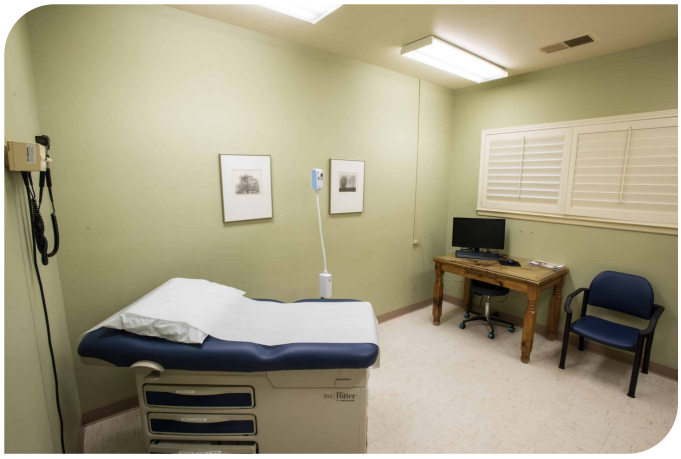

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GENDER & SEXUALITY, LAW

Why I Provide Abortions

My patients and I don't use words like "choice" or "viability."

Christine Henneberg

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When I was a pre-med biology student, our professor gave us a lab assignment that involved pinning an earthworm to a small piece of wood, then probing it with an electrode to observe its response. The lab was intended to show us a primitive nervous system at work. (The question of whether earthworms feel pain is a gray area in invertebrate physiology—or it was at the time.)

I followed the instructions and flicked at one end of my earthworm. It writhed and squirmed; I drew my hand back. Whatever the earthworm was experiencing, it looked like pain to me. After a few more tries, I asked the professor to excuse me from the rest of the assignment, explaining that I couldn't bear to torture a living creature.

Knowing all the details of what happens in that procedure room, what exactly does an abortion doctor believe?

A classmate overheard, and later she mocked me for what I suppose she interpreted as my timidity. "What are you going to do when you become a *doctor*?" she hissed. "Doctors have to *hurt* people sometimes. You're going to have to be able to *handle* it."

I wondered if she was right. Perhaps I had failed some important test.

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This classmate, I later learned, went on to become a neurologist. I became an abortion doctor.

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On a recent afternoon in my clinic, fifteen years after the earthworm experiment, a young medical assistant named Jenny approaches me between patients. “Can I show you something?”

She pulls up an ultrasound video on her phone: a fetus, its perfectly formed limbs, fingers and toes, squirming and jumping in its wedge-shaped sonographic window, bounded by the fuzzy, white-gray walls of a uterus.

“Awwww! Adorable!” I look at Jenny; she is beaming. I have known for some time that she is pregnant. (She occasionally asked for my advice during the eight months it took her to conceive.) “How many weeks are you now?” I ask her.

“Fifteen.”

“Fifteen weeks! Wow! Look at that little baby. So cute!” It wasn’t long ago that I was pregnant with my own children, gazing lovingly at their ultrasound photos.

The demographics of our clinic closely reflect those around the country: most patients are low-income. (In California public health insurance pays for abortion care.) The vast majority of my patients are in their

The vast majority of my patients are in their first trimester, but I typically perform a few second-trimester abortions each day.

first trimester, but I typically perform a few second-trimester abortions each day. Later that afternoon, Jenny assists me during a fifteen-week procedure. The fetus on the ultrasound screen looks just like Jenny's, in every recognizable, perfectly formed detail: fingers, toes, beating heart. But this image is very different because of the context in which I am viewing it.

The woman is lying on the table, awake but sedated by medications. I dilate her cervix and place a small plastic tube inside her uterus. I watch the ultrasound screen. I flip a switch; a humming noise fills the room. At this instant, the fetus seems to jump as though startled; then it squirms in the tight, already shrinking space of the uterus. It continues to move in this very human, baby-like way until the last instant, when it is overpowered by the force of the vacuum and sucked through a plastic tube, whisked out of the uterus and into a glass jar in a rush of blood. Gone.

