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Commentary

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Tracy A. Weitz & Katrina Kimport†

ABSTRACT

State-based abortion-related restrictions are increasing in number and intensity. Our study contributes to a growing body of scholarship examining the relationship between law and the production of abortion-related stigma. Here, we explore the discursive production of abortion stigma through the formation of and debate over such restrictions, using as an example a Texas law mandating pre-procedure ultrasound viewing. We performed a content analysis of public documents related to House Bill 15, which was passed in 2011 by the Texas legislature, challenged and enjoined in the District Court, upheld in the Fifth Circuit Court of Appeals, and implemented in 2012. Our analysis finds that proponents of the law discursively construct ultrasound viewing as informational and abortion providers as predatory. In addition, women seeking abortions are tautologically marked as incapable of knowing about their pregnancies and what an abortion will do to the fetus by virtue of having considered abortion. These constructions rely on frames in which abortion is stigmatized and, in turn,

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perpetuate that stigmatization. While opponents of the law contested framing women as unable to make an autonomous abortion decision and displaying providers as predatory, they did not challenge the underlying assumption that the ultrasound image is informational content capable of affecting a woman's decision. Our study concludes that, in order to more proactively address abortion stigma, a reverse discourse must be developed. This discourse will disrupt the presumptions that the abortion decision is abnormal and that women cannot autonomously decide to terminate their pregnancies.

INTRODUCTION

To date, most research on abortion laws has centered around measuring the empirical impact of laws on the pregnant woman’s decision or on her ability to obtain an abortion. Scholars have also explored the relationship between abortion legality and social markers such as crime, child abuse, contraceptive method choice, and overall abortion rates. This collection of research findings often serves as evidence of “undue burden” in constitutional challenges to

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1. See, e.g., Amanda Dennis et al., The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review (2009); Stanley K. Henshaw et al., Restrictions on Medicaid Funding for Abortions: A Literature Review (2009); Theodore J. Joyce et al., The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review (2009); Diana Greene Foster et al., Denial of Abortion Care Due to Gestational Age Limits, 87 CONTRACEPTION 3 (2013); Ushma D. Upadhyay et al., Denial of Abortion Because of Provider Gestational Age Limits in the United States, 104 AM. J. PUB. HEALTH 1687 (2014).
6. See Casey v. Planned Parenthood of Southeastern Pennsylvania, 505 U.S. 833 (1992) (holding that a law restricting access to abortion will be unconstitutional if it places an undue
abortion regulations. Less scholarship, however, has explored how abortion laws operate symbolically to construct social meanings of gender and pregnancy that systematically burden all women, not just women who seek to terminate a pregnancy. Our study seeks to contribute to this nascent literature by exploring how laws produce and reproduce stigma. Rather than arguing that an abortion regulation constitutes an undue burden at the individual level, we argue that abortion regulations operate at the social level to perpetuate understandings of gender that negatively affect all women.

Studies of abortion point to an undefined relationship between stigma and the contested nature of abortion in American society.⁷ Research has documented the prevalence and experiential qualities of stigma for women who obtain abortions and for health care workers who provide abortions or might consider burden on the right to abortion, and explaining that a state regulation constitutes an undue burden when it “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”).


⁸. See, e.g., Brenda Major & Richard H. Gramzow, Abortion as Stigma: Cognitive and Emotional Implications of Concealment, 77 J. PERSONALITY & SOC. PSYCHOL. 735, 741 (1999) (finding that almost half of women surveyed felt that they would be looked down on by others because of their abortion and felt the need to keep their abortion secret from their families and friends); Marcia A. Ellison, Authoritative Knowledge and Single Women’s Unintentional Abortions, Adoption, and Single Motherhood: Social Stigma and Structural Violence, 17 MED. ANTHROPOLOGY Q. 322, 331-32 (2003) (finding that all women participants in focus groups and interviews reported enduring social stigma after their abortion); Lisa L. Littman et al., Introducing Abortion Patients to a Culture of Support: A Pilot Study, 12 ARCHIVES WOMEN’S MENTAL HEALTH 419, 426-27 (2009) (finding that women discussing abortion stigma list family, social attitudes, certain religious groups, anti-abortion advocates, the media, friends, and the self as sources of some women feeling that they need to keep their abortions secret); Kristen M. Shellenberg & Amy O. Tsui, Correlates of Perceived and Internalized Stigma Among Abortion Patients in the USA: An Exploration by Race and Hispanic Ethnicity, 118 INT’L J. GYNECOLOGY & OBSTETRICS S152, S153-55 (finding region of residence, number of previous abortions, not having one’s mind made up about the abortion at the time of making the appointment, and not informing the man involved with the pregnancy about the abortion to be four common predictors of abortion stigma, and discussing differences in women’s experience of stigma based on factors such as race, class, geographic location, and religious group) (2012); Lisa H. Harris, Stigma and Abortion Complications in the United States, 120 OBSTETRICS & GYNECOLOGY 1472, 1473-74 (2012) (discussing the health consequences for women who experience abortion complications after attempting to keep their abortions secret).

