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Abortion as a Sociological Case

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Abstract

For over a century, abortion has been politically and socially contested, affecting people's lives through personal experience and/or public discourse. In the United States (US), abortion is sometimes exceptional—treated differently from other procedures, professions, and political issues—and sometimes an exemplar—an accessible example of a commonly occurring social, political, or personal phenomenon. It is, in other words, an excellent sociological case study. Yet the sociological literature on abortion is relatively thin. In this essay, we review research on abortion and opportunities for future sociological work in eight areas: gender; race; the body and embodiment; political economy; organizations, occupations, and work; medical sociology; law and society; and social movements. Sociologists have much to contribute to characterizing and understanding abortion, particularly following the 2022 US Supreme Court decision overturning the constitutional right to abortion. The discipline also has much to learn from studying abortion as a case. With its multifaceted social and political status and intersections with key areas of sociological interest, abortion offers a generative case for advancing sociological concepts, subfields, and constructs. While not exhaustive, our review aims to spark interest and inquiry, showcasing how a topic that spurs strong opinions can also catalyze sociological insights.

Introduction

Abortion is a topic relevant to gender, sexuality, race, (im)migration, class, inequality, health, healthcare, embodiment, technology, organizations, occupations, religion, social movements, politics, economics, culture, institutions, interactions, and individuals. For over a century, abortion in the United States (US) has been politically and socially contested, with the dynamics of that contest changing substantially over time even as the contest itself persists. Sometimes, abortion is exceptional, for example when policy regulation treats abortion clinics differently from other health clinics. Sometimes, abortion is an exemplar, for example as a politically contested issue with two identifiable opposing movements. As dually—and often simultaneously—exceptional and an exemplar and as an issue with a long history of social import, abortion is an excellent sociological case study for a myriad of sociological interests. It is also an accessible case. Abortion affects many people's lives, whether through personal experience or public discourse, and is regularly talked about by politicians, religious leaders, activists, health professionals, friends, and families. Through the case of abortion, the operation of social forces, including power, is observable and measurable.

And yet, the sociological literature on abortion is relatively thin—and siloed (Kimport and Kreitzer 2023)—considering its wide relevance to numerous areas of deep sociological interest (Purcell 2015). One aim of this review is to spur that to change. The June 2022 US Supreme Court majority

decision in *Dobbs v. Jackson Women's Health Organization* (hereafter "*Dobbs*") overturning the constitutional right to abortion captured public interest and set into motion (re)new(ed) conversations, protests, public policy debates, and values clarification. Sociologists have much to contribute to characterizing and understanding these phenomena: what explains this decision? What are the social impacts in the US and globally? How did we get here? The discipline also has much to learn from studying abortion as a case. With its multifaceted social and political status and intersections with key areas of sociological interest, abortion offers a generative case for advancing sociological concepts, subfields, and constructs.

This review focuses on abortion in the US context. Following a brief background section on abortion in the US, we describe general trends in sociological work on abortion by reviewing abortion research—much of it outside of sociology—relevant to eight subfields of the discipline. We start with abortion as a matter of gender, not only because regulation of abortion disproportionately affects people who identify as women but also because constructs of gender both inform access to abortion and are produced through abortion discourse and utilization. We then turn to how abortion has been understood through race, with race and racism undergirding social movement claims-making, disparities in abortion rates, and the stigmatization of abortion. Our third subfield focus is on the body and embodiment, highlighting how research on abortion surfaces failures of dominant constructs of time, variation in embodied experiences, and

complexity in the regulation of bodily remains. Fourth, we review abortion and the political economy, exposing how financial insecurity can be both a motivator for and barrier to abortion and describing the structural responses to the centrality of economics in abortion decision-making.

In the fifth subfield, we trace abortion as a case for organizations, occupations, and work, reviewing research using abortion to explore the decrease in physician autonomy and its implications as well as the changing role of health care workers beyond physicians in care provision and some of the peculiarities of the organization of abortion care (i.e., as marginalized from mainstream medicine). Turning to medical sociology, we describe scholarship on the role of technology in medicine, both as a tool to regulate care (e.g., ultrasound) and as a resource for bypassing regulation all together (e.g., self-managed medication abortion). Seventh, law and society-relevant research on abortion grapples with state-level variation in legality, dependence on extra-legal enforcement, and the absence of protections for conscientious provision. Finally, the case of abortion has informed social movements' scholarship on professionalization and formalization, the relationship between social movements and political parties, and opposing movement dynamics.

While sociologists have made important contributions using abortion as a case, this work is hardly exhaustive. There are rich, untapped opportunities for future sociological research using the case of abortion, some of which we point to for each subfield reviewed. Importantly, our review and suggested

avenues for future research are partial, perhaps most notably in our focus on the US context. Nonetheless, we hope to spark interest and inquiry, showcasing how a topic that spurs strong personal opinions can also catalyze sociological insights.

Abortion 101

Abortion is common. An estimated one in four women will have an abortion in her lifetime (Jones and Jerman 2022). Following the recognition of a constitutional right to abortion in the 1973 US Supreme Court decision *Roe v. Wade* (hereafter "*Roe*"), the annual number of abortions rose steadily, peaking at 1.6 million in 1990 (Jones et al. 2008). Changes in contraceptive practices and reduced availability of abortion led to a subsequent decline in utilization. In 2020, slightly fewer than one million abortions took place in health care settings (Jones, Kirstein and Philbin 2022). In June 2022, the *Dobbs* decision allowed states to determine the legal status of abortion and, within eighteen months, twenty-one states had fully criminalized or severely restricted abortion (KFF 2023). Nonetheless, initial evidence suggests that the number of abortions occurring in health care facilities following *Dobbs* has not dropped and is, instead, rising (Society of Family Planning 2023), with one in five abortion seekers traveling out of state for care (Forouzan, Friedrich-Karnik and Maddow-Zimet 2023).