Then all I see on the ultrasound is the fluffy, whitish-gray lining of the uterine walls; after a few more seconds, even that disappears. All that is left is the empty uterus, and the memory—mine and Jenny's alone—of what was there before.

This, I suppose, is precisely the kind of test my pre-med classmate thought I had failed: a test of my strength to do what is asked of me, to handle the most difficult, even painful moments. How wrong she was. And how wrong, how ill-informed, was the very premise of that test. My willingness—I would call it a conscientious compulsion—to perform abortions has nothing to do with toughness or timidity.

Later it occurs to me that by showing me her video, Jenny may have been posing a question

When it comes to the definition, and even the value of life,

for me, even testing me in her own way. Perhaps she wanted to know what any thoughtful supporter of legal abortion might wonder: What *is* the basis for my conscientious compulsion? Seeing everything I see, knowing all the details of what happens in that procedure room, what exactly does an abortion doctor believe? What are the principles upon which I base my beliefs and actions?

context matters.

To start with, let's make one thing clear: my answer has nothing to do with "viability"—the standard (established in *Roe v Wade*, preserved in *Planned Parenthood v Casey*, and which the Supreme Court is almost certain to reverse later this term) that theoretically protects legal abortion up to about twenty-four weeks.

Much of the abortion debate in this country has historically revolved around the question of when life begins—a point on which scientists and philosophers have never been able to agree.

Consider an embryo, frozen in a dish, preserved in a life-sustaining augur in a private fertility clinic. At some point, the individual or couple paying to sustain that embryo in hopes of a future pregnancy (or, for that matter, the researcher saving it for study) decides the embryo is no longer needed. The dish is removed from the freezer and disposed of as biomedical waste.

What are our feelings about that embryo?

The staunchest "personhood" advocates would argue that it is morally wrong to dispose of any embryo, because it constitutes a life. But most anti-abortion lawmakers and advocates won't go

that far. Even Alabama state senator Clyde Chambliss (who purports to believe that life begins at conception, and who, in 2019, sponsored that state's near-total abortion ban) said of the IVF embryo: "The egg in the lab doesn't apply. It's not in a woman. She's not pregnant."

For abortion opponents and advocates alike, this is another way of stating the truth I face every day: when it comes to the definition, and even the value of life, context matters.

Why I provide abortions has nothing to do with "viability"—the standard that theoretically protects legal abortion up to about twenty-four weeks.

In *Roe* the Supreme Court explicitly declined to wade into such murky depths as the definition and beginning of life. "We need not resolve the difficult question of when life begins," the court said. Instead, the only "compelling" boundary the court could name for legal abortion was fetal viability, i.e. the point in embryologic development when a fetus stands a reasonable chance of surviving outside the woman's body. Arguing that the state would have "logical and biological justifications" at that point for protecting fetal life, the Court granted that states may "go so far as to proscribe abortion during that period." In circumventing the difficulty of "life" and replacing it with the apparently simpler concept of "viability," the court created both a limited protection for abortion and a profound problem for how we talk and think about it. Viability is not, and never has been, a sound or sustainable premise for protections or prohibitions on abortion.

For one thing, viability is a moving target. In 1973, at the time of *Roe,* neonatal life-support technology could sustain a premature baby born around or after twenty-eight weeks of gestation. Since then, improvements in medical technology have moved that point to twenty-four weeks or even slightly earlier, depending on the hospital's equipment and the experience of its neonatologists. If neonatal resuscitative technology continues to improve, to the point that we can sustain a baby born at twenty or sixteen weeks —then what? Such advances would certainly benefit women with desired pregnancies who give birth to extremely premature babies, babies whose lives they—and we—would wish to save. But what if a five-week embryo, removed from a woman's body, could be placed in an incubator, sustained, and coaxed to life as a fully formed human being? Then "viability" would come to mean essentially the same thing as the fetal "heartbeat"—the vaguest, most primitive sign of cellular potential, which can be used to draw some supposedly logical, biological, or ethical line around the fetus, to delineate its rights and keep the rest of us morally comfortable.

