine laceration or perforation. The fact that dismemberment procedures (surely “gruesome” in their own right) are not prohibited by the ban suggests that the incentive behind the ban is not to protect women (or fetuses) from that which is cruel but, rather, to subject women who choose second trimester abortion to increased discomfort (and greater risk) than they would experience with the safer, more comfortable D&X procedure.

Another benefit of D&X is emotional. Many of the women I have known who chose abortion during the second half of the second trimester experienced some ambiguity around their decisions: nationally, about ten percent choose to abort a previously-wanted pregnancy in the second trimester because of changes in family situation (divorce, chronic illness of another child, loss of employment, etc.), about two percent choose to

abort a wanted fetus that has developed health complications with which the family is not prepared to cope, and almost half undergo a late abortion because the woman was financially or emotionally unprepared for an abortion earlier in the pregnancy (Allan Guttmacher Institute 2005). In any of these cases, the woman may have developed emotional connections to the fetus growing inside her. In these situations, it can be beneficial to the woman (and often to her family) to have an opportunity, post-procedure, to hold her fetus' body, to say goodbye to her baby, to grieve for a child rather than for a mass of dismembered tissue. I know women who have been allowed to spend time with their intact aborted fetuses' bodies, and they feel that this time was important to their healing in a difficult—and chosen—situation.

When faced with questions about this “gruesome” procedure, abortion rights leaders have been disappointingly weak in its defense. Why did these activists fail to explain the physical and emotional benefits of D&X procedures when the ban was being debated in the public arena? In order to do so, they would have had to speak honestly about the fetal body and some pregnant women's relationships to their fetuses. As Frances Kissling has so eloquently argued, this is not a discussion abortion rights activists have been able to engage in to date, in spite of repeated calls by some feminist theorists that we do so. She argues, “For some the right to choose abortion seems to include the right to be protected from thinking about the fetus and from any pain that might result from others' talking about the fetus in value-laden terms” (2004/2005, 3). If we in the abortion rights movement would only speak honestly about the fetus and practice an embodied abortion praxis, we would be able to insist on the legality of this procedure, not because it is rare and necessary, but because it makes the abortion experiences of all women, regardless of age, class, or living situation, safer and more comfortable, as they should be.

Pro Child Pro Choice

Another popular slogan used by abortion rights advocates is the seemingly simple “Pro Child Pro Choice.” Although it may be read as reinscribing the dichotomies that characterize the abortion debate, including the dichotomization of fetus from woman, of child from autonomous choice, and the construct “pro child” echoes with traces of “pro-natalism,” this slogan does come closer than most to providing a deconstruction of the dichotomies that shape the abortion debate. As with any deconstruction, the key to understanding the relationship between the dichotomized terms is in the gap between the terms. If anti-abortion discourse effectively “aborts” the woman's body from their descriptions of the fetus and, as Frances Kissling suggests, “the conventional wisdom in the prochoice

movement has been that talking about fetal life is counterproductive" (2004/5, 4), then the varied relationships with their fetuses that women describe, and discursively produce, have been relegated to the gap between these political poles. As Linda Layne writes about feminist responses to miscarriage (which doctors call "spontaneous abortion"), "feminists have avoided any discussion of fetuses for fear of adding fuel to the anti-abortionists' fire" (1999, 251). Layne proposes that in order to open the discourse of pregnancy to the experiences of all women, feminists should "focus on the iterative process by which individuals and their social networks materially and socially produce (or opt not to produce) a new member of the community" (252). In other words, Layne challenges us to recognize that the distinction between a fetus and a baby is defined not by gestational development but through social relationships—the pregnant woman's with her fetus, her family, and her community—whether the pregnancy ends in childbirth or miscarriage or, I would add, abortion.

The powerful work of Judith Arcana, both her poetry in the recently published *What If Your Mother* (2005) and her scholarship on motherhood, explores the influence of this matrix of relationality on women's experiences with pregnancy and abortion. In "Abortion Is a Motherhood Issue," she writes about the separation of abortion from "discussions of mothering, even when those discussions are carried on in the voices and writings of women of consciousness." This separation, she notes, has many causes, including strategic separation in order to deflect the responses of "right-to-lifers." But "sometimes," she writes, the separation of abortion from motherhood happens because "we forget that abortion is, in the ordinary motherhood-type way, the concern of women who are taking responsibility for the lives of their children" (1994, 160).