Most US abortion patients are 20-29 years old, nonwhite, poor, and already parenting (Jones and Chiu 2023, Kortsmit et al. 2023). People from all religious backgrounds have abortions, including adherents of religions

that are formally opposed to abortion (e.g., Catholicism and evangelical Protestantism)(Jerman, Jones and Onda 2016). At the time they present for care, ninety-four percent of abortion patients have high certainty about their abortion decision (Ralph et al. 2017). Considering abortion for a pregnancy is common, even when people do not proceed to abortion: in a survey of nearly 600 new prenatal patients, Roberts et al. (2019b) found that around thirty percent reported considering (even briefly) but not obtaining an abortion for their current pregnancy.

Abortion is exceedingly safe (National Academies of Sciences and Medicine 2018) and has a lower complication rate than childbirth (Stevenson 2021). Prior to *Dobbs*, the majority of abortions took place in outpatient, standalone health care facilities that primarily offered reproductive healthcare, with only four percent of abortions occurring in hospitals or physicians' offices (Jones, Kirstein and Philbin 2022). Since the approval of mifepristone (aka the abortion pill) by the US Food and Drug Administration (FDA) in 2000, medication abortions using this drug have grown in popularity. In 2020, over half of all abortions provided by outpatient facilities were medication abortions (Jones, Kirstein and Philbin 2022). Since *Dobbs*, there is evidence that abortion seekers are using international telehealth to obtain medication abortion pills to self-manage their abortions outside the clinical setting (Aiken et al. 2022), a practice that the World Health Organization finds safe (Sexual and Reproductive Health and Research (SRH) 2022) but that complicates standard methodologies for capturing the

abortion rate based on healthcare facility reports (Weitz and O'Donnell 2023).

After abortion, the vast majority of patients feel relief and that the abortion was the right decision (Rocca et al. 2020). When people report negative post-abortion feelings, including regret, these emotional responses occur in social contexts, influenced by experiences of social disapproval of abortion, associated relationship loss, or the rare but real experience of pregnancy outcome ambivalence (Kimport, Foster and Weitz 2011, Kimport 2012) and alongside antiabortion framings of fetal personhood and fetal embodiment (Leach 2021).

Abortion and Gender

We start our discussions of sociological opportunities using the case of abortion with the area of gender. Most people who have abortions identify as women, which means that policies targeting abortion disproportionately impact people who identify as women. When abortion is legally restricted or unavailable, the state denies full reproductive citizenship to some bodies, namely bodies with the capacity for pregnancy (Ona Singer 2020). Such restrictions both leverage and reify normative understandings of women, including that they are unreliable decision makers, that they are vulnerable and in need of protection, and that they are naturally desiring of becoming mothers (Doan and Schwarz 2020, Siegel 2008). Abortion seekers navigate these social expectations as they aim to enact their reproductive desires. For example, in explaining their decision to have an abortion, abortion patients

often articulate a prioritization of motherhood (Combellick 2023, Jones, Frohwirth and Moore 2008, Thakkilapati 2019). In interactions with healthcare providers, an abortion seeker's performance of gender, specifically normative gendered sexuality, can inform whether or not physicians directly provide or refer for abortion care (Kimport, Weitz and Freedman 2016). With the case of abortion, scholars of gender have a common occurrence, experienced by a racially, age, and geographically diverse population, with which to investigate the (re)production of, resistance to, and evolution of gender, including when and how gender intersects with other identity characteristics.

It is predominantly women, too, who bear the social responsibility for abortion, as an offshoot of the broader process of gendered responsibility for fertility (Littlejohn 2021). Women describe themselves as emotionally and formally more responsible for abortion decisions than their partners because they carry the pregnancy (Kimport 2022b). While most abortion seekers involve their partners in their abortion decision, if not the abortion decision making (Altshuler et al. 2016, Jones, Moore and Frohwirth 2011), men do not always identify as responsible for engaging in pregnancy decision making. Some abdicate their responsibility to participate even when asked to do so by their pregnant partner (Kimport, Foster and Weitz 2011) or position themselves as opposed to abortion even as they facilitate their partner's abortion care (Nguyen et al. 2018).

The feminized social assignment of responsibility for abortion is complex. Scholars have noted how justifications of the feminization of contraceptive responsibility assert it as the reasonable effect of the biotechnological facts of available (highly effective) contraception, thereby erasing—and reifying—the importance of gendered social norms (Fennell 2011). The social frame of abortion as primarily or even exclusively women's responsibility has a relationship to these social practices, marking this frame as an extension of a broader set of social constructions of women that centers their capacity for pregnancy and motherhood. Abortion is thus understood through and constrained by gendered social processes, not just gendered policies.

However, while the majority of people who seek abortion care identify as women, the clinical and social science literature on abortion increasingly recognizes that transmen and gender non-binary people also have abortions (Moseson et al. 2021). The intersection of abortion care and gender identity offers scholars of sex, gender, and sexualities intriguing prospects for interrogating the conflation of the capacity for pregnancy with gender identity. After all, not all cisgender women have the capacity for pregnancy, due to their biology, their partnership, and/or medical interventions. The case of abortion therefore offers opportunities to think about reproduction and reproductive capacity outside of gendered body frames (Johnson 2023, Smietana, Thompson and Twine 2018).

Abortion politics, too, are tied to normative ideas about gender and, specifically, women's roles. Luker's (1984) classic text examining the claims of activists in both the abortion rights and antiabortion movements identified two competing worldviews of motherhood, rooted in different understandings of gender. While supporters of abortion conceptualized women as able to independently prioritize their lives and responsibilities, opponents of abortion thought about women as naturally inclined to subordinate themselves to the needs of the fetus. Their political framings of abortion, thus, were informed by competing ideologies of gendered norms, origins, and responsibilities. Ferree et al. (2002) illustrate how gendered ideologies inform who has the authority to speak about abortion in public spaces, underscoring through a comparison of the US to Germany how authority is not innate but socially constructed. These texts are decades old, inviting renewed attention to how gender operates— and whether these observations hold—in contemporary abortion politics. Change or stasis both would inform theories of how gender is done and undone.

