Tech-ing the Trade: Notes on Reformulating Abortion and Its History

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Tech-ing the Trade: Notes on Reformulating Abortion and Its History

KELLY O’DONNELL

In the introduction to her 2014 treatise *Pro: Reclaiming Abortion Rights*, feminist author Katha Pollitt confessed that in the face of mounting legal restrictions and the degrading landscape of abortion care in many parts of the country, she found herself daydreaming, there is something, some substance already in common use, that women could drink after sex or at the end of the month, that would keep them unpregnant with no one the wiser. Something you could buy at the supermarket, or maybe several things you could mix together, items so safe and so ordinary they could never be banned, that you could prepare in your own home, that would flush your uterus and leave it pink and shiny and empty without you ever needing to know if you were pregnant or about to be. A brew of Earl Grey, Lapsang Souchong, and ground cardamom, say. Or Coca-Cola with a teaspoon of Nescafé and a dusting of cayenne pepper. Things you might have on your shelves right now, just waiting for some clever person to put them together, some stay-at-home mother with a chemistry degree rattling around her kitchen late at night.¹

Such a substance, she claimed, would subvert “the whole elaborate panop- ticon that governs abortion today.” This was partially the promise, Pollitt observed, of mifepristone, otherwise known as RU-486—but “the French abortion pill” had as yet failed to deliver. Few doctors were prescribing it, the law regulated it just as heavily as surgical abortions, and it was still fairly difficult to obtain.² The allure of the abortifacient lingered, but no pregnancy-ending panaceas seemed forthcoming.

By 2020, only a few years later, the landscape of abortion care in the United States had changed dramatically. Hastened in part due to the COVID-19 pandemic and its many disruptions of routine medical practice, medication abortion suddenly accounted for more than half of all

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² Ibid., 12–13.
abortion in the country, jumping from 39 percent in 2013 to 54 percent in 2020 according to Centers for Disease Control and Prevention data (as reported recently by the Guttmacher Institute). Approved for use up to ten weeks of pregnancy, the combined regimen of misoprostol and mifepristone pills, taken sequentially over a series of a few days, is now the procedure of choice for early pregnancy termination.\(^3\) That same year, the American College of Obstetricians and Gynecologists (ACOG) issued an updated practice bulletin regarding the use of medication abortion, outlining its safe use for up to seventy days of gestation. The organization found that “patients can safely and effectively” use or administer medication abortion at home, and that “routine in-person follow-up is not necessary after uncomplicated medication abortion.” However, the Food and Drug Administration’s regulatory guidance around one of the drugs—mifepristone—required that it be administered in person, under the guidance of a medical professional. After taking this part of the regimen, patients could then self-manage the procedure at home using the remaining dose. ACOG found this risk and evaluation mitigation strategy (REMS) unnecessary and urged the FDA to remove this requirement in order to broaden access.\(^4\)

The following year, as pandemic-era telemedicine flourished and the Supreme Court heard \textit{Dobbs}—a case that was widely expected to challenge if not overthrow core tenets of \textit{Roe v. Wade}—access to medication abortion was significantly expanded. In December 2021, the FDA moved to permanently allow access to mifepristone by mail.\(^5\) As ACOG had suggested, the agency altered its REMS Program for the drug, removing the “in-person dispensing requirement,” thus allowing for greater autonomy in self-management.\(^6\) In March, \textit{JAMA Internal Medicine} reported new data showing that pandemic-era data collections proved that a physical exam was unnecessary prior to prescription of the drug in the overwhelming

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majority of situations. An editorial in the same issue explicitly called for a new, freer standard in the use of medication abortion, heralding a new consensus emerging among clinicians. When the draft of the majority opinion of Dobbs v. Jackson Women’s Health Organization was leaked in May 2022, panicked women and abortion rights advocates across the country looked to medication abortion with renewed hope. Two days before Dobbs was officially decided, a Vox headline asked, “Should you keep abortion pills at home, just in case?,” pointing out that mifepristone and misoprostol have shelf lives of five and two years, respectively. Links to the website PlanCPills.org, a popular clearinghouse of information about how to obtain abortion pills by mail, abounded on social media.

Medical technologies and therapeutics are the literal stuff of our historical inquiries. Some histories of reproductive health care are already deliberately centered on technology. Take, for example, the powerful reimaginings of the trajectory of the field of gynecology that foreground the speculum, from Sims’s experimentations in the 1840s to the adoption of a plastic version for self-exams during the women’s health movement in the 1970s. Or the history of childbirth, in which historians have written extensively about tools such as forceps and various forms of obstetric anesthesia, and how practitioners and patients alike have used them to

