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*Health Rights at the Crossroads:
Women, New Science, and Institutional
Violence*

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Producing and Mobilizing Science to Oppose Abortion Rights in the United States

Introduction

Abortion is the most polarizing social issue of the modern era (DiMaggio, Evans and Bryson 1996; Evans 2003) understood generally as a political "war" between those who support abortion rights (the Pro-Choice Movement) and those who oppose abortion rights (the Pro-Life Movement). Sociologists and legal scholars studying these social movements have argued that individuals in opposing camps share differing worldviews (Luker 1984; Tribe 1992) animated by divergent ideas about the fetus, the authority of religious doctrine, the role of women in society, etc. In this paper I explore how despite these differences, supporters and opponents of abortion rights, throughout the two centuries of contestation in the United States, have sought to resolve their differences by making appeals to scientific "facts." This paper adds the topic of abortion to the body of literature on health issues in which scientific claims-making is understood as a fundamental strategy of social movements (Brown et al. 2012; Epstein 1996). I examine both how scientists themselves engage in interpretive claims-making (Aronson 1984) and how non-scientist social movement actors appeal to the credibility of science (Gieryn 1999) as objective and neutral, as a means to affect public policy-making regarding women's right to abortion. It problematizes the growing understanding that social conservatives distrust all science (Gauchat 2012; Mooney 2005), by examining how science is used by these conservatives in strategic ways to garner public policy changes surrounding abortion. Finally, I argue that lost in the debate over which scientific facts are "true" is a challenge to the commonality in both pro-life and pro-choice perspectives that science, courts, medicine, and religious entities should have the authority to decide whether women can terminate their pregnancies.

This paper begins by examining the earliest debates over abortion in the United States, led by organized medicine which sought to limit the provision of abortion by those not trained as physicians in formal settings. Organized medicine used scientific and professional arguments to gain control over abortion, shaping how fetal life was understood as expert medical knowledge which could not be understood by women themselves. As a result, abortion was made illegal unless it was deemed necessary by the treating physician. After a decade of criminalized abortion, public health advocates used data on the health consequences of illegal abortion to argue in favor of abortion law

reform. Based in part on these arguments, the U.S. Supreme Court in 1973 liberalized abortion in the *Roe v. Wade* decision [410 U.S. 113 (1973)]. The decision balanced women's right to abortion with the state's interest in protecting fetal life. Abortions were allowable until the time at which a fetus could potentially live outside the woman's body, called "viability." Under this construction, the right to abortion was left to the determination of the treating physician whose expert scientific knowledge was unquestioned. In many ways, *Roe* can be understood as a decision about medical authority (Ginsburg 1984; Koh 1987).

The first public fights over abortion after *Roe* surrounded the passage of a human-life amendment to the U.S. constitution that would recognize fetal life from the moment of conception. These efforts were ultimately unsuccessful and abortion rights opponents shifted to a state-based strategy to limit abortion access (Rose 2007). Initially state-based restrictions, which included waiting periods and expanded informed consent requirements, were struck down by the U.S. Supreme Court. After several decades of conservative restructuring the Court eventually found in favor of those laws, creating a new "undue burden" standard for abortion regulation. Within the public fights over restrictions, arguments against abortion shifted from morally based to scientifically based, mobilizing findings from a body of ideologically produced scientific studies undertaken with the intent to prove abortion's harm. Simultaneously, court decisions upholding these new laws reveal a shift away from deference to the physician to acceptance of arguments based on the scientific claims produced and mobilized by abortion rights opponents.

The Mobilization of Scientific Claims to Oppose Abortion Prior to Roe

At the time of the formation of the U.S., abortion was a common and unregulated practice. Because childbirth, the alternative to abortion, was so dangerous for women, abortion was relatively safe by the standards of the time. The first efforts to regulate abortion surfaced as part of a professionalizing project within medicine during the mid-19th-century struggle between regular (or elite) physicians and other health-care providers including midwives, homeopathists, and apprentice-trained physicians (Mohr 1978). As a component of this professionalizing project, medical knowledge became disciplinary power in the hands of organized physicians to produce and reproduce ideologies to maintain the privileged status of a hegemonic gendered elite structure (Smith-Rosenberg 1985). The social process by which the professionalizing project was successful is linked both historically and ideologically with the issue of abortion. In opposition to abortion, regular physicians could distinguish themselves from other health-care providers, espe-

cially midwives who were the major providers of abortion care (Luker 1984). In demonstrating the ability to enforce standards of behavior, the profession of medicine was able to separate its "expert" physicians from other unregulated practitioners. Because of its capacity both to control and to distinguish the profession, abortion became a high priority for the newly formed American Medical Association (AMA) in the mid-1800s. In many ways, the AMA can be thought of as the first abortion-related social movement organization in the U.S.