Abortion and Race

Abortion is also a fruitful case for examining race, racism, and racialization. Research finds that US abortion patients are disproportionately Black (33%) or Hispanic (26%) (Jones and Chiu 2023). Scholars have sought to explain the racial distribution of abortion patients by pointing to racial disparities in pregnancy rates and circumstances (e.g., Kim, Dagher and Chen 2016). Evidence shows, for example, that the feature combinations of

existing contraceptive methods (e.g., efficacy, duration, side effects, provider dependence) are less likely to meet the desires of Black women, compared to white women (Jackson et al. 2016), making non-use and subsequent unwanted pregnancy reasonably more common. Work by Littlejohn (2021) suggests that non-use of contraception by Black women may also be a form of resistance to gendered compulsory birth control, contesting the framing that women bear the sole responsibility for preventing pregnancy yet thereby increasing the likelihood of pregnancy. Scholars also find higher rates of reproductive coercion among racial and ethnic minoritized populations offering additional explanations for variation in pregnancy rates (Holliday et al. 2017). Other research has identified upstream structural disadvantages in economic wealth, employment, education, housing, carcerality, and access to general health care as contributors to racial disparities in abortion rates (Dehlendorf, Harris and Weitz 2013).

It is possible, however, that rather than the abortion rate of Black and Hispanic women being high, white women's abortion rate is suppressed by social factors. We do not have a baseline abortion rate; rates by racial/ethnic group are comparative. Brown et al.'s (2022) review of the literature on race and stigma reports findings that abortion patients' experience of stigmatization differs by race, with white women reporting higher rates of stigma than women of color. To the extent that abortion stigmatization is a deterrent, it may cause white women to seek abortion at lower rates. When

abortion is conceptualized not as a negative health outcome, but rather an expression of reproductive autonomy, the higher utilization by minoritized populations provides a constructive case for scholars to reconceptualize healthcare utilization differences by race. That is, how can variation in social stigmatization—potentially because of protective factors—provide increased self-determination by those socially marginalized in other ways? Other salient social factors that may contribute to variation in the abortion rate by race/ethnicity include geography. Access to clinic-based abortion is geographically stratified, with urban areas that often have higher populations of people of color more likely to have abortion access compared to disproportionately white rural areas (Bearak, Burke and Jones 2017), potentially contributing to differential rates by race.

The politics of race undergird social movement claims-making about abortion, too. Beisel and Kay (2004) trace the antiabortion claims-making of the 19th century, situating it in a politics of structural racism that privileged the reproduction of Anglo-Saxon women. Indeed, racism and abortion have been intertwined throughout US history (Latimer 2022). Analyses of more contemporary opposition to abortion illustrates that structural racism remains at the center of the movement. Holland's (2020) analysis of white evangelical prolife activism in the American west reveals how claims of "fetal rights" enabled white activists to bypass reckoning with historical and ongoing anti-Black racism by positioning the fetus as the ultimate victim and their anti-abortion activity as civil rights activism. Research has highlighted

antiabortion movement practices of token inclusion of Black advocates and surface-level attention to Black perspectives, showcasing the movement's impoverished understanding of race and racialization (Kelly and Gochanour 2018, Norwood 2021)—an understanding that is hardly unique to this cause.

Race is likewise an undercurrent in abortion supportive activism. The reproductive rights movement of the late 20th century—aka the pro-choice movement—centered white, middle-class concerns, to the detriment of the needs of low-income people and people of color (Luna and Luker 2013, Ross and Solinger 2017). The work of activists of color toward reproductive freedom was often left out of the story of the movement and systematically decentered from movement resource allocations (Nelson 2003, Silliman et al. 2004). In 1994, a group of Black women activists, disillusioned with the US pro-choice movement and inspired by international human rights framings, organized the reproductive justice movement, which centered the reproductive needs of women of color (Price 2020). The reproductive justice movement calls for the right to bear children, to not bear children, and to raise children in safe and sustainable communities (Ross and Solinger 2017), thereby bridging abortion activism with claims about racial and environmental justice, police brutality, and maternal mortality, among other issues. Abortion is a rich case for examining the operation of race within movement coalitions (Cole and Luna 2010), including how activists from different racial backgrounds negotiate and produce a shared "women of color" identity (Luna 2016) and how controlling images of specific racial

groups dictate opportunities for advocacy—and how such images are contested (García 2022).

Abortion, the Body, and Embodiment

Abortion is an embodied experience, one that takes place in the body and is conditioned by emotions, interactions, and social meanings. Moreover, there are embodied activities that precede an abortion—including sex—and embodied experiences following abortion. The literature has generally overlooked the sexual embodiment of abortion, conceptualizing abortion as a causal factor or a social problem and missing a productive area of exploration (Kimport and Littlejohn 2021).

Abortion care, due to the constraints of laws, is largely organized by gestation, with declining access to care as the pregnancy advances. Pregnant individuals, however, may not understand their pregnancy according to this logic. Historically, pregnancy was established at quickening, the point at which a pregnant person felt fetal movement—notably a person-centered evaluation—which is in contrast with contemporary regulation of abortion that posits pregnancy at the point of implantation. Watson and Angelotta (2022) note the gap between becoming physically pregnant and a person's recognition of pregnancy, which is typically earlier for people trying to become pregnant (Ayoola 2015). Indeed, even the language of pregnancy duration, premised on the date of the last menstrual period (usually two weeks before ovulation), includes time when a person is definitively not pregnant. Watson and Angelotta propose a distinction between biological

pregnancy, measured based on scientifically defined markers, and cognitive pregnancy, which centers the pregnant person's recognition of pregnancy.

Notions of linear time, which undergird dominant logics of pregnancy, have been objects of critique for feminist scholars (Forman and Sowton 1989) and scholars of racial inequality (Agathangelou and Killian 2016, Mahadeo 2019, Tadiar 2012). They have argued that constructs of time as objectively and externally measurable are disconnected from life processes, which can be subjective and internal. Literature on reproduction has challenged the utilization of linear time in modern obstetrical practices (Fox 1989) and fetal surgery (Van der Ploeg 2001). In abortion care, scholars have documented how the construction of provision—and, indeed, legality—according to linear time does not accord with the embodied experiences of people who have abortions (Beynon-Jones 2017, Erdman 2017). Alongside critiques of linear time, other kinds of time (perhaps conceptualized as time rooted in the body, the time of growing) remain meaningful and consequential for pregnancy and abortion. Human pregnancy cannot last two years, for example. As sociologists interrogate time as a social structure, abortion and pregnancy represent a case for examining the negotiation and meaning making of different kinds of time.