⁹. See, e.g., CAROLE JOFFE, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE 152-56 (1995) (discussing the experience of stigma by abortion providers pre- and post-Roe, including doctors being denigrated or ostracized for their work as “abortionists” by their colleagues); Jenny O’Donnell et al., Resistance and Vulnerability to Stigmatization in Abortion Work, 73 SOC. SCI. & MED. 1357, 1359-61 (2011) (discussing abortion providers’ experience with stigma in interactions with patients, professional peers, friends, family, and strangers); Lisa H. Harris et al., Dynamics of Stigma in Abortion Work: Findings from a Pilot Study of the Providers Share Workshop, 73 SOC. SCI. & MED. 1062, 1064-66 (2011) (finding that abortion providers face stigma from patients and coworkers as well as strangers and the legal atmosphere, and discussing strategies for managing stigma, including self-censorship and non-disclosure of one’s occupation).
providing abortions. Largely, however, scholarship analyzing the experience of stigma associated with the receipt, provision, or consideration of abortion (hereafter “abortion stigma”) explores stigma either as an outcome of or as an explanatory factor driving the abortion decision. Less research has sought to rigorously examine the social production of such stigma, but there are notable exceptions. For example, Anuradha Kumar and colleagues argue that abortion is stigmatized because women who seek abortions transgress deep-seated gender norms. Additionally, Lisa Harris and colleagues posit a cycle of stigma and silence wherein providers of abortion care choose not to disclose their abortion work in order to avoid stigma, which reinforces the stigmatization of that work and thus strengthens the impulse to remain silent. Finally, Alison Norris and colleagues hypothesize that abortion opponents use stigma as a tool to preserve and perpetuate the marginalization of abortion care, providers, and patients.

Our study, continuing to explore the production of abortion stigma at the social level, posits abortion stigma as an ongoing discursive practice produced in part by law. As initially described by Michel Foucault, the concept of “discursive practice” is a framework for considering language as a process that does not simply signify objects and relations, but serves to produce the objects and relations themselves. That is, discourse contributes to the dynamic construction of the world, supplying interpretive lenses that shape social beliefs, opinions, and understandings. We argue that the stigmatization of abortion is such an active construction, accomplished through language, including the law. An examination of Supreme Court decisions on abortion illustrates how language

10. See, e.g., Jody Steinauer et al., Predictors of Abortion Provision Among Practicing Obstetrician-Gynecologists: A National Survey, 198 AM. J. OBSTETRICS & GYNECOLOGY 39.e1, 39.e3, 39.e5 (2008) (finding that availability of abortion training during residency increased the likelihood that obstetrician-gynecologists would perform abortions and that exposure to abortion in residency correlates with more accepting attitudes toward abortion); Lori Freedman et al., Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice, 42 PERSP. ON SEXUAL & REPROD. HEALTH 146, 149 (2010) (concluding that some physicians who want to provide abortions ultimately do not do so due in part to the stigma around abortion, expressed through policy restrictions on the practice of abortion or through the disapproval of others).
15. Id.
16. See Patrick W. Corrigan et al., Structural Stigma in State Legislation, 56 PSYCHIATRIC SERVICES 557, 557 (2005) (explaining that the policies of private and governmental institutions contribute to stigma by restricting the opportunities of stigmatized groups); Scott Burris, Stigma and the Law, 367 LANCET 529, 530 (2006) (discussing the Helms Amendment, which prohibited government-funded safe sex brochures from depicting homosexuality, as an example of intentionally using law to promote stigma).
bears on social understandings of its legitimacy. For example, the Supreme Court’s opinion in *Gonzales v. Carhart* rests on and reproduces negative stereotypes about women’s judgment and moral authority, including the notion that women cannot make appropriate decisions about their own healthcare and need the state to intercede. As the law endorses stigmatizing attitudes toward women when it seeks to protect them from making decisions they may come to regret, Harris and colleagues posit that stereotyping abortion providers as dangerous and morally suspect leads to an acceptance of restrictive abortion provision laws which in turn further enhance those stereotypes.