By arguing that women could not know what they were doing, medicine gained authority both to define and to control the meanings of abortion. Where once "quickening," that is the capacity of a woman to feel fetal movement, was the standard for up to when abortion was acceptable, now the medical definition of life was privileged knowledge understood only by physicians (Storner 2002). Physicians needed to wield that authority to control women's socially unacceptable behavior. Storer, the lead architect of the AMA campaign against abortion, explained: "If each woman were allowed to judge for herself in this matter, her decision upon the abstract question would be too sure to be warped by personal considerations, and those of the moment: Woman's mind is prone to depression, and, indeed, to temporary actual derangement, under the stimulus of uterine excitation . . ." (Storer 1866:74).

Textured within the anti-abortion ideology were gender, racial, ethnic, and class conflicts (Petchesky 1984). To the elite members of society, abortion threatened traditional gender relations and represented potential race suicide as rates of abortions were higher for white, affluent, Protestant women. Abortion was therefore seen as an indulgence of privileged women whose out-of-control behavior needed to be disciplined, in this case by both the elite society and the profession of medicine (Storner 2002). Nebinger, another physician opponent of abortion, explained in 1897: "The act is mainly committed to avoid the labor and expense of raising children, and the interference with pleasurable pursuits, fashions and frivolities" (cited in Beisel 1997:31).

Abortion laws, while criminalizing most abortions, allowed for "therapeutic abortions" to save a woman's life. This distinction between what constituted a legal and an illegal abortion would perpetuate physicians as the arbiters of the meaning and practice of abortion. However, abortions occurring outside medicine were viewed as criminal and thus determination of their meaning belonged to the state. The state needed physicians in order to enforce criminal abortion laws and in many instances, the state utilized the power of coercion to engage physician involvement. Consequently, physicians lost some of their authority over abortion. The state through its process of enforcement continued the anti-abortion hegemony created in the nine-

teenth century using its power to maintain sexual and gender norms (Reagan 1997). Within medicine, the lack of uniformity in medical standards for what constituted a “therapeutic abortion” challenged the professional cohesion of medicine around the issue of abortion. In an effort to self-regulate, hospital abortion committees were formed to monitor the actions of physicians and stabilize the profession (Joffe 1995). While these committees succeeded in limiting the number of therapeutic abortions, they did not reduce, but rather increased, the number of criminal abortions.

In 1955 the Arden Conference on abortion, sponsored by Planned Parenthood Federation of America (PPFA) and the New York Academy of Medicine, reached the conclusion that abortion was no longer a dangerous procedure, and thus could be performed safely by trained physicians (Calderone 1958). This new position continued to mirror medicine’s long-standing professional interest in control over abortion and the belief that only in medical hands abortion could be safe. As medical advocacy for abortion developed, the arguments focused only on expanding the circumstances under which therapeutic abortions could be performed (Hull and Hoffer 2001). In 1967, the AMA issued a statement favoring the liberalization of abortion laws although it continued to reflect traditional views of women as unable to be trusted with the full authority over abortion. Physicians present at the AMA debate over the new statement argued that if a woman were allowed an abortion simply because she requested it, she would not learn her lesson and would just become pregnant again (Garrow 1998). Medicine maintained adherence to traditional conservative sexual norms even as women were gaining increased access to abortion services (Corea 1977).

Physicians’ arguments for abortion reform were articulated as a need to reduce death and serious injury by affording women access to trained physicians (Greenhouse and Siegel 2010). Physicians stressed how access to legal abortion would save lives, improve the health of children, and make society healthier. As a result of this advocacy, several states reformed their abortion laws, allowing a greater number of women access to safe, legal abortion care (Nossiff 2001). In 1970, after a century of criminalization, the AMA voted for the legalization of abortion (Garrow 1998). While medicine changed its position on the legal status of abortion, it did not change its position on the role that medicine should play in making that determination. Advances in scientific knowledge, not the recognition of improper ownership of a woman’s decisions, animated the policy position change.