Even as gestational duration remains a metric controlling abortion care, there is nonetheless also a role for preference in method of abortion (e.g., medication versus procedural abortion). At most stages of pregnancy, more than one method of abortion is appropriate. When abortion seekers are

offered a choice, how they navigate that decision can be informed by their understanding of the embodied experience of each method. For example, research with trans and gender expansive abortion seekers found preferences for medication versus procedural abortion out of a belief that it was less invasive and more private (Moseson et al. 2021). As another example, Kerns et al. (2012) found that emotional coping style was central to patients' abortion method preferences in cases of pregnancy complications identified after the first trimester, with different methods anticipated to afford different coping opportunities. In essence, different abortion methods are associated with different embodied experiences and different bodies experience abortion differently (Aiken et al. 2023, Broussard 2020, Purcell et al. 2017). What social, interactional, and political factors contribute to patient preferences and how these preferences are patterned, however, remains under-examined. Exploring abortion method preferences in the context of systemic inequalities and political contention can illuminate new avenues of embodiment theory, including whether and how legislation and politicization influence embodied experiences.

Finally, it bears highlighting that abortion does not just involve the body of the pregnant person. There is also an aborted fetal body—sometimes termed the "products of conception"—which is often ignored in abortion scholarship despite the high priority placed on the aborted fetal body by abortion opponents (Ludlow 2020, Schoen 2015). Antiabortion activists have controlled the management and meaning of this body, forwarding legislation

requiring, for example, particular disposition of fetal remains and reflecting an expansion of the necropolitics of reproduction (Cromer and Bjork-James 2023, Mullings 2021). Limited work has considered abortion patients' experiences of interacting with the aborted fetal body, for example finding that viewing the products of conception can make the abortion feel more real for patients (Becker and Hann 2021). The rise in the popularity of medication abortion, which requires users to individually deal with the aborted fetal body, presents new opportunities to think about the pregnant body, the reproducing body, the aborting body, and the aborted fetal body. With the case of abortion, the multiplicity of bodies, their integration and separation, and emerging state interest in the disposition of aborted fetal bodies (but not other bodies) call for sociologists to increase engagement with theories of necropolitics.

Abortion and the Political Economy

In the US, the need for and access to abortion care as well as the consequences of not receiving that care are structured by the political economy. Examinations of individualized reasons for choosing abortion identify financial concerns related to the costs of raising a(nother) child as motivating a plurality of patients (Biggs, Gould and Foster 2013). Being low income can also serve as a barrier to abortion care (Kimport 2022a, Roberts et al. 2019b, Roberts, Berglas and Kimport 2020). The average cost of a first-trimester abortion in 2020 was over $500 and costs increased incrementally as gestations exceeded 13 weeks (Upadhyay et al. 2022). These costs are

not nominal, with studies finding abortion patients forgo paying other living expenses such as rent, utilities, and food in order to pay for a needed abortion (Dickman et al. 2022, Karasek, Roberts and Weitz 2016, Roberts et al. 2014).

A basic reason low-income abortion seekers struggle to pay for care lies in the insurance structure for abortion care. Abortion patients are more likely to have public insurance or be uninsured than rely on private insurance (Jerman, Jones and Onda 2016) and those with public insurance are often prevented from using that insurance. First passed in 1976 (and upheld in a series of Supreme Court decisions), the Hyde Amendment prevents federal tax monies from being spent on abortion care. Many states replicated this language for their state spending, with the upshot that, pre-*Dobbs*, people who relied on public insurance (i.e., Medicaid) had to pay out-of-pocket for abortion care if they were a resident of thirty-four states or the District of Columbia (KFF 2023). This disproportionately affected people of color who are more likely to rely on public insurance (Donohue et al. 2022). In parallel, most privately insured patients also paid out-of-pocket for care due to high deductibles (Kimport and Rowland 2017), confusion about whether there is coverage (Jones, Upadhyay and Weitz 2013), or concerns over privacy (Van Bebber et al. 2006).

The economic consequences of whether abortion seekers can terminate their pregnancies are substantial. Abortion denial—that is, someone who presents for abortion care but is turned away, most commonly

because their pregnancy is beyond the facility's or state's gestational limit—is associated with higher rates of bankruptcy and lower credit scores (Miller, Wherry and Foster 2023). People who are unable to obtain a wanted abortion are also more likely to rely on the social safety net, rather than live independent of government support, compared to people who get the abortion they wanted (Foster et al. 2018). Abortion thus represents a case in which federal and state policies differentially affect healthcare access and outcome by income (and race/ethnicity and gender) even as the policies are technically class neutral.

Activists in support of and opposition to abortion have recognized the complex role of economics in abortion. Antiabortion members of the pregnancy help movement (a thread of the prolife movement sometimes called the crisis pregnancy movement (Munson 2008)), for example, have grappled with whether providing free material support to low-income pregnant women who are not considering abortion is consistent with their mission to end abortion (Hussey 2019). Abortion rights advocates, meanwhile, have developed abortion funds, non-profit organizations that give grants to offset the costs of abortion (Ely et al. 2017). With local, regional, and national funds, low-income abortion seekers can cobble together resources to pay for their abortion and cover ancillary costs such as transportation and accommodations. Studies find that clients of both pregnancy resource centers and abortion funds are more likely to be young, Black, and/or extremely low income, compared to their comparator

population of pregnant people or abortion patients (Ely et al. 2017, Ely, Hales and Agbemenu 2020, Kimport 2020, Leyser-Whalen, Torres and Gonzales 2021, Matthiesen 2021, Rice et al. 2021). Given the engagement and long histories of both types of organizations, abortion offers a case with which to study the role of citizen dependency, marginalization, and the state devolution of social safety net services.