11. For example, one viral tweet (with currently almost 8,000 retweets) by a public health researcher based at Emory University instructed that there were three things readers could do “RIGHT NOW to help people get abortions”: donate to abortion funds; donate to independent clinics; and “share accurate information about safely self-managing an abortion at home: plancpills.org.” Hayley McMahon (@McMisoprostol), “What you can RIGHT NOW to help people get abortions,” Twitter, June 24, 2022, https://twitter.com/McMisoprostol/status/154034017205903600.
create radical changes in medical practice. We also know that in the history of abortion too often the tools of the trade—that is, advances in medical technology intended to create better health outcomes for abortion patients—have been co-opted by antiabortion activists, used as bricks to build their case against the procedure itself and for the sanctity of fetal personhood. Johanna Schoen has written compellingly about the right to life movement’s fixation on the imagery of fetal remains and their thick (though inaccurate) descriptions of the use of vacuum suction machines. Technologies ranging from the fetal heart rate monitor to smartphone apps have similarly captured scholars’ attention for their roles in reconfiguring the imaginaries of early pregnancy. But we can push this emphasis further and more closely interrogate these material cultures of abortion and fertility control’s biomedicalization in our scholarship. We should consider tech-ing the trade, so to speak. Medication abortion, or abortion pills, offer one such opportunity.

The widely discussed prospect of self-managed, relatively easily accessed medication abortion as a potential safeguard for maintaining some level of abortion access—though imperfect—was one hopeful note among all the bleakness surrounding Dobbs over the summer and into the fall of 2022. You could do it at home. You didn’t even need a doctor. It would seem like a late, heavy period. It would be nice to have something on hand, just in case, wouldn’t it? Stockpile Plan B (emergency contraception) and Plan C (abortion pills)! If this discourse sounds at all familiar to you, it should. Anyone who has ever taught the history of abortion or reproductive health knows how important it is to remind our students that in an earlier era—for example, the early nineteenth century—women did not necessarily differentiate between abortion and contraception in the way we think of those categories today. Nor did they even necessarily ascribe much meaning to what in historical hindsight we would today consider an abortion or miscarriage. And all this reproductive self-management took
place within the context of domestic healing traditions, almost entirely outside the (still developing) medical gaze.17

Medication abortion is a disruptive technology for both abortion practice today and the history and historiography of abortion. Furthermore, historians of medicine should be paying far more attention to histories of technology, pharmaceuticals, and drugs—particularly, but not only, in the history of abortion in America. An act linked so closely in the popular imagination not only to surgery but specifically to potentially dangerous back-alley butchery has now been fundamentally transformed. For the earliest—and now majority of—abortions (facilitated by earlier and earlier pregnancy confirmations thanks to the different but interlinked technological advancement of the mass-produced home pregnancy test), it is no longer an operation or even a procedure per se, but rather a therapeutic drug.18

In the wake of the American Medical Association’s anti-quackery and anti-midwifery campaigns in the late nineteenth and early twentieth centuries and with the rise of the modern drug regulatory regime in the late twentieth century, the classic underground abortifacient patent medicine advertised as “female pills” and the like may have disappeared. But did our basic understanding of those mechanisms for the inducement of abortion or miscarriage also vanish? Today’s contemporary abortion medications offer a sustained continuity with the past in terms of reproductive self-management via the ingestion of substances, with the crucial distinction that they are demonstrably safe pharmaceuticals backed by reams of clinical trial data. It also occurs in a private, domestic sphere, almost wholly self-determined by those seeking to end their pregnancies and self-manage their own bodies and fertility. The outcome of this particular therapeutic revolution, perhaps, is the new reality of the abortionist “who wasn’t there,” but rather was replaced by a permissive drug regulatory regime.19

Perhaps our current discursive framework around abortion—emerging


after quickening and self-knowledge of reproductive status fell out of use as a guiding concept, and intensely guarded medical authority and oversight fell into place in its stead—is overly reliant on a twentieth-century understanding of the procedure as only ever a surgical or mechanical intervention, using the tools of an allopathic medical profession at the peak of its cultural authority.

My first inkling that I might one day dedicate myself to the history of reproductive health came one day in the late 2000s at a Borders Books, where I was browsing the women’s studies section while on a break from school at Sarah Lawrence College and back home in Delco, Pennsylvania. Newly fascinated by the menstrual cup and its users’ political advocacy (which I wanted to write my senior thesis about), I was looking for more. Inga Muscio’s *Cunt: A Declaration of Independence*, with its neon orange flower on the cover, caught my eye. First published in 1998, the book by this point was already a few years past its prime as a third-wave feminist manifesto. I would soon go on to graduate school to study the history of women’s health, with reproductive justice and a notion that Barbara Seaman once called “pelvic autonomy” guiding my way. But this book stuck with me.

The heart of the book is a tale of two types of abortion experiences. The first is the story of Muscio’s clinical abortion at a Planned Parenthood at age nineteen. Sterile and painful, the procedure was legal and readily accessible, but deeply unpleasant in her memory. She recalled “the ugliest needle” shooting “something” into her cervix, resulting in overwhelming pain. Then came “a quiet motor whirring,” as she struggled, at the doctor’s suggestion, to recite her ABCs during the procedure. She screamed about letters as her “organs were surely being mowed down by a tiny battalion of Lawn-Boys.” When the whirring stopped, she was “delirious.” “For two weeks,” she wrote, “there was a gaping wound in the center of my body. I could hardly walk for five days.” Her second abortion was a few years later, also at a clinic. As she recalled, it “took place in a clinic that was under so much political pressure, I wasn’t even allowed to recuperate. Twenty minutes after the vacuum cleaner was out of my body, I was dressed and walking home. Felt like a piece of shit.” Muscio eventually found herself unintentionally pregnant for a third time. Feeling burned by her previous clinic experiences and newly fascinated by alternative healing modalities, she sought a different approach. A friend “found some herbal tea recipes a Boston anarchist-feminist group printed.” The friend