Roe v. Wade and the Deference to Medical Authority

Abortion was legalized nationally in the 1973 U.S. *Roe v. Wade* Supreme Court decision. Based on the medical trimester divisions for preg-

nancy, Blackman drafted the language that would become law: unregulated abortion in the first trimester, under proper medical conditions in the second, and at the state's discretion after "viability" in the third. Authority over the abortion decision was left to a woman *and her physician*. The inclusion of "her physician" in the decision was not trivial and represented the success of a century of activity on the part of the medical profession to define abortion as a medical problem (Lucas and Miller 1981). Physicians maintained all authority over the performance of abortions and the determination about when in pregnancy an abortion was no longer allowable.

Despite its limitations as a legal decision about doctors' rights, *Roe* had an enormous and swift impact on public health. Rates of hospitalization for women suffering the medical consequences of an unsafe abortion dropped as did the number of abortion-related deaths (Tietze 1975). Numerous studies documented the low medical risks from legal abortion (Cates et al. 1977), reaffirming the importance that abortion be performed by physicians. The relationship between abortion criminalization and poor health outcomes is evident in the almost 70,000 women who die each year as a consequence of unsafe abortion (Grimes et al. 2006). Consequently most efforts to address this tragedy focus on the importance of women's access to trained physicians; a narrative in which women are victims of unscrupulous actors who need to be saved by noble physicians whose authority should be recognized with legal changes. Women's basic human right to terminate a pregnancy continues to be less compelling when it is seen solely as a "desire" on the part of women and not a necessity validated by public-health scientific facts.

The Mobilization of Scientific Claims to Oppose Abortion Following Roe

Almost immediately after *Roe*, abortion rights opponents sought to develop counterarguments to reverse the legal status of abortion. Early efforts to pass a human-life amendment to the U.S. Constitution failed and efforts were undertaken to elect conservative politicians who would alter courts' compositions with the long-term goal of developing majorities that would overturn the *Roe* decision. A state-based incremental strategy was undertaken to test the limits of *Roe* (O'Connor 1996; Rose 2007). Prior to 1989, efforts to restrict abortion prior to viability were struck down by the courts as violating the tenets of the *Roe* decision. However, following a conservative restructuring of the Supreme Court under Presidents Reagan and George H. W. Bush, abortion restrictions would find more sympathetic justices. In 1992, the Supreme Court altered the constitutional standard for abortion regulation, allowing waiting periods and mandatory counseling as long as these new laws did not cause an "undue burden" on a woman's right to have an abortion [*Planned Parenthood of Southeastern Pennsylvania v.*

Casey (505 U.S. 833 1992)]. Stimulated by a judicial acceptance of abortion regulations, opponents of abortion rights sought to develop new and more expansive laws to restrict access to abortion care. Central to these new laws were scientifically crafted arguments against abortion in which abortion was found to be harmful to women's physical and mental health. Opponents of these claims argue against the scientific methods employed to reach these conclusions, pointing out faulty study designs, inappropriate sample sizes, and inaccurate statistical analysis. Central to their arguments is the need to protect the integrity of science itself, what Aronson (1984) calls cultural claims-making. They do not question whether science is the appropriate vehicle through which to adjudicate questions related to abortion, and do not ask whether women themselves find the topics of the debate relevant to their decision-making. Rather they, like their opponents, share a belief that whichever science wins out should get to dictate the answer to the question of whether abortion should be legal or not.

Abortion Is Harmful to Women's Physical Health

Regardless of the consensus within the public health and medical communities that legal abortion contributes to improvements in women's health (Department of Reproductive Health and Research 2011), opponents of abortion rights argue that abortion is actually harmful to women's physical health. The most successful of these claims surrounds the purported link between abortion and breast cancer. Americans United for Life, a public-interest law and policy organization opposed to abortion, promotes model legislation on mandatory counseling which includes language on the link between abortion and breast cancer (Burke 2010). As a result of their advocacy, five states require women be told that abortion may increase their risk of breast cancer (Guttmacher Institute 2012) despite the lack of support for this position in the broader scientific community.