Along these lines, it is notable that both abortion funds and pregnancy resource centers are financed by private donors and institutional philanthropy. To the extent that these organizations seek to shore up the fraying social safety net (Matthiesen 2021), as private organizations, they are inherently inadequate to absorb the responsibilities of the state toward its residents (Kimport 2020). They are also plagued by entrenched systems of oppression: one study of an abortion fund seeking to broaden its agenda to include more tenets of reproductive justice found that the fund experienced a subsequent reduction in white donors (Daniel and de Leon 2020). Abortion is a useful case for heeding the nearly decade-old call for sociologists to take the study of philanthropy more seriously (Rogers 2015). In the case of abortion, scholars of philanthropy will find a complex ecosystem, with individual donors, religious organizations, foundations, and state governments involved in agenda-setting and meeting individuals' basic needs that affects both who does and does not obtain abortion care and at what costs they abort or continue a pregnancy.

Although economists have long been interested in how changes in the economy impact fertility, relatively few scholars have examined how the abortion rate may be related to macro-economic activity. One study seeking to understand the relationship between abortions and economic fluctuation at the state level found that the results were mediated by whether the state restricted access to Medicaid funding for abortion (Gonzalez and Quast 2022). Indeed, scholars of abortion across several decades have found that between twenty and twenty-five percent of Medicaid eligible state residents are unable to obtain a desired abortion when coverage is restricted (Levine, Trainor and Zimmerman 1996, Roberts et al. 2019a). Studies of individual abortion seekers find that Medicaid restrictions result in more difficulty obtaining a desired abortion (Upadhyay et al. 2021) and drive people to seek the means to terminate their pregnancy outside the formal health care system (Higgins et al. 2021, Johnson et al. 2021).

Research, however, suggests that abortion is more likely to change the timing of a birth than eliminate a birth all together. Women who were able to get a wanted abortion were more likely to have a wanted pregnancy in the next five years than those who were denied an abortion and gave birth (Upadhyay et al. 2019). Sociologists can situate individual reproductive decision making in the larger imperatives, incentives, and constraints of the US economy. Set in the context of an inadequate social safety net and the high cost of raising children, abortion is collectively a response to the constraints of poverty, impeded by poverty, a poverty management strategy,

and a poverty exacerbator, compelling important questions of what constitutes structural economic coercion.

Abortion, Organizations, Occupations, and Work

Early scholars of the profession of medicine in the US identified advocacy for the criminalization of abortion as central to the formation of the physician occupation (Mohr 1979, Starr 1978). Control over abortion emerged as a professional concern in a different way in the 1960s, when physicians, worried about encroachment on their ability to provide abortions, began advocating for limited abortion reform in which they, not the law, were the arbitrators of what was appropriate. The resulting *Roe* decision is often thought of as a women's rights decision, but was fundamentally a decision about the rights of physicians to practice medicine (Abrams 2012).

Contemporary abortion provision showcases a different battleground: physician autonomy. Early work on medicine posited physicians as the archetypal profession, with significant power, including autonomy in decision-making about their practice of medicine (i.e., their work) and the ability to resist external influences that challenge their professional authority (Freidson 1970). Using the case of abortion, Imber (2017) found that the decision to perform abortions and under what circumstances was essentially up to individual physicians in the decade following *Roe*. By the early 2000s, however, Freedman (2010) found that institutional constraints—not intention, training, or willingness to provide—explain whether physicians provide abortion after residency. Post-*Dobbs*, there are emergent questions

about continued decline in physician autonomy, particularly related to abortion care delivery and advocacy. Despite the firm commitment to abortion care among physicians trained to provide this care, there is no evidence of systematic civil disobedience within the profession post-*Dobbs*. This is notably in contrast to the active, underground, largely safe provision of abortion pre-*Roe* by physicians in defiance of its criminalization (Joffe 1995). Unpacking how and why the profile of abortion-providing physicians has changed and their apparent aversion to risk can inform sociological theories of why people enter and leave professions, the navigation of physical and legal risk, and the overlaps between occupations—especially highly-paid ones—and advocacy.

Beyond physicians, nurses have received the next highest level of inquiry from health services scholars, arguing for their unique orientation toward patient need (e.g., Benner 1984). Abortion provides a challenging case for this framing of nursing, with evidence of nurses navigating non-participation in abortion care irrespective of patient need (e.g., Bennett et al. 2020). Post-*Dobbs*, nurses may be shouldering a larger portion of the abortion provision work than before: the states that have preserved abortion access are also ones in which the majority of abortions are provided by advanced practice nurses (Jones, Ingerick and Jerman 2018). In abortion, occupational sociologists will find fertile ground to study the transference of a socially contested task from physicians to nurses, an example of professional deskilling that is not about technological innovation, and the

construction of (and tensions in) the nursing profession and its professionalization.

Abortion work is not exclusive to physicians or nurses. Ward (2021), for example, examines the role of medical assistants in abortion care, identifying how this position—one more likely to be occupied by people of color and/or from lower income backgrounds—engages in more of the “dirty work” of provision and less of the emotionally valuable intimacy work. Roles in abortion care, in other words, are stratified within the clinic, offering different opportunities and rewards, some of which replicate structural inequalities outside the clinic. Along these lines, work on the abortion clinic has identified the depth of emotion work staffers engage in, noting both the feminization of the abortion workforce (Simonds 1996) and the gendered aspects of the emotional work demanded (Wolkomir and Powers 2007).

Abortion further offers a case for examining the role of personal commitment and ideology in occupations. While people who began offering abortion care immediately following the *Roe* decision did so for a variety of motivations, including entrepreneurship (Goldstein 1984), the contemporary abortion workforce is defined by its ideological motivations. There is ample evidence of the costs to the abortion workforce exacted by social stigmatization of abortion (e.g., Martin et al. 2014), state-level regulations (e.g., Cohen and Joffe 2020), and threats of criminalization or reputational harm (e.g., Freedman 2010), all of which may play a part in this shift. Workforce scholars will find abortion a generative case for examining what

happens when a (healthcare) job is tied to political beliefs and the consequences of that relationship.