Because of the highly politicized nature of abortion, the formation of and disputes over abortion regulations are ideal sites for inquiry into how law can produce and perpetuate stigma, especially as social movement actors directly target the law as a site of action. To date, however, none of the literature has explored the dynamic process of stigma production and contestation in the process of law formation. As state abortion-related restrictions increase in number and intensity, analyses such as the one undertaken here can reveal how laws discursively produce social understandings of abortion and its overall cultural legitimacy. To that end, this paper examines a Texas abortion regulation implemented in 2012 that governs the use of ultrasound in abortion care. As of December 2013, five states had passed laws requiring physicians to, on all women deciding whether to have an abortion, perform ultrasounds, display the real-time fetal image for the women to see, provide an oral description of the image, and make the fetal heartbeat audible. Each of these laws was initially enjoined, but in January 2012, the Fifth Circuit Court of Appeals upheld the Texas law, House Bill 15 (H.B. 15), which subsequently went into effect.

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17. Paula Abrams, *The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma*, 19 Mich. J. Gender & Law 293, 301-318 (2013) (closely examining the language used in *Roe, Casey,* and *Carhart* for depictions of women as, for example, “wombs” and “mothers,” and discussing the effect of this language use on the perceived autonomy of women and legitimacy of abortion).


H.B. 15 and the associated legal debate afford a unique opportunity to examine the social production of abortion stigma. While H.B. 15 is a single law in a single state, it is of particular scholarly importance because, in the wake of its success, similar laws will likely follow. As the first law of its kind, H.B. 15 and its related documents provide an effective entry point for understanding the production of abortion stigma through law.

I. METHODS

To understand how abortion stigma is discursively produced, we examine one law that regulates abortion provision: Texas’s H.B. 15. We analyze the text of the law in addition to the public documents associated with its contestation and defense as an example of how state legislation can mark abortion as socially problematic and, in turn, stigmatize it.

A. Materials Reviewed

From its introduction to its implementation, H.B. 15 underwent significant legislative and legal debate, much of which was captured in public documents. In total, we reviewed seven documents related to H.B. 15, including the legal briefs challenging and supporting the law, and the court decisions on its constitutionality. We introduce each document below in chronological order of publication.

Document 1: House Bill 15 (Introduced), “An act relating to providing a sonogram before an abortion; providing penalties.” This document contains the bill as it was initially introduced. It mirrors the model legislation, Women’s Ultrasound Right to Know Act, distributed by the anti-abortion organization Americans United for Life.


27. Norris et al., supra note 13, at 51.


29. Women’s Right to Know Act, in DEFENDING LIFE 2012, supra note 26, at 273-78.

reflecting compromises made during the legislative process. As enrolled, H.B. 15 sets out four requirements that must be satisfied prior to an abortion (with a few narrow exceptions). First, all women must be informed of the medical risks of abortion, the alternatives to abortion, and the existence of financial support for pregnancy continuation. Second, the physician who will perform the abortion must perform an ultrasound on the pregnant woman at least twenty-four hours prior to the abortion (or at least two hours before the abortion if a woman lives a hundred or more miles from a provider). Third, the ultrasound image must be in the patient’s view, and the physician must verbally explain the image, including the presence of external members and internal organs. The heartbeat must be made audible to the pregnant woman. Fourth, providers are prohibited from accepting any payment related to the abortion at the time of the ultrasound and can only bill for the ultrasound at a rate established by the state.