This is the real problem with the "protection" of viability—the reason why Sandra Day O'Connor denounced the Roe framework as "clearly on a collision course with itself": it leaves the woman with nothing. It gives the fetus (or the state supposedly representing its interests) all the protection and all the power.

If fetal viability—or, for that matter, a fetal heartbeat—isn't an acceptable standard for thinking about abortion, then what is? For me the standard is what I call the woman's *contextualized autonomy*.

I distinguish this term from a simple notion of autonomy that ignores the constraints women face in an unequal and unjust society. Rather, I mean to invoke a more expansive and just notion of autonomy that is synergistic with the goal of bodily autonomy outlined by the Reproductive Justice Movement. This autonomy includes a woman's control over her body, but it also acknowledges the ways in which her own decisions about her body impact her family and her children.

I trust that my patients can take the facts I offer and make their own well-informed decisions. It is often very, very difficult.

At its heart, *contextualized autonomy* flows from equality. It centers the woman's experiences. It rejects a paternalistic view (recently and strategically popularized by the anti-abortion movement) of the woman as passive and childlike, requiring the state's protection against predatory abortion doctors who would trick her into killing her baby. Instead it demands an unrelenting trust from society at large (including her physician) in the woman's ability to make her own decisions about her life, her goals for her future and for the futures of children, even in the face of difficulty, complexity, and constraint.

This is the autonomy I try to uphold for my patients every day. This is not a moving target. It is fundamental, solid, and real.

This is where it gets even more difficult: If the woman's contextual autonomy is the standard, then we come to the question of unrestricted abortion. Is this what I am proposing?

Am I suggesting, in the words of Donald Trump in the 2016 presidential debates, that abortion be legally available "in the ninth month" or "just prior to the birth of the baby?"

Yes and no. Again, context matters.

Yes, my value of the woman's bodily autonomy above all else leads me to believe that women should have access to legal *post-viability* abortion. This is (for the time being) within the realm of constitutional law. *Roe* doesn't explicitly ban abortion after viability; it only permits states to regulate or "go so far as to proscribe abortion during that period." A handful of states do permit abortion in the third trimester. (When I meet a patient who is past the point of viability seeking abortion in my state of California, I refer her to a clinic in New Mexico.)

My patients grapple with emotional and moral contradictions, using words such as "life," "death," "baby," and "grief"—the very words that are off-limits in public discourse.

The second part of the answer is no, I do not support "ripping" a full-term fetus "out of the womb." Nor is this what a post-viability abortion looks like.

Imagine a woman in her third trimester, thirty or even forty weeks pregnant. What differentiates her abortion from an abortion before twenty-four weeks is not the arbitrary, technology-based boundary of viability; rather, it is these undeniable facts: she has already endured more than half of her pregnancy; she is visibly, publicly pregnant; and she can no longer opt out of the process of childbirth. All of this drastically changes

the nature of her decision. Abortion is never, as abortion opponents would have us believe, an easy escape route for the capricious, self-righteous woman. Nor is it a dangerous and dirty procedure performed by callous, untrained doctors. It is particularly misleading to portray post-viability abortion in this way. If a woman decides to proceed with an abortion after twenty-four weeks, she must accept the terms: that she will deliver a baby, and that baby will be dead.

Let us imagine that she accepts these terms and decides to proceed with terminating her pregnancy—for reasons other than her own health. (Is it hard to imagine the circumstances that would prompt her to seek such a late abortion? Yes—which is part of the point. These situations are extremely rare.) Because this woman has been visibly, publicly pregnant for some time, she no longer has the luxury of considering only the private, personal consequences of her decision. Consider all the people who have, by now, seen her pregnant, and all the questions she's already answered: Boy or girl? What's the name? When will she be going off work (her boss wants to know), and when will she be back? If she has the abortion, her pregnant abdomen will suddenly disappear, and she will have no baby to show for it. Then the questions will really start. She will have to answer to the harshest court in the world: her peers, friends, and family. This is not something she or her doctor can take lightly—even if, bizarrely, they intended to.