Finally, the institutions that comprise the abortion ecosystem also offer a useful site of inquiry for organizational scholars. Abortion care is provided primarily in standalone, outpatient clinics (Jones, Kirstein and Philbin 2022), an organizational form that is the upshot of market actors, entrepreneurship, technological research, state regulation, and social movement advocacy (Halfmann 2021, Piazza and Augustine 2022) and that results in their location in high population urban areas (Bearak, Burke and Jones 2017). Consequently, many people live far away from an abortion-providing facility. Distance to such facilities is negatively associated with the abortion rate (Brown et al. 2020, Lindo et al. 2020). Indeed, the absence of local abortion providers can eliminate abortion as a pregnancy option all together (Kimport 2022a, O'Donnell et al. 2018). The distribution of abortion clinics also means that the abortion workforce is concentrated geographically, yielding abortion as a case in which organizational and rural sociologists can examine the role of organizational geography in the (re)production of social inequality.

Abortion and Medical Sociology

Abortion has long been a case for medical sociologists, including as a case to examine the role of technology, in line with Clarke et al.’s (2003) conceptualization of biomedicalization. In the context of abortion, technologies define, perform, and regulate both meaning and provision. For example, in clinical abortion care, providers utilize ultrasound technology to

confirm pregnancy and determine gestational duration (to inform abortion method). How they use this technology is not value neutral; it has consequences for how patients make sense of what is on the screen, including understandings of fetal personhood and their positionality in relation to the fetus (Kimport, Johns and Upadhyay 2018, Mitchell and Georges 1997, Williams, Alderson and Farsides 2001). Clinicians' use of ultrasound is informed by their own social expectations and meanings, including antiabortion understandings of the meaning of the fetus (Kimport and Weitz 2015), prompting questions of when and how ostensibly neutral technologies become gendered, raced, and classed (Franklin 1993). Outside of abortion care, opponents of abortion have mobilized ultrasound imaging as a purported evidence base in support of their political position and to establish the concept of inherent fetal personhood (Palmer 2009, Petchesky 1987, Taylor 2008).

Ultrasound and other technologies are also implicated in both compelling a desire to end a pregnancy and the institutional denial of abortion. Ultrasound imaging, prenatal testing, and other screenings may yield results demonstrating a serious fetal health issue that makes a pregnancy no longer desired, thereby being central to abortion decision making, and sometimes affording social legitimacy to an abortion decision (Kimport 2022c, Rapp 1999). In other instances, ultrasound can become the barrier to abortion when gestational duration is assessed as beyond a legal limit. Even before the *Dobbs* decision, all but seven states banned abortion

after a specified point in pregnancy, most commonly “viability,” asserted as the point in pregnancy after which the fetus can survive outside the uterus (Guttmacher Institute 2021). The concept of “viability,” however, has its roots in law, not medicine (Garrow 2015), which has compelled medical professionals to construct a method for determining potential viability. To do so, clinicians have relied on ultrasound technologies to measure gestation, using gestation as a proxy for ability to survive outside the uterus and thereby rendering ultrasound a tool to regulate access to abortion. Pre-*Dobbs* analyses estimated approximately four thousand women annually were denied abortion care because they exceeded gestational duration limits as determined based on ultrasound findings (Upadhyay et al. 2014). Medical sociologists can use abortion to examine the genealogy of technologies in medicine, including how they displace or replace the discretional authority of physicians and how, anticipating a future with human genomics-based testing, suggestive technological findings become concretized and shape access to healthcare and social legitimacy more generally.

Meanwhile, another technological innovation in abortion has enabled abortion seekers to avoid the formal healthcare setting—and its technologies of regulation—all together. Termed “self-managed abortion,” pregnant people can complete a medication abortion safely and effectively without medical oversight (Moseson et al. 2020). Prior to *Dobbs*, most abortions in the US took place in the formal healthcare system, although there is evidence that some people attempted to end their pregnancies on their own

(Ralph et al. 2020). As states have banned abortion and eliminated clinic-based care, self-managed medication abortion has grown increasingly common (Aiken et al. 2022), pointing to significant change in understandings of medical authority. People who self-manage their abortions report being motivated not only by barriers to facility-based abortion care, but also out of a desire for privacy (Aiken et al. 2018), with some describing abortion outside of the formal healthcare system as preferred rather than a last resort (Aiken et al. 2023).

However, outside of the context of the criminalization of abortion, the movement towards self-managed medication abortion more generally remains constrained by the well-established, yet no longer scientifically supported, belief that medical supervision is required for safe outcomes of abortion. Medical sociologists may be interested in exploring what structures and norms impede the wide utilization of medication abortion without the involvement of professionalized health care. Similarly, how do abortion-providing physicians adjust to a role that deprioritizes their oversight (see Baldwin et al. 2022, Karlin and Joffe 2023)? Scholars of social networks, too, may find self-managed abortion an accessible case for examining the diffusion of innovations (Rogers, Singhal and Quinlan 2014): how do people learn about online abortion pills? How do they decide to trust these systems, especially for an innovation that is not legally endorsed? Additionally, scholars studying the growth of autonomous health movements more generally (Braine 2020) and their implications for the health of traditionally

marginalized populations specifically (Raudenbush 2020) will find abortion a productive case.

Abortion, Law, and Society

Under the current regulatory regime, abortion law is state-specific. With up to half of US states having already banned or expected to ban or severely restrict abortion in the near future (Myers, Jones and Upadhyay 2019), millions of women and other people who can become pregnant in the US are legally prohibited from obtaining abortion care in their home state (KFF 2023). (As noted above, this does not mean that people are not getting abortions. What it means is that how they obtain care is different from how people obtained care pre-*Dobbs*, i.e., through travel and self-managed medication abortion.) Post-*Dobbs*, the differences between states in abortion law are particularly stark, but the long history of incremental restrictions on abortion means that abortion access has been a patchwork since soon after *Roe* (Ziegler 2020).