Document 3: Complaint, Texas Medical Providers Performing Abortion Services v. Lakey. This is the legal brief presented by the plaintiffs to challenge H.B. 15. It provides information on what was problematic about the statute from the perspective of those supportive of the right to abortion. Only Reproductive Services of San Antonio, a not-for-profit clinic founded in 1973, and its owner and physician, Alan Braid, MD, are specifically identified as plaintiffs. Two Texas attorneys and two attorneys from the Center for Reproductive Rights, a New York-based legal organization that specializes in abortion regulation litigation, filed the case.

Document 4: Brief submitted by Senator Dan Patrick and Representative Sid Miller, the authors of H.B. 15, as amici curiae in support of Defendants. The brief clarifies the overall legislative intent that is not recorded in the bill language itself. Attorneys from the Liberty Institute, a Texas-based non-profit law firm founded in 1972 and dedicated to defending and restoring religious liberty across the United States, filed the brief.

Document 5: District Court opinion, Texas Medical Providers Performing Abortion Services v. Lakey. This is the original decision finding in favor of the plaintiffs and preliminarily enjoining several provisions of H.B. 15 for unconstitutional vagueness and violation of the First Amendment (by compelling doctors and patients to engage in government-mandated speech).

Document 6: Fifth Circuit opinion, Texas Medical Providers Performing Abortion Services v. Lakey. This is the appellate decision overturning the preliminary injunction and reinstating the law as originally passed, finding that none of its provisions were unconstitutional.

II. ANALYSIS

This article explores how the law discursively produces abortion stigma, taking Texas’s H.B. 15 as an example. It does not attempt to adjudicate the constitutional questions disputed in the litigation, nor does it evaluate the “facts” presented in the reviewed documents. Instead, it examines what kinds of arguments were advanced, including both legal claims and normative claims about gender. We first investigate the assumptions about abortion that underlie the production, protection, and rejection of H.B. 15. Next, we investigate how those assumptions structure social meanings of abortion, including the stigmatization of women who consider abortion and of physicians who provide abortion care.

The first author reviewed all documents in their entirety and coded for general themes, with a particular focus on the construction of abortion as a stigmatized decision and act. She created a list of rhetorical mechanisms through which these documents negatively marked abortion as a decision, women who seek abortions, women who obtain abortions, and abortion providers. The two authors reviewed this list of mechanisms. The second author then read all documents in their entirety for the appropriateness of the first author’s coding, adding emergent themes and combining redundant themes. Both authors then read the documents a final time to confirm that all discursive constructions related to abortion, women, and providers were coded. When the authors did not identify any additional codes, they considered the analysis complete. As this study did not use data collected from human subjects, we were not required to obtain institutional review board approval.

III. RESULTS

In the language of H.B. 15 and the ensuing debate, we find two discursive constructions—that is, emergent frameworks that forward an interpretation with


36. See id. at *2 (“[A]lthough the panel only specifically says strict scrutiny analysis does not apply to compelled speech by doctors where informed consent is concerned, it appears the panel has effectively eviscerated the protections of the First Amendment in the abortion context. . . . [D]octors may permissibly be compelled to parrot anything the state deems necessary to further its ‘legitimate interests in protecting the potential life within’ the pregnant woman, provided the message does not impose an undue burden on the woman’s right to have an abortion. That is, within the abortion context, the doctor’s right to speak, or not to speak, is wholly dependent on the contours of a woman’s right to an abortion.”).
social implications—of abortion and people associated with abortion: ultrasound viewing as informational, and abortion providers as predatory. We discuss the two constructions in turn, identifying how they are created and how they are contested. Crucially, they both are premised on the status of abortion as stigmatized and, in turn, they perpetuate that stigma.

A. Constructing Ultrasound Viewing as Informational to the Abortion Decision

Ultrasound is a procedure that allows medical professionals to observe and diagnose a range of medical problems. The text of H.B. 15 describes ultrasound as a technology that secures information. However, the law positions the patient as the appropriate recipient of that information, not the medical professional: “The purposes of this Act include, but are not limited to: (1) protecting the physical and psychological health and well-being of pregnant women; (2) providing pregnant women access to information that would allow her [sic] to consider the impact an abortion would have on her unborn child.”