Now consider the details of what her abortion will look like:

A late second-trimester abortion (between roughly sixteen to twenty-four weeks of gestation) is performed as a procedure called a Dilation and Evacuation—in which the fetus, too large to fit through a plastic tube, is removed in parts through the woman's cervix with the use of surgical forceps. This is the fastest

and safest way to get the fetus out of the woman's body. It is also the only legal way. The "Partial Birth Abortion Ban" of 2003, ostensibly enacted to protect the fetus from the (theoretical) pain of suffocation and death, makes it a crime for a physician to intentionally remove an intact, live fetus from a woman's uterus.

After twenty-four weeks, however, when the fetus and uterus have grown substantially larger (in the third trimester, the uterus circulates approximately one-third of the woman's entire blood supply), the removal of the fetus in parts becomes less safe and effective than the alternative: inducing labor. Such inductions are accomplished with the same medications used on Labor & Delivery wards to induce live births. The major difference is that, in large part because of the Partial Birth Abortion Ban, the doctor first ensures intrauterine fetal death by injecting a medication that stops the fetal heart, usually very quickly.

If a woman decides to proceed with an abortion after twenty-four weeks, she must accept the terms: that she will deliver a baby, and that baby will be dead.

After that the induction looks much like any other delivery. The woman's uterus begins to contract. She feels pain, which doctors try to ease with medications, comfort measures, and soothing words. After minutes or hours, a small, still fetus emerges from the woman's vaginal canal and into the doctor's hands. The placenta follows. The woman may see and hold the baby, or she may choose not to. Her bleeding is monitored and controlled. Sometimes she requires stitches. She always requires some

recovery, both physical and emotional. She has just delivered a baby—or a fetus. What we decide to call it, and whether it is viable or non-viable, are entirely beside the point.

I can think of one very tempting, though ultimately flawed, argument for prohibiting abortion after viability. If a woman no longer wishes to be pregnant, and she is already carrying a viable fetus, she would seem to have an excellent alternative to abortion. Why not simply induce a live birth? She may then place the baby for adoption if she wishes. This solution would seem to satisfy both sides, as far as rights are concerned: the woman maintains control over her body by ending her pregnancy; the fetus can have its life.

Like most things in medicine and in life, however, post-viability abortion is infinitely more complex than it would first appear—because "viability" is not an on-off switch.

If viability means "potential for survival," we are talking about vastly uncertain potential within different contexts.

Doctors use the term "periviable" for pregnancies between twenty to twenty-six weeks, a word that captures this wide swath of potentiality and uncertainty. Babies born in this gestational window, if they make it out of the delivery room at all, cling to life by a thread. They cannot breathe without artificial ventilation; they cannot eat without a feeding tube. Although they may ultimately survive after weeks of intensive care, more than half of twenty-four-

week babies will never make it out of the hospital. A large percentage of those who do survive will have major, lifelong limitations, including blindness, cerebral palsy, and other physical and intellectual disabilities.

The odds of meaningful survival improve with each week of intrauterine gestation, up until "term," or about thirty-seven weeks, at which point the fetus has excellent odds of surviving outside the uterus. But before then, even at thirty-five or thirty-six weeks, survival remains tenuous. Preterm babies have enormously increased risk of complications and death compared to those born at term.

If we understand viability to mean "potential for survival," and then consider that we are talking about this vastly uncertain potential within a wide range of contexts—for example, a parent's financial and emotional capacities to care for such a child; and how doctors should approach life-and-death treatment decisions with parents who did not intend to have a child in the first place—it begins to seem absurd that viability should be treated as a clear and simple point at which to restrict abortion. It may seem morally dubious for a woman with an undesired, periviable pregnancy to seek abortion rather than attempt a live birth; but it seems equally morally dubious to require this woman to give birth to an extremely premature baby.