Researchers have examined the effects of individual laws on abortion seekers' decision making (e.g., Roberts et al. 2016, Upadhyay et al. 2017) and on service availability (e.g., Grossman et al. 2014, Roberts et al. 2015). They find that individual abortion restrictions can remake people's understanding of abortion care (e.g., Kimport, Johns and Upadhyay 2018) and stigmatize categories of people (e.g., Coleman-Minahan et al. 2021), but questions about the cumulative effects of multiple laws not only on individuals seeking abortion but also on the social construction of gender,

race, and class remain. Law and society scholars can use the case of abortion to examine how (the proliferation of) laws change social expectations about medical interventions and the people who seek, provide, or facilitate access to them.

The regulation of abortion is additionally useful as a case where enforcement of laws depends on people outside the legal and criminal justice systems. Medical professionals and institutions, for example, have been compelled to take on a legal gatekeeping role not premised in their clinical skills but, rather, in their understanding of law (Chiarello 2013, Goodwin 2020), and sometimes they exceed the restrictions required by the law (Zeldovich et al. 2020). Prior to the *Dobbs* decision, people criminalized for self-managed abortions were often discovered when health care professionals reported them to legal authorities, believing that such reporting was required (Paltrow and Flavin 2013). In a post-*Dobbs* iteration of this gatekeeping role, when states allow only very narrow exceptions to abortion bans, physicians struggle to understand whether and when they can offer the standard of care—which includes abortion—in medically complicated pregnancies (Arey et al. 2023). Abortion law, in other words, produces physicians and other healthcare professionals as state actors. Scholars of law and society can use this political moment to examine how non-state actors become state actors, including through, in the case of abortion, physicians’ practices, hospital policy, and the training of healthcare practitioners.

Indeed, gatekeeping access to abortion leverages a range of extralegal actors. In addition to healthcare professionals, government bureaucrats can create substantial administrative burdens on abortion clinics, interfering with their ability to provide care (Heymann et al. 2023). National regulatory bodies like the FDA, which established the rules around distribution of medication abortion, control the ease with which the pills are available. The FDA's decision, for example, to apply a regulatory regime known as the risk evaluation and mitigation strategies (REMS), with requirements including physician registration and direct to patient dispensing (i.e., no pharmacy dispensing), on mifepristone, one of the two drugs in medication abortion, has attenuated access to this technology and hindered the realization of widespread clinical abortion access outside of existing abortion providers (Joffe and Weitz 2003). Heightened scrutiny related to abortion concerns is not restricted to abortion-specific medications. Timmermans and Leiter (2004) argue that abortion politics are implicated in the FDA review of all drugs with the potential to harm a fetus. The case of abortion enables law and society scholars to explore the long shadow of social narratives—and social panic—into seemingly unrelated regulatory areas. The geography of abortion regulation and its consequences, in other words, is not exclusively spatial (Calkin, Freeman and Moore 2022).

Regulation of abortion, moreover, notably lacks protections for conscientious provision (Harris 2012). As scholars of organizations have demonstrated, hospitals and private practices constrain physicians' ability to

provide abortion care, even when they are trained and interested in doing so (Freedman 2010). Sometimes with reference to institutional religious values, as in the case of Catholic healthcare, physicians are prohibited from offering abortion care even in other settings (Freedman 2023), representing a case for law and society scholars to interrogate the ongoing negotiation of institutional versus individual rights, the expansion of institutional and state claims of religious freedom, and the legitimacy of conscience in medicine.

Finally, abortion represents a rich consideration for scholars examining seemingly incompatible social policies. For example, buffer zones and protest policing at clinics compel questions of the role of the state in protecting free speech, guarding against hate speech and violence, and enabling the free market provision of services—and doing so in public spaces, some of which become coopted in the abortion debate (Brown 2016, Calkin 2019). As another example, although incarcerated people are guaranteed healthcare, research finds low numbers of abortions among incarcerated individuals despite regular experiences of pregnancy and reported desire not to continue their pregnancies, suggesting a failure of the carceral system to meet its healthcare provision duty (Paynter et al. 2023, Sufrin et al. 2023). Similarly, hostility to immigrant births has been paired with the denial of abortion for detained migrants (Leach 2022), which appears contradictory on the surface. Abortion is a case in which incompatible policies with incongruent outcomes can be examined for their

underlying logics, particularly those related to state power, carcerality, and inequality.

Abortion and Social movements

Abortion social movements have served as an exemplar for several formative insights for the sociological subdiscipline of collective behavior and social movements. Staggenborg (1988, 1991) charted the professionalization and formalization of the pro-choice movement in the years following *Roe*, identifying a key process of social movements that gain mainstream status. In the decades since, the abortion rights movement and its participants have changed. By the end of the 20th century, doctors were among the fiercest advocates for abortion rights, leading to some complicated coalition politics with women's health movement activists who had been historically suspicious of medicine (Joffe, Weitz and Stacey 2004).

The antiabortion movement as a component of the Christian Right, meanwhile, serves as an example of how and with what effect social movements anchor political parties, in this case the Republican Party (Schlozman 2015). Prior to 1973's *Roe* decision, support for abortion was not polarized by political party. After being buoyed by Christian Right voters concerned about religious schools losing their tax-exempt status, the Republican party sought an issue that would motivate evangelical voters to the polls in support of Republican candidates. They found such an issue in abortion. Although Ronald Reagan had signed legislation liberalizing abortion when he was governor of California (Luker 1984), he campaigned as "pro-

life" as the Republican nominee for president. His success in getting voters and votes cemented the Republican party's antiabortion position, a stance that has grown increasingly strict with time.

It would be a mistake, however, to understand the antiabortion movement as exclusively focused on political change. Munson's (2008) exploration of pathways to advocacy, using the case of the pro-life movement, argues that the movement has multiple threads that are distinguished by their targets, tactics, and participant demographics. He charts how many of the prolife activists he interviewed identified as such only after participating in antiabortion activities, thereby upending dominant assumptions that ideology precedes action and demonstrating how participation in social movement activities can itself be a source of ideological attachment.