In their amicus brief, the supporters of H.B. 15 employ a similar discursive strategy that asserts that the ultrasound image is no different than any other kind of medical information physicians are required to provide as part of informed consent. They write: “[R]equiring doctors to provide descriptions of sonograms and heartbeats is functionally identical to any other information that the state requires doctors to give to patients.” Further, the bill’s supporters explicitly define this medical information as relevant to a woman’s abortion decision: “H.B. 15 merely mandates that a physician consulting with a patient about an abortion provide truthful, non-misleading information that is relevant to a patient’s decision to have an abortion.”

This discursive construction was persuasive to the Fifth Circuit, which echoed the idea of ultrasounds as purely informational in its decision upholding H.B. 15. The court described the contents of ultrasound images as “the epitome of truthful, non-misleading information” and more “scientifically up-to-date” than otherwise available information, suggesting that a woman’s prior knowledge about pregnancy is superseded by the new information she learns from viewing the ultrasound. The court then elevated ultrasounds beyond neutral, informational devices to an essential component of the medical standard of care. Without citing specific medical authorities, the court wrote, “[T]he provision of sonograms and the fetal heartbeat are routine measures in pregnancy medicine today. They are viewed as ‘medically necessary’ for the mother and

32. Id.
33. Lakey II, 667 F.3d 570, 578 (5th Cir. 2012).
34. Id.
Moreover, the court asserted that denying a woman the opportunity to view her ultrasound prior to abortion would be unethical, constituting “more of an abuse to her ability to decide than providing the information.”

This discursive construction of ultrasound viewing as informational is present in the opponents’ narrative about the law as well. Opponents of H.B. 15, in their complaint, did not challenge the contention that ultrasound viewing is relevant to women’s abortion decisions. They instead contended that the ultrasound image, description, and fetal heartbeat represent a form of ideological speech: “The Act conveys to the woman the state-mandated message that she should prioritize the fetus (and the continued life of the fetus) above all other considerations.” In other words, opponents of the bill accepted that ultrasound viewing would make the pregnant woman cognizant of the fetus she carries in a way she previously was not. Through the absence of an explicit challenge, H.B. 15 opponents reified the assumptions inherent in the law: that ultrasound viewing provides necessary medical information and that a woman’s decision to choose abortion is vulnerable to that information. By taking issue not with the premise that ultrasound viewing is “informational,” but with the ideological content of this information, opponents revealed the assumption that seeing an image, hearing a description, and listening to a heartbeat would make it more difficult for a woman to choose abortion.

As supporters of H.B. 15 constructed ultrasound viewing as medical information, they simultaneously built a discursive portrait of the women seeking abortion services. Supporters’ language, evident in H.B. 15 as introduced and enrolled, revealed how the state views women’s agency in the abortion context. Rather than something women do, abortion is something done to women. Throughout both the introduced and the enrolled legislation, women are referred to as “the pregnant woman on whom the abortion is to be performed.” This language illustrates that, in the eyes of the state, women are passive recipients of the abortion procedure. It also implies that a woman makes the decision to have an abortion only after arriving at the abortion-providing facility; she arrives seeking an abortion but does not actually consent to the procedure until after receiving medical information presumed to influence her decision. By constructing women as passive creatures who are especially vulnerable at the time they are seeking an abortion, the law provides the needed justification for its own insistence that women should not have control over whether and how ultrasound information is provided.

Although opponents of the law failed to dispute supporters’ construction of
ultrasound viewing as informational, they did challenge the bill’s portrayal of women. Indeed, the denial of women’s agency was a core issue in the plaintiffs’ legal challenge, which argued that H.B. 15 “treat[ed] women as less than fully competent adults.”47 The challenge further highlighted the gendered nature of this treatment, asserting that “[t]he Act seeks to steer women into gender-stereotyped roles in family and society.”48 Finally, in contesting the construction of women as passive, opponents made a link between the law and the production of gendered stereotypes, arguing that the law “perpetuat[es] patronizing and paternalistic stereotypes of women as in need of special ‘protections’ and unable to make medical decisions on their own; and . . . enforce[s] the notion that a woman’s primary and proper role is that of mother.”49

To the extent that abortion stigma relies on—and reinforces—normative conceptions of gender, the stereotyping effect of the law further contributes to the production and perpetuation of stigma.