One way around this dilemma would be to simply compel the woman to prolong her pregnancy a bit, to get her past that tenuous window of periviability or extreme prematurity. Knowing that her fetus's chances of survival will improve every day that it stays inside her uterus, a woman with an undesired pregnancy might gladly agree to delay delivery. Such a delay could save the life of her fetus and absolve her of a harrowing decision—even if she won't go on to care for the child as its mother.

But what kind of delay are we talking about? At twenty-four weeks, she has a long way to go before the fetus is considered "safe." How long should she be asked—or compelled—to wait? Thirty-six weeks? Forty weeks? If this becomes a legal issue rather than a medical one—a decision made by the courts rather than one made by the woman—isn't this just another way of forcing the woman to carry an unwanted pregnancy to term?

To fully capture the fraught nature of such questions, it helps to examine them through a different lens: the experiences and choices of women with desired pregnancies.

A woman may be clear in her decision. She may be certain it is the right decision for her. That does not make it easy.

A few years ago, I took care of a pregnant woman in her mid-thirties, an elementary school teacher who came to her appointments dressed in shorts and a sweatshirt, her hair in a ponytail, usually with her two young children in tow. She and her husband were looking forward to adding a third child to complete their family.

When she was around twenty-one weeks pregnant, she began to complain of a gnawing pain in her upper abdomen and mid-back, which initially sounded like bad heartburn—a common pregnancy problem. But the pain did not respond to all the usual heartburn remedies, and it was getting worse every day. Her exam, vital signs, and blood work were normal, and an ultrasound showed a healthy growing baby. Over the course of a week, she saw me and two other doctors, begging for some relief from her pain. Troubled, we ordered a second set of labs, which

revealed a marked change: her liver enzymes were suddenly elevated, and her platelets had dropped precipitously. We sent her to Labor & Delivery, where her blood pressure had skyrocketed.

She had an early and severe case of preeclampsia, a life-threatening condition that usually develops near term, and for which the only cure is delivery of the baby. At exactly twenty-two weeks gestation, she was at the limit of potential viability, meaning we knew that her baby had a tiny chance of survival, and almost no chance at a normal life. We also knew neither she nor the baby would survive the devastating seizures, strokes, and bleeding that would come with progression of her disease, were she to remain pregnant. After an agonizing discussion, she decided on an induction of labor that evening. Her baby died.

She and her husband went home to their two children. She grieved; I don't know how, or for how long. Presumably she is still grieving—and, somehow, she is carrying on with her life, raising her other children.

These are the hardest cases. We do the best we can to protect the pregnant woman and her wishes, but sometimes we cannot do both.

But cases like this one also raise an important question: What do we mean by choice? Did this woman's induced delivery at twenty-two weeks constitute an abortion (albeit one that many would call "acceptable")? Or was it a tragedy, a "choice" that was never hers to make?

I would argue that every abortion is, in this sense, a tragedy, but not in the sense that the anti-abortion

We do the best we can to protect the pregnant woman and her wishes, but

movement would have us believe. It is a tragedy for the woman, one that lays bare the very limited and unjust version of autonomy available to her: a "choice" that isn't really a choice at all.

sometimes we cannot do both.

The more I use words such as "baby" and "tragedy," the less I may sound, to some, like an abortion doctor, and the more I may sound like a pamphlet from an anti-abortion "crisis pregnancy center," portraying abortion as a traumatizing procedure that women will later regret.

Certainly, some doctors and advocates would have us normalize abortion by treating it like any other medical procedure, a tummy tuck or a tooth extraction. I've heard doctors try to present abortion this way to patients. But such a falsely cheerful, no-big-deal attitude only amplifies the simplistic "right" vs. "wrong" polarity that ignores women's real experiences. (*If you're not doing anything "wrong," then why are you crying?)*

I don't mean to say that every woman grieves or suffers as a result of her abortion. Grief and suffering are not the same as difficulty. What I mean by "difficulty" or "tragedy" is that there is a context to her decision. That context might include conflicting or uncertain goals for herself and her future; the pressures of living in a society that values motherhood above almost any other ideal of womanhood; or difficulty accessing a full range of reproductive options, whether that be the option to afford and use contraception, to have a legal abortion, or to raise a child in a safe, sustainable community. (It might also include severe fetal anomalies. But such cases raise a different set of issues—and may even serve as a distraction or intellectual escape—from the difficulty I am talking about here.)