The abortion and breast cancer story began in 1980 when two scientists with religiously based opposition to abortion, Jose and Irma Russo, engaged in research efforts to find a link between breast cancer and abortion. Using rat models, they argued that abortion significantly increased the risk of breast cancer by disrupting the breast changes that occur in pregnancy (Russo and Russo 1980). Throughout the next decade, epidemiologic studies on the link between abortion and breast cancer were published with conflicting results and interpretations. The studies that found a positive relationship used a study design in which the life histories of women with breast cancer were compared with those of women who did not have breast cancer. These studies found higher reported rates of prior abortion among women who had breast cancer. In 1994, one of these studies was published in the *Journal of*

the *National Cancer Institute*. Authors Daling et al. (1994) interviewed women with and without breast cancer about their life histories and found that women with a history of abortion had a 50 percent higher risk of developing breast cancer. Despite the limitations to the study's retrospective-recall design, abortion opponents would embrace this study as proof that abortion was harmful to women's health. Joel Brind, Ph.D., a professor of biochemistry at Baruch College in New York City, would become one of the most virulent supporters of the belief that abortion increased a woman's risk of breast cancer. Seeking to use his scientific expertise to forward the positions of his newly adopted Catholic religion (Mooney 2005) in 1996, he published a summary of the existing studies in which he concluded that abortion contributed to at least a 30 percent chance of increased breast cancer (Brind et al. 1996). In 1997, the *New England Journal of Medicine* published the results of the first study appropriately designed to answer the question of whether abortion causes breast cancer. This study found no relationship between abortion and breast cancer, and the authors heavily criticized Brind for his prior work, noting his manipulation of poor-quality studies to create the appearance of scientific certainty (Melbye et al. 1997). Specifically called into question were the studies that suffered from "recall bias" in which women with breast cancer are more likely to disclose having had an abortion than women not suffering from a cancer diagnosis because they are seeking an explanation for their disease and likely to recall many more events in the past. The effect of abortion-recall bias on estimations of breast cancer risk results was demonstrated in several studies designed to examine that question (Lindfors-Harris et al. 1991; Rookus and van Leeuwen 1996).

The new evidence did not seem to halt the growing interest among abortion opponents in elevated breast cancer risk among women who had abortions. New advocacy organizations were founded to promote the idea of an abortion-breast cancer link. Brind and colleagues launched the Breast Cancer Prevention Institute to train spokespersons on the "ABC link" and The Coalition on Abortion/Breast Cancer was founded with support from Concerned Women for America, a Washington DC-based socially conservative social movement organization (Jasen 2005). In 1999, along with then Congressman Tom Coburn, Brind and his supporters pressured the National Cancer Institute (NCI) to modify its web page to call the evidence on abortion and breast cancer risk "inconsistent." Under further pressure from the George W. Bush presidential administration, the NCI again revised its website and suggested an association between abortion and breast cancer (Mooney 2005).

The NCI actions led to outrage in the scientific community, which in 2003 pressured the NCI to call a scientific conference to review the issue. The conference concluded that there was *no credible evidence* of an associa-

tion between breast cancer and abortion (National Cancer Institute 2003). The following year, in 2004, the *Lancet* published a reanalysis of available data which again failed to find a link between abortion and breast cancer (Beral et al. 2004). Since then, several additional studies have lent credibility to the finding that abortion does not increase a woman's risk of breast cancer (Henderson et al. 2008; Reeves et al. 2006). Although the issue is essentially resolved in the scientific community, state governments require patients to be told of this link, legal advocates push for new laws to expand this requirement, and websites of abortion rights opponents promote the information (Dubow 2011).

Abortion is Harmful to Women's Mental Health

The claim that abortion harms women's mental health also dates to the early 1980s when abortion rights opponents sought to broaden their concerns about abortion beyond its effect on the fetus. In 1981 Vincent Rue, Ph.D., a psychologist opposed to abortion, testified before Congress that he had treated women with post-traumatic stress disorder (PTSD) from abortion. Support for this claim grew among abortion opponents, and in 1988 President Ronald Reagan asked his Surgeon General, Dr. C. Everett Koop, to investigate the effects of abortion on women's mental health. Koop had been selected by the Reagan Administration in large part because of his opposition to abortion rights, having formed the first evangelical Christian abortion opposition group with Reverend Billy Graham in 1975. Despite his personal opposition to abortion, Koop reviewed the literature, met with scientists, and eventually concluded that there was insufficient data to find that abortion had negative consequences on women's psychological health (U.S. House of Representatives 1989). His report of his findings would reaffirm his opposition to abortion while criticizing efforts to alter the focus of abortion opposition: "The pro-life movement always focused—rightly, I thought—on the impact of abortion on the fetus. They lost their bearings when they approached the issue on the grounds of the health effect on the mother" (Koop 1991:274-275).