B. Constructing the Predatory Provider

In our content analysis, we find a second discursive construction in H.B. 15: that of the abortion provider as predatory. Supporters justified the bill as a means to protect women from untrustworthy physicians, arguing that an additional purpose of the Act was to “protect[] the integrity and ethical standards of the medical profession.”50 In their amicus brief, the authors of H.B. 15 explained that “[a]n abortion performed without a medical professional’s full disclosure to a pregnant woman of the impact on the fetus and the potential health consequences of an abortion could undermine the woman’s trust in medical professionals.”51 Thus, the bill protects not only women, but also other health care practitioners by controlling the behavior of physicians who provide abortions.

In addition to asserting that physicians are untrustworthy in this regard, the bill’s supporters further attempted to discredit providers by asserting a financial motivation for their abortion provision. When H.B. 15 was challenged, the defendants made an explicit claim that the physicians’ interest in providing abortions conflicted with their patients’ interest in being informed about the abortion procedure.52 Moreover, the direct mandates of the law were predicated

48. Id. at 25.
49. Id. at 37.
50. H.B. 15 (Enrolled), supra note 30, at ¶ 12(3).
52. State Defendants’ Response to Plaintiffs’ Motion to Strike Portions of the Declarations of Katharine Hill and Molly White at 2, Lakey I, 806 F. Supp. 2d 942 (W.D. Tex. 2011) (No. 1:11-cv-00486-SS) (“Because the plaintiffs’ interest in providing abortions conflicted with women’s interests in being informed about certain aspects of the procedure, it is improper for the plaintiff physicians to purport to represent the interests of their patients in this lawsuit.”).
on the assumption that abortion providers are motivated by greed. Prior to H.B. 15, women paid one fee that included both the pre-procedure work (e.g., an ultrasound) and the abortion procedure. Asserting that this fee structure encouraged abortion providers to push women toward abortion, the bill delineated how payments should be segregated:

During a visit made to a facility to fulfill the requirements of Subsection (a) [the ultrasound], the facility and any person at the facility may not accept any form of payment, deposit, or exchange or make any financial agreement for an abortion or abortion-related services other than for payment of a service required by Subsection (a). The amount charged for a service required by Subsection (a) may not exceed the reimbursement rate established for the service by the Health and Human Services Commission for statewide medical reimbursement programs.53

In effect, the bill requires that women who obtain abortions make two separate payments, justifying the extra administrative work through the construction of the provider as a predator who, takes advantage of passive women for financial gain.

This narrative of the predatory provider was hotly contested in the public documents. While supporters of H.B. 15 framed the law as safeguarding the ethics of the medical profession, opponents insisted that H.B. 15 forced doctors to act against their medical ethics by potentially overriding a patient’s desires: “The Act violates the most basic standards of medical ethics by requiring physicians to subject their abortion patients to an experience ... even when the patients have chosen not to receive this information and experience and do not believe this information will inform their autonomous choices.”54

While opponents of the law did not contest the presentation of ultrasound images as medical information, in effect reinforcing the notion that ultrasound viewing would provide women with information relevant to their abortion decision, they drew on the language of medical ethics to dispute the idea that physicians would maliciously withhold such “information.” These efforts mitigated the stigmatization of abortion providers, but did not challenge the premise that ultrasound viewing would convey medical information not otherwise available to the woman. That is, they argued against the necessity of this information for women’s pregnancy decisions, but accepted that ultrasound viewing conveyed medical—as opposed to social, emotional, or experiential—information.

IV. DISCUSSION

This content analysis finds that the Texas ultrasound law is predicated on two discursive constructions tied to the stigmatization of abortion. Both constructions rely on understanding women as passive in the abortion context.

First, the law asserts that ultrasound viewing conveys medical information that is necessary for women’s abortion decision-making. This contention bundles several premises: that a woman’s abortion decision should be made on the basis of the medical “facts” she will learn from the ultrasound, that the ultrasound will tell her something new about what will happen to her fetus if she chooses abortion, and that this information is necessary to protect her psychological health. Thus, constructing ultrasound viewing as informational assumes that women entering an abortion facility do not and cannot already know enough about their pregnancies to make an abortion decision. Women’s decision-making is thus constructed as inadequate until they engage with the scientific knowledge that the ultrasound provides.