Research on the antiabortion movement has also offered insights into how collective action messages are developed and incubated. Antiabortion pregnancy resource centers, for example, have served as incubators of antiabortion messaging, including the construction of the scientifically debunked "post-abortion syndrome" (Kelly 2014). In parallel, elements of antiabortion advocacy have sought to medicalize their activities, laying claim to the associated authority of medical institutions. Hutchens (2023) explains this phenomenon through the conceptualization of "affective care," positing that while antiabortion pregnancy resource centers do not offer meaningful medical care (even as they sometimes claim to), their clients—often reliant

on public health systems—get emotional connection, validation, and affirmation during their visits. Social movements scholars can use the antiabortion movement to explore the utility of medicalizing interactions for social movement claims-making—and how medical framings and claims of medical expertise are used to further social movements' goals.

Research on both the abortion rights and antiabortion movements has undergirded major scholarship on opposing movement dynamics. Movement tactics, targets, and frames are both constrained and facilitated by their opposition (Meyer and Staggenborg 1996, Meyer and Staggenborg 2008). Halfmann (2011), in a comparison of abortion politics in the US, Britain, and Canada, argues that the tri-part system unique to the US makes contention over abortion virtually unavoidable: if supporters are successful legislatively, opponents look to the courts, and so on, producing an endless loop of contention. This continuous contention may frustrate activists, but it affords social movement scholars the opportunity to investigate what we might call "repeat players" in protest. These repeat players operate at multiple levels, from policy and legislative testimony (generating questions about the construction of expertise (e.g., Romell et al. 2022)) to direct action (e.g., Ginsburg 1998, Wilson 2013). Indeed, clinics are a common site of antiabortion protest, with the same protesters showing up regularly, using the same protest materials. In response, abortion-rights clinic supporters have developed the role of the clinic escort, typically a volunteer who shields patients from antiabortion protesters. Escorts and antiabortion protesters

frequently find themselves face-to-face and get to know each other, albeit in a field of contention. In clinic protests, social movement scholars can examine protest consisting of the same players making the same claims in the same location repeatedly. What do we learn about the practices of counterprotest when there is familiarity among opposing activists? What do we learn about social change efforts when protest becomes a regular performance?

Post-*Dobbs* social movements for and against abortion pose many questions for scholars of social movements. Both have long characterized themselves as the underdog, prompting questions about what recent antiabortion legislative successes tell us about long-term social movement strategies. Although early antiabortion advocates pushed for a personhood constitutional amendment—representing an absolutist position—other long-running organizations have instead pursued an incrementalist strategy, chipping away at the right to abortion. Is the *Dobbs* decision appropriately understood as the culmination of those efforts? And what does it mean that, when voters are asked about abortion specifically, they have voted to protect abortion (e.g., Ohio’s Amendment 1 in November 2023) even as they continue to elect politicians who vow to end abortion?

Analyses of the abortion rights movement can examine the role of institutions and—or versus—the role of direct action. Abortion rights advocates engage in a large amount of political activity but not a lot of protest, potentially the legacy of organizational professionalization in health

policymaking (Harris 2017). Social movement scholars can examine abortion rights as a case of what happens when a “movement” is mostly comprised of institutional actors. How do political opportunity, resource mobilization, and repertoires of contention apply post-*Dobbs* to a movement that lacks a robust network of volunteer activists beyond those few protecting abortion clinics? How do ideologically aligned people find a role in a movement that relies primarily on paid workers?

Finally, abortion social movements can be explored for how and for whom dominant collective action frames percolate into everyday life. Scholars have critiqued abortion rights frames such as “safe, legal, and rare” (Weitz 2010) and the strawman debate over whether abortion recipients subsequently feel regret or relief (Weitz et al. 2008). These frames, while expedient politically, are not rooted in the lived experience of abortion seekers; they are rhetorical debates. The social movements literature has focused on collective action frames as a tool to motivate, bridge, and build support (Benford and Snow 2000, Snow et al. 1986), yet research points to how frames for and against abortion influence abortion seekers’ decision making (Kimport 2022a), post-abortion coping and description of their abortion experience (Allen 2015, Cockrill and Nack 2013, Kimport 2012, Siegel 2020), and abortion providers’ practices (Kimport and Weitz 2015, Martin et al. 2017). The case of abortion illustrates how the intersections of embodied experience and collective action frames about abortion can inform and even constrain subsequent social movement messaging (Keys 2010,

Siegel 2021). In abortion, social movement scholars have a case to examine how and when collective action frames are negotiated in, facilitate, and constrain real people's lives.

Conclusion

In this article, we have barely scratched the surface of the broad body of public health, epidemiologic, economic, and social science research on abortion. We have not substantively covered the sociological literature on abortion and culture including public opinion; religion; the media; abortion communication and rhetoric; and how people make sense of their abortion experiences through recourse to and revision of cultural narratives. Perhaps most glaringly, we have only occasionally referenced the superb research on abortion outside of the US.

Nonetheless, we hope we have made the case here that there are significant opportunities for sociologists to build knowledge using the case of abortion. Much of the published research on abortion, often in public health, epidemiology, and other social sciences, has expanded how we understand abortion. Sociologists have much to contribute to these understandings, particularly following the overturning of the constitution right to abortion via the *Dobbs* decision.

In addition, we contend that research on abortion can help us understand more about social institutions and processes and serve as a generative case for sociological analyses. Abortion is the site of, among other things, political contestation, negotiations of institutional and

professional autonomy, and the (re)production of sex, gender, sexualities, race and ethnicity, class, nation, and multiple other identities. It is treated as an exception to normal practices (e.g., provided primarily in standalone clinics rather than through mainstream medicine), while also regularly serving as an exemplar of social processes (e.g., the professionalization of physicians). It is also a site where some of the many tensions in social policy are manifested, producing explicit contradictions that sociologists can mine to reveal underlying logics of governance. And abortion has a long history, affecting millions of people's lives, in the US and globally. As it has remained a site of social processes, it has also changed, with shifting patient demographics, evolving political support, and new technologies—all occurring alongside and epitomizing broader social patterns of change and entrenchment. We invite sociologists to consider the questions: what are we fighting over when we fight about abortion? What can we learn sociologically from that fight?

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