Having been activated by Koop's inquiry in on the issue, mental health scholars soon weighed in on the controversy when a task force of the American Psychological Association (APA) published its conclusions in the journal *Science*: "[s]evere negative reactions after abortions are rare and can best be understood in the framework of coping with a normal life stress" (Adler et al. 1990:43).

Neither Koop's findings nor the consensus in the mental health community that abortion was *not harmful to women's mental health* stopped the growing interest in this issue among abortion rights opponents. In 1987,

David Reardon, a leading architect of the “abortion-hurts-women” argument, had published the first of many books, *Aborted Women: Silent No More* (1987) which told the stories of women who suffered emotionally after having an abortion. These stories and many more were shared by activists in the growing Women Exploited by Abortion (WEBA) network. In many ways, WEBA used the techniques developed by the women’s health movement (Weisman 1998) to argue that structures of power could not silence the experience of individual women who regretted their decision to have an abortion.

Reardon and his colleagues recognized that for the claims of harm to be taken seriously by policy-makers, greater scientific evidence was needed. In 1988 Reardon founded the Elliot Institute specifically to produce that research (Chamberlain 2006). To increase his own legitimacy, Reardon obtained a Ph.D. in biomedical ethics from Pacific Western University, an unaccredited correspondence school offering no classroom instruction. New colleagues joined the Institute and collectively they became increasingly sophisticated in using the apparatus of scientific investigation to create a body of literature on abortion’s harmful effects on women’s mental health. These studies have found higher rates of depression, anxiety, suicide, substance abuse, and psychiatric admissions among women who have abortions (Coleman 2011). Uniformly these studies have been criticized for their poor study design and inappropriate statistical methods (Charles et al. 2008; Major et al. 2009; Robinson et al. 2009).

This body of research, however, became the backbone of the 2005 effort by the state of South Dakota to challenge the legal status of abortion. Charged by the state legislature with assessing the scientific facts of abortion, the South Dakota Task Force on Abortion concluded that there was a scientific as well as moral reason to ban abortion. They overtly rejected both the scientific literature showing no evidence of harm and the significant methodological flaws in the studies which did. The Task Force concluded, “this evidence was overwhelmingly in support of protecting life and preventing harm to women caused by abortion” (South Dakota Task Force To Study Abortion 2005:7). In response, the South Dakota government mandated that all women obtaining abortions be told of the increased risk of suicide ideation and suicide [H.B. 1166 (S.D. 2005)]. The law was immediately challenged and enjoined.

As the law was winding its way through the court system, the American Psychological Association again convened a task force to assess the state of the science on abortion and mental health, reaffirming that there was no credible evidence of widespread mental health harm from abortion (APA Task Force on Mental Health and Abortion 2008; Major et al. 2009). In part based on these conclusions, in 2011 the Eight Circuit Court of Appeals struck down the South Dakota suicide counseling requirement in a 2-1 deci-

sion [*Planned Parenthood Minn., N.D., S.D. v. Rounds*, 653 F.3d 662 (8th Cir. 2011)].

In 2007 the Supreme Court, in the *Gonzales v. Carhart* decision, upheld the *Partial Birth Abortion Ban Act of 2003* [550 U.S. 124 (2007)]. Writing for the majority, Justice Kennedy argued: "While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. . . . Severe depression and loss of esteem can follow" (*Carhart*, 550 U.S. at 159). Of the twenty states that include information on possible psychological responses to abortion, eight continue to describe only the negative emotional responses (Guttmacher Institute 2012).

Gonzalez v Carhart and the Decline in Medical Authority

The significance of the *Gonzalez v Carhart* decision goes well beyond its endorsement of discredited theories of the negative mental health consequences of abortion and displays a significant shift in the Court's deference to physicians' authority over scientific claims adjudication. In upholding the ban on an infrequently used technique of later abortion, intact dilation & extraction (D&E) [named "partial birth abortion" by abortion rights opponents although the name appears nowhere in medical literature (Weitz and Yanow 2008)], the Court overtly discredited the expert testimony of physicians who perform abortion. These experts had successfully argued in lower court trials that under some circumstances intact D&E was the safest method available to them [*Planned Parenthood Fed'n v. Ashcroft*, 320 F.Supp. 2d 957 (N.D. Cal. 2004), overruled by *Carhart*, 550 U.S. 124 (2007)]. Justice Anthony Kennedy, writing for the majority, rejected these claims: "The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community" (*Carhart*, 127 U.S. at 163). Kennedy's conclusion directly conflicts with Justice Blackmun's holdings in *Roe* which deferred to the medical authority of the physician who performs the abortion: "Up to those points [fetal viability], the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician" (*Roe*, 410 U.S. at 166). In *Carhart*, in direct contrast to *Roe*, the expertise of physicians who perform abortions does not necessitate deference on the part of the Court.