Second, the law constructs abortion providers as untrustworthy predators who prey on vulnerable women. This depends in part on the first construction: by framing ultrasounds as conveying necessary, relevant medical information, H.B. 15’s supporters can paint abortion providers as predatory in that they would otherwise withhold this information from women but for this law. By emphasizing the predatory nature of providers, the text of H.B. 15 also reinforces that the ultrasound information is objective and essential. In this way, the two central discursive constructions we identify feed into one another, making each argument appear more logically sound and, in a word, true.

However, empirical research challenges the validity of both of these constructions. Despite the claims put forth by H.B. 15 supporters, extensive research has found that the reasons women give for deciding to terminate a pregnancy are rarely medical in nature. Instead, the factors that usually inform the abortion decision are within any individual woman’s expertise: e.g., insufficient finances to support a(nother) child, an inadequate or unhealthy relationship, or a desire to pursue other life plans. Similarly, while most women cope well following an abortion, those few women with negative emotional reactions often reference issues not influenced by fetal development, including lack of social support, relationship loss, and the gendered division of labor. Perhaps most importantly, research does not support the proposition that

56. See Brenda Major et al., Abortion and Mental Health: Evaluating the Evidence, 64 AM. PSYCHOLOGIST 863, 885 (2009) (“[T]he majority of adult women who terminate a pregnancy do not experience mental health problems.”).
57. See Katrina Kimport, (Mis)Understanding Abortion Regret, 35 SYMBOLIC INTERACTION 105, 105-06 (2012); Katrina Kimport et al., Social Sources of Women’s Emotional Difficulty After Abortion: Lessons from Women’s Abortion Narratives, 43 PERSP. ON SEXUAL & REPROD. HEALTH 103, 103 (2011).
ultrasound viewing dissuades women from having abortions.58

The notion that the information contained in the ultrasound image and sound will affect women’s abortion decisions is not rooted in empirical data, but rather embedded in a social framing of abortion as an aberrant decision—a framing that undergirds the overall stigmatization of abortion. Such stigmatization reinforces the idea that outside information is necessary for women to understand their pregnancies. Specifically, in H.B. 15 and its supporters’ contentions, women are constructed as unable to make decisions about their bodies and their pregnancies without the participation of a “knower”—the state, a technician, a doctor. We argue that, insofar as the construction of ultrasound viewing as informational is uncontested, the conversation around H.B. 15 discursively reproduces abortion stigma.

The idea that women will understand the abortion decision differently once “informed” by a purportedly neutral party is not new. For instance, in the late nineteenth century, the newly formed American Medical Association (AMA) sought to criminalize abortion, which until then had been widely practiced and available in the United States.59 Indeed, the medical campaign against abortion, grounded in physicians’ pursuit of authority60 and developed as medical knowledge of reproductive organs, became a means of controlling women’s advancement in society.61 Women were increasingly depicted as the emotional captives of their reproductive organs.62 Throughout the medical literature of the time, women who had abortions were portrayed as unable to understand what they were doing, and it was physicians’ role to (re)educate women about their

58. Ellen R. Wiebe & Lisa Adams, Women’s Perceptions About Seeing the Ultrasound Picture Before an Abortion, 14 EUROPEAN J. CONTRACEPTION & REPROD. HEALTH CARE 97 (2009) (finding that providing women with the choice to view an ultrasound before an abortion is feasible and useful); Anthony A. Bamigboye et al., Should Women View the Ultrasound Image Before First-Trimester Termination of Pregnancy?, 92 SAMJ 430 (2002) (finding no emotional effects from ultrasound viewing on women who subsequently have abortions); Mary Gatter et al., Relationship Between Ultrasound Viewing and Proceeding to Abortion, 123 OBSTETRICS & GYNECOLOGY 81, 81 (2013) (“Voluntarily viewing the ultrasound image may contribute to a small proportion of women with medium or low decision certainty deciding to continue the pregnancy; such viewing does not alter decisions of the large majority of women who are certain that abortion is the right decision.”).


60. See Jonathan B. Imber, Abortion Policy and Medical Practice, SOCIETY, July-Aug. 1990, at 27, 27-28 (“[N]ineteenth-century physician authority . . . was founded on the belief that abortion was a morally and medically problematic matter.”).