I don't use the word "tragedy" with my patients. I don't bring up earthworms or dead babies. When they ask me tough questions, though, I don't gloss over the answers. I trust that my patients can take the facts I offer and make their own well-informed decisions, even if it is difficult. And it is often very, very difficult.

When a woman asks to see a copy of her ultrasound image, I show it to her. When she asks to see the fetus after I've removed it (some women do), I will bring it into the room afterward in a small dish. One twenty-five-year-old mother of five asked if she was allowed to take the fetal tissue home to perform a funeral for it. I explained that in our clinic, this isn't permitted; the consent she'd signed specified that all fetal tissue would be disposed of with biomedical waste. So instead she bowed her head toward the dish in my hand, closed her eyes, and whispered, "I love you. And I'm sorry."

I would argue that every abortion is a tragedy, but not in the sense that the anti-abortion movement would have us believe.

I have seen a whole range of emotional responses to abortion from my patients, from agony to relief to liberated elation. But I have never, in twelve years of this work, met a woman for whom the decision to have an abortion was *easy*. The notion that women or doctors approach abortion with a cavalier or self-righteous attitude is a myth propagated by the anti-abortion movement, and it erases the lived experience of the patients I see every day. A woman may be clear in her decision. She may be certain it is the right decision for her. That does not make it easy.

I wish I could go back to that day in pre-med biology and tell my classmate what I now understand. Causing pain, lasting harm, or even death to another living being is not in itself intolerable to me. I have learned what any good doctor (and any woman who has had an abortion) knows: there is a difference between timidity and compassion. Context matters.

When probed, the questions raised by abortion—its ethics, its spiritual significance, its impact on women's lives—represent a vast gray area. Words like "viability" and "choice" erase this gray area by invoking black-and-white concepts, right vs. wrong, or even some notion of consumerist entitlement. Meanwhile, in the procedure room, my patients grapple with emotional and moral contradictions, using words such as "life," "death," "baby," and "grief"—the very words that are strictly off-limits in public discourse because to use them is to reveal some dark and shameful secret.

But what is that dark secret? It is *not* that women seek abortion out of a callous disregard for "life," or out of a self-righteous obsession with their own "right to choose." Nor is it that perverse and predatory doctors rush women through discussions about abortion, or discourage women from examining their complex and often contradictory emotions. It is the opposite, in fact.

The real secret is that abortion is difficult. It is difficult because in a pregnant woman, there are no clear physiologic boundaries, no clean line showing what belongs to whom. Also—and this might sound shocking, coming from someone on this "side" of the debate—it is difficult because mothers love their children, and they often don't know exactly how to think about, or whether they are allowed to love, an unborn child.

Every woman has her reasons for seeking abortion. She may not view her reasons as tragic—probably very few women do. But I am always aware of the tragedy in the shadows, the silent gray area: all the things she will never say outside of that room, the messy truths no one else wants to hear; all the ways we, as women, are squeezed into impossible choices by a society that decontextualizes our autonomy, devalues our work, and disregards our equality.

If there is one thing I learned in my medical training it is this: in medicine and in life, tragedy and difficulty are not things we can eradicate. When we try to eliminate them with a law or with some arbitrary boundary, or when we try to hide them behind words such as "viability" or "choice," we are being timid, at best. At worst, we create a new tragedy, with new victims.

If I back away from the difficulty of abortion—in my private conversations with women, or when I speak and write publicly—then I am not only censoring myself; I am also silencing the very women whose rights I seek to protect. My job, instead, is to operate out of compassion—to move toward the difficulty, toward a more genuine and stalwart support for the women whose rights I aim to uphold. Those women are the most viable thing I know.

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