When I began working in an abortion clinic, the clinic director was an activist who was not afraid to discuss the fetus. She told me a story about her appearance on a syndicated radio call-in show during which a caller challenged her to deny that late-second trimester abortions "kill babies." "At that stage of pregnancy," the caller said, "you can't tell me it's not a baby. And you can't tell me that, if that baby is aborted, it won't die." Rather than engage in discussion about the definition of life (a discussion anti-abortion discourse has already delimited in the public realm, if not yet in the medical and legal realms), she simply said to him, "Yes. It's a baby and yes, it is killed. I want to talk about all the reasons why so many women choose to have abortions even though they know this, and why it is important that women are allowed to make that choice." The caller simply hung up the phone. When the director told me this story, I thought, I guess he did not have an argument prepared that would answer the complexity of women's lived experiences. During my first two months in training at the clinic, I worked closely with women who were able to think clearly and compassionately about the fetus and about women who choose

abortions for whatever reason (even reasons with which I am uncomfortable). Although I identified as strongly pro-choice and had benefited from my own abortion experience when I was younger, I was initially surprised by some of the practices followed at the clinic to allow each woman to articulate her own "iterative process" by which her relationship to her fetus was produced.

When I speak with a woman about her abortion decision during our intake screening, I am always careful to use the language she uses to name the fetus. Some women say "pregnancy" and a great many merely say "it"; when a woman says "it," I usually say "fetus," deliberately choosing the most medical-sounding term. Very few patients say "fetus" or "embryo." The majority say "baby," as in "this baby is making me sicker than my previous ones did" or "I just can't have this baby at this time." When I began my training, I was shocked to hear clinic employees calling fetuses "babies"—as a strong feminist activist, I had learned to separate the two. But, as one of my co-workers explained to me, "if the woman who is choosing abortion experiences this as a baby, how are we helping her deal with her decision if we tell her she is wrong?" Now, when my patient calls her fetus "baby," I do, too. Sometimes women will express their wish that they could have this baby as they explain why they cannot, as in, "I would really like to have this baby. I hoped it might be a girl. But my relationship is not stable and I cannot afford another child on my own." This is an iteration of the fetus that illustrates how many women do think about their relationships to the fetus when they make their choices to abort, and many consider the baby that fetus is (or will become) to them. Often, patients who indicate that spirituality is important to them tell me that they have prayed about their abortion decisions and have asked the deity to which they pray to send back to them the child they are aborting, at a time in the future when they are better able to care for it.

I acknowledge that these iterations of maternal-fetal connection are challenging in the context of current abortion politics. However, I am convinced that if we in the abortion rights movement told more of these stories, the stories would come to seem less shocking to us. Their telling would not lead to a weakening of our stance, to a strengthening of anti-abortion politics, as is often feared. Rather, I believe that these stories, which integrate traces of anti-abortion principles into abortion experiences, could begin the process of deconstructing the dichotomies that characterize the U.S. abortion debate and strengthen general public support for even challenging situations.

These stories complicate the simplistic politics of abortion by emphasizing the similarities between abortion and motherhood and collapsing the differences between concern for women and our choices and concern for fetal life. In other words, the honest stories of complex lives made a little less difficult by complicated choices would allow more people to

recognize abortion as one possible outcome of potential motherhood, as Arcana describes it. One of the charges that the anti-abortion movement makes of abortion rights activists, abortion providers, and women who abort is that we are "heartless." Kissling quotes John Garvey who wrote in *Commonweal* that "perhaps there has been a 'hardening of the heart' resulting from the prochoice position" (2004/5, 5). I see Garvey's point, but I wish he could talk with the patients and co-workers I have known at the clinic, that he, and others who think similarly, could see what goes on in some abortion clinics.⁶