61. See CARROLL SMITH-ROSENBERG, DISORDERLY CONDUCT: VISIONS OF GENDER IN VICTORIAN AMERICA 217-44 (1985) (outlining the medical community’s participation in political and physiological regulation of abortion); Judith Walzer Leavitt, “Science” Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century, 70 J. AM. HIST. 281 (1983) (explaining and critiquing America’s transition from social childbirth to scientific and physician-directed childbirth); Michael Thomson, Woman, Medicine and Abortion in the Nineteenth Century, 3 FEMINIST LEGAL STUD. 159 (1995) (“Opposition to abortion, for example, was a more open defence of existing gender roles and relations.”).

62. See Leavitt, supra note 61.
bodies and supposed true nature.\textsuperscript{63}

Physicians’ insistence that they were necessary participants in an abortion decision was arguably one of the initial steps in the development of abortion stigma. Additionally, their attempt to claim credibility backfired: as physicians became advocates for women’s right to make abortion decisions (with their approval), they, too, became suspect.\textsuperscript{64} Laws like H.B. 15 insist on the legitimacy of an outside party—in this case, the state—to impart the truth of abortion to women, contributing to the legacy of stigmatization initiated by physicians’ insistence on authority over the abortion decision. At the same time, when an individual physician accepts a woman’s ability to choose abortion, this associates the physician with the stigma placed on women who contemplate abortion.

CONCLUSION

This study considers the discursive production of abortion stigma through law. As it examines only the publicly available documents related to the development of and legal debate over one law, more work is needed to understand how the constructs identified here present or do not present in other social debates over abortion regulation. However, as H.B. 15 represents a trend in abortion regulation, our conclusions can provide guidance to further inquiries.

The capacity of laws to perpetuate stigma makes them an important site for debate among those concerned with social inequalities.\textsuperscript{65} Our work examines the relationship between the law and stigma, using content analysis to illuminate how the ultrasound requirement in Texas discursively produces abortion stigma. Yet, for stigma production to be effective, the regulation must be part of an ongoing discourse that stigmatizes abortion. Thus, the law’s intrusion into women’s decision-making and into medical practice is societally acceptable because abortion is already a stigmatized decision and act. In turn, the law further entrenches the stigmatization of abortion, marking the women who consider or have abortions, and the physicians who provide them, as suspect and in need of regulation.

The long history of the presumptions undergirding abortion restrictions means that simply reversing these laws, including the ultrasound law examined

\textsuperscript{63} See generally Nathan Stormer, Articulating Life’s Memory: U.S. Medical Rhetoric About Abortion in the Nineteenth Century (2002) (articulating the historical development of antiabortion rhetoric and physician involvement in construing abortion as a threat to the national, racial, and sexual viability of the United States).

\textsuperscript{64} See Carole Joffe et al., Uneasy Allies: Pro-choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights, 26 SOC. HEALTH & ILLNESS 775, 783-85 (2004).

\textsuperscript{65} See Abrams, supra note 17, at 297 (“In the debates about abortion regulation, both sides of the dispute also seek to dominate the terms of public discourse through vocabulary. Their strategy is similar: reduce complex and controversial issues into simple, powerful, and opposing paradigms . . . . This very public rhetoric finds its way into court documents, oral arguments, and, ultimately, court opinions.”).
in this article, is insufficient to address abortion stigma. The repeal of H.B. 15 will not eliminate the cultural construction of abortion-seeking women as passive, vulnerable, and incapable of making autonomous decisions about their pregnancies. Similarly, a repeal will not undo the characterization of abortion providers as predatory. Instead, a reverse discourse is required: one that insists on the normality of choosing abortion and on women’s autonomy over pregnancy. Such a discourse would disrupt the idea that medicine and science are integral components of the abortion decision.\textsuperscript{66} Instead, the discourse would insist that a woman herself has the knowledge necessary to determine the outcome of her pregnancy. Women could choose to involve medical professionals and use medical technologies, but they would not be obligated to do so. In addition to working to dismantle the stigma that accrues to women who seek abortions, when abortion decision-making is understood as rightfully a woman’s own, informed by self-knowledge, physicians are less likely to be positioned as taking advantage of women. Physicians cannot be predators when women are not considered potential prey. Only with such reverse discourses can we truly counter the production of abortion stigmatization.

\textsuperscript{66} See Tracy A. Weitz, Producing and Mobilizing Science to Oppose Abortion Rights in the United States, LXVI W. HUMAN. REV. 103 (2012).