Conclusion

Scientific claims-making is a critical tool for social movements. Both scientists themselves and non-scientist actors engage in claims-making, reaf-

firming the idea that science is not separate from social problems (Aronson 1984) and that these boundaries are fluid (Gieryn 1999). This paper traces the history of scientific claims-making amongst abortion opponents before and after the 1973 *Roe v. Wade*'s Supreme Court decision legalizing abortion in the U.S. Beginning in the mid-1800s, organized medicine used scientific arguments against abortion to consolidate professional power and assert control over the meaning of pregnancy and abortion, thereby stripping women of that capacity. As a result, abortion became acceptable only to the extent that it was deemed necessary by physicians. This control, however, was limited as the state maintained control over abortion criminalization, often using physicians as a tool of enforcement. After a century of support for abortion illegality, organized medicine reversed its position and became a major supporter of legal abortion, mobilizing public-health arguments about the harms to women from criminalization and the need to give women greater access to physicians. It did not, however, abdicate its complete control over abortion, both as technical knowledge and as part of its professional authority. The *Roe* decision reaffirmed medical authority over the meaning of abortion even as it granted women greater access to services prior to fetal viability, which was left to the treating physician to determine.

Soon after *Roe*, abortion rights opponents began mobilizing scientific arguments about the relationship between abortion and breast cancer and the effect of abortion on women's mental health to advocate for greater abortion restrictions. Scientists themselves used the apparatus of science, peer-reviewed publications and technical claims-making, to assert their authority over the questions under debate. And while their scientific conclusions have little support within the mainstream scientific community, they have been affirmed by many state legislatures and judiciaries, including the U.S. Supreme Court. The most recent Supreme Court decision on abortion, *Gonzalez v. Carhart* demonstrates a decline of the authority of physicians over scientific claims adjudication.

The story told in this paper could be read as one of scientific relativism in which all claims are equally suspect. Such an interpretation, however, would be highly problematic for the millions of women who utilize abortion to affirmatively control the timing, spacing, and formation of their families. Rather than accept that conclusion, the analysis in this paper suggests an alternative approach. Currently, the debate is structured as one in which the state must decide whether or not abortion should be legal and under what circumstances and conditions. Social movement actors—both scientists and non-scientists—seek to have the state make the adjudication using their scientific claims. What is lost in this approach is the larger question of whether or not the state should be allowed to make this determination at all.

Women have had abortions since the beginning of time and have abor-

TRACY WEITZ

tions whether or not they are legal. They make those decisions based on what they know to be the true about their own lives—whether or not they can give birth to a child, and parent that child, once born, or allow another to assume that role. Women use their lived experience to make these determinations, not the abstract notions addressed in the scientific claims contested by the existing social movements. For some women, the question of what effect having an abortion will have on their mental health is of relevance; however, the tools of epidemiology cannot predict the outcome for any individual woman. Thus the scientific debate that is waged at the level of the general is not relevant to the individual woman's decision, which is rich with the specifics of her life. Likewise, the question of whether abortion causes breast cancer is unlikely to be the tipping point for a woman's decision about continuing a pregnancy. The debates that are occurring in society have little to do with women's embodied experiences of pregnancy and the reasons they might choose to terminate a pregnancy, whether or not it was legal.

Unfortunately, the path of the abortion debate in the U.S. was established by the first efforts to control abortion by organized medicine which created the hegemonic understanding of the question as one to be adjudicated by technical experts and not women themselves. Women's best interest is not served by this framing. Unfortunately, supporters of abortion rights are engaged in a war of scientific claims-making that is more about the role of science than about what women need to make decisions for their lives. Thus, regardless of how the scientific claims discussed in this paper are resolved, women's autonomy over their reproductive lives remains compromised.

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