In a 2003 *Glamour* article titled "Are You Ready to Really Understand Abortion?" the techniques of a particular group of abortion clinics are examined. This group's strategies were developed in response to an onslaught of Operation Rescue actions in 1989. Through my work, I have attended workshops with employees of these clinics, and many of our clinic practices are similar to theirs. Our services include grief counseling (for women who want it), and options counseling about adoption and motherhood (for most women). We strive to incorporate into the abortion experience each patient's own religious values and emotional needs on an individual basis. Our patients fill out charts which include questions about their emotional responses to their pregnancies/abortions (are you happy? confident? relieved? sad? angry? trapped? scared?), their religious beliefs regarding abortions, and their support systems at home. We see a range of needs and responses, from the woman who is happily relieved not to be pregnant anymore to the woman who grieves deeply the child she will not birth and help the latter plan coping strategies for their grieving. In the clinics featured in the *Glamour* article, patients can write heart-shaped letters to their fetuses, to other women in the clinic, or to their god telling about their feelings. These letters are posted on clinic walls. One is quoted: "I love you even though I know in my heart I can't keep you. But the memory of you will make me strong." It is signed, "All my love, the mom you'll never meet" (Chen 2003, 264). A very similar letter hangs in the clinic where I work; this one was written by a 15-year-old patient. These are not experiences of disembodiment, of separation of woman from fetus, of mother from child. These are the experiences that speak to the complexity of abortion as it is lived by women rather than as it is expounded by activists.

Imagine the following scene in an abortion clinic: the patient is ready to go home after her abortion. Before she leaves, however, there is one more thing she wants to do. She enters the surgery lab with a clinic advocate and walks to the lab table under the window. There, in a glass lab dish, is her fetus. The advocate explains, "The dark red tissue at the top of the dish is endometrial tissue. The spongy pinkish tissue in this corner is the sac tissue. And this is the fetal tissue on the right. Does this look like what you expected?" The patient nods. She motions toward the forceps propped

against the dish and says, "Can I?" The advocate looks to the lab tech, who nods. The patient puts on the rubber gloves they hand her and picks up the small forceps, which she uses to grasp the fetus' tiny hand, moving it slightly, somewhere between a wave and a handshake. "Goodbye little baby," she says softly. "I'm sorry I couldn't have you right now." After a few more moments, she puts down the forceps, removes the gloves, and hugs the advocate. "Thank you all so much for making this a little easier for me."

In the clinic where I work, a lab technician examines every patient's post-procedure fetus and supporting tissue, in order to age it (by size) and to verify that the procedure is complete. In the process, the technician arranges the different elements of the fetus and tissue so that we may provide each patient an option to see her post-procedure fetus. About five percent of the women who have abortions at our clinic choose this option. We are, of course, very careful to prepare the women for what they are going to see. We have a fetal development guidebook, put together by two nurses who worked at our clinic in the 1990s, which we use for this purpose. With the patient who wishes to see her fetus and tissue, we look first at a line drawing of a fetus of the same fetal age as the woman's. The line drawing is accompanied by descriptive text:

The fetus is approximately 6.1–6.4 inches long. If the fetus is a female, the uterus is formed and the vagina starts developing. If the fetus is a male, the testicles begin to move from the abdomen down into the scrotum. The toenails are beginning to develop. (18 wks fetal age; 20 wks LMP)

In addition to this description, the text notes that "most internal organs are rather well developed. However, the lungs and nervous system are still not mature and if the fetus were born prematurely, it would not survive."

While going over this page with the patient, I explain that a fetus or baby develops like a house is built—the outside develops first, and then the organs are able to develop within the completed shell. This is why, for example, at 20 weeks LMP, the fetus has toenails but not yet working lungs or nervous system. I ask the woman if she has any questions, and I answer those as completely and accurately as I can, checking with the doctor or head nurse when necessary. After I answer her questions, I ask her if she is still interested in seeing her own post-abortion fetus and tissue. If she is, I explain that I will next show her another picture from the fetal development guidebook, a picture of similarly aged fetus and tissue after an abortion done at our clinic. This picture is a color photograph taken by a nurse (with permission, of course) of post-abortion fetus and tissue arranged in a backlit glass dish on a light box. The technician had arranged the elements so that the endometrial tissue, the sac tissue, and the fetal body are distinctly recognizable. Depending upon the age of the

fetus, the woman might see tiny little dark spots, which are eye buds, and some flipper-like limbs, or she might see a small ribcage and fully-formed legs and arms, and when second-trimester intact abortions were still legal, she might have seen a small, intact, fully-formed body.

Many women, of course, choose not to see their fetuses. The women who do give a variety of reasons for that choice. Several tell me that they are “just curious,” that they have seen pro-life images of abortion or of fetuses and are interested in what “it really looks like.” Other women say that seeing their fetus provides them with a sense of finality—they can see that the pregnancy is no longer in their bodies, and this reassures them. Some women choose to see their fetuses because they want to say goodbye, and some ask us to pray with them or for permission to sprinkle the fetus with holy water that they have brought with them. This, I think, is the perspective that makes some abortion rights advocates uncomfortable. But if abortion rights discourse embraced discussion and images of the fetus and honest stories of the full range—from joy to grief—of women’s relationships to their fetuses and emotional responses to abortion, perhaps we could challenge the simple dichotomization of woman from fetus. Laury Oaks argues that the international pro-choice movement needs “a reproductive politics that takes seriously both fetuses as subjects in general, and how women ‘see’ their fetuses in particular” (1999, 192). Frances Kissling’s article, and the outcry surrounding it, prove Oaks’ point. When a patient at our clinic takes my hand, looks into the glass dish with her fetus in it, and says, “That’s what I thought it would be,” I feel we have allowed that woman to make the best choice for herself in a supportive environment while taking seriously her relationship with her fetus. We have provided her a space from which to iterate her own abortion experience, in the words of Judith Arcana, with “open recognition of [her] regret or loss or joy or relief—even of mourning—and [with] acceptance of the responsibility of [her] choice” (1994, 163).

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Notes

1. For generous feedback and ongoing support, I thank Ellen Berry, Rachel Buff, Marcus Ricci, and Vicki Patraka, members of the Summer Writing Group (Kim Coates, Susie Castellanos, Mandy Heddle, Nancy Patterson, and John Warren)

and of the Faculty Writing Group at the BGSU Institute for the Study of Culture and Society (Jonathon Chambers, Kim Coates, Becca Cragin, Beth Greich-Pollele, Vikki Krane, Vicki Patraha, and John Warren) for reading versions of this paper. In addition, the anonymous readers for NWSAJ were invaluable to the process of honing my argument. Thank you to the two research assistants who helped with this project, Jesse Houf and Megan Scanlon, both of whom know well what clinic work is like. This essay is dedicated to my co-workers and patients at the abortion clinic where I work.

2. I recognize that my claim might seem overblown; I make it based on others' responses. In fact, although one of the anonymous readers for NWSAJ "worr[jied]" that I was "overstat[ing]" this risk, another asked me to consider whether having accurate representation of women's abortion experiences "is more important than losing the right to choose" and a third suggested that my approach might "just put women and feminists in a position where they have to justify 'killing' and where they have to endure further criminalization." Although I respect these concerns, I trust that my argument makes evident my dedication to abortion rights and my conviction that these accounts can do the abortion rights movement much more good than harm.
3. Other feminist critics have published studies that examine what goes on in abortion clinics. One of the best is Wendy Simonds' *Abortion at Work* (1996), an ethnographic study of one clinic's staff, which focuses on the labor, politics, and interpersonal relationships of those who work to provide safe and legal abortions. Elizabeth Poppema's memoir, *Why I Am an Abortion Doctor* (1996), describes abortion provision from a physician's perspective, while two collections of women's personal abortion stories, *Our Choices, Our Lives* (2002), edited by Krista Jacob, and *Abortion: A Collective Story* (2002), by Cara J. MariAnna provide patients' descriptions of their experiences with abortion.
4. The phrase "head-first presentation" is either an error in the law or a loophole: the D&X procedure would not be performed using a head-first removal of the fetal body. The whole purpose of the intrauterine cranial decompression (which the congressional findings calls "removing the baby's brains") is to allow the fetal head, the largest part of the fetal body, to be removed through the woman's cervix without extensive cervical dilation. If a head-first presentation were being performed at this stage of pregnancy (after twenty weeks), the most likely methods would be hysterotomy (surgical removal of the fetus through the abdominal wall) or induction abortion, in which a substance is introduced into the fetal body, labor is induced and the woman gives birth to a dead fetus/baby. This is only one example of the ban's ambiguities, which many critics argue point to its potential applicability to multiple abortion procedures. Since the law includes description of a head-first presentation, it could possibly be applied to induction abortion or hysterotomy as well as D&X.
5. It is ironic that the activists and politicians who have for years invoked representations of dismembered fetuses to show how terrible abortion is have

now made it nearly impossible for women to obtain abortions that do not dismember fetuses.

6. I am not claiming universality here. Feminist author Renate Klein reminds me that not all clinics and not all doctors are like the ones I have been fortunate to work with. I thank her for her thoughtful responses to my work and for her encouragement.

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