22. Ibid., 45.
visited “almost every night and massaged [her] uterus where you are not supposed to massage pregnant women who want to keep their babies.” She also practiced reflexology techniques, “rubbing either side of [her] Achilles tendon on both feet.” Muscio believed in the healing power of “imaging,” so each night she visualized her body changing, “vividly, consistently . . . imagin[ing] the walls of [her] uterus gently shedding.” After eight days of this, her “embryo plopped onto the bathroom floor” as she miscarried. “Me and my women friends did magic,” she concluded.23

Historians of medicine are familiar with several (in)famous examples of woman-controlled, self-managed abortions resulting in safe outcomes despite taking place outside the traditional medical system. For example, Carol Downer and Lorraine Rothman toured the country demonstrating their technique of “menstrual extraction,” a method of emptying the uterus’s contents that would result in either a conveniently short period or the termination of an early pregnancy.24 In my own work, I have examined the historical memory of the Chicago group known as Jane.25 Emerging first as an abortion referral service associated with the Chicago Women’s Liberation Union and reliant on underground male abortionists, Jane or “the Service” transitioned into more of a counseling service and then, ultimately, one that provided its own abortions.26 The tale of the laywomen of Jane taking up the tools of the trade themselves, upon discovering that their preferred provider was not a licensed physician, has been retold across the decades by both scholars and activists as a lesson about women’s resilience and empowerment in the face of unjust laws.

In the aftermath of Dobbs, panicked journalists reported on dangerous herbal remedies being shared through viral videos on TikTok. But in the same publications, they praised the representations of Jane on film in the recent documentary and the fictionalized film account of the group’s history.27 Historians usually do not dwell in counterfactuals, but given the

23. Ibid., 49–50.
evolution of abortion technology in recent years, one type of thought experiment is worth contemplating. What if Lorraine Rothman’s Del-Em device had been an herbal concoction, like the recipe Muscio found in an underground feminist zine? What if rather than intervening with surgical tools, the women of Jane had brewed a special pot of tea? What if, rather than an unlicensed abortionist, they had approached a pharmacist to teach them how to compound capsules of synthetic hormone-based drugs? How would we as historians have interpreted and told this version of these stories? Would we tell tales of liberation from regulatory guidance as well as the usual medical authority they were recognized as (usually nobly) subverting? Would we have found or told these stories at all? Would they become “good” stories to be taken up as anecdotes for our lectures?

Here the history of contraception can provide insight. In her work on the history of emergency contraception (colloquially known as “Plan B”), Heather Munro Prescott has been at the forefront of this scholarship, combining reproductive health histories with careful attention to processes of technological development, drug regulatory debates, and ongoing policy implications for consumers of such medications. The slow process of refining emergency contraception, then battling to have it made accessible over the counter, while still facing hurdles in the form of pharmacists’ attempts to deny access to it based on moral grounds, offers clear lessons in the current and looming battles over medication abortion. In particular, while Plan B is theoretically easier to buy and have on hand as a precautionary measure, the FDA has been reluctant to cede “advance provision” status to abortion pills, even over the objections of health advocates and organizations like ACOG. Likewise, a robust “Free

28. As Leslie Reagan has so compellingly demonstrated in her use of dying declarations and legal sources, our understanding of the full scope of abortion practice is biased given the biased nature of our historical records. While we know of the women who had “bad” illegal abortions leading to injury and death, and therefore became visible to the medical and legal systems that generate our primary sources, we can never really know the true number or character of successful illegal abortions. Leslie J. Reagan, “About to Meet Her Maker”: Women, Doctors, Dying Declarations, and the State’s Investigation of Abortion, Chicago, 1867–1940,” J. Amer. Hist. 77, no. 4 (1991): 1240–64.


the Pill” campaign has been putting pressure on the agency to make oral contraceptive pills accessible over the counter as well.32 Ironically, as medical providers themselves seem increasingly willing to effectively give up their gatekeeping role via the prescription pad, federal safety regulations meant to safeguard patients’ health from potentially dangerous drugs could be causing harm itself. Even more fundamentally, however, this technological reorientation teaches us that there is no true distinction between the history of birth control and the history of abortion. As it was prior to the twentieth century, the control of fertility falls along a spectrum of approaches whose meanings cannot be cleanly parsed out. Linda Gordon perhaps unintentionally made this point when in 2002 she retitled the revised edition of her classic history of birth control Woman’s Body, Woman’s Right, calling it instead The Moral Property of Women. The new title was drawn from a quote from the French minister of health in 1988 about mifepristone, the abortion pill.33

No one knows what the future of abortion in this country holds, as we wait (and brace) for new developments in the legal realm. Currently, it appears that antiabortion activists are turning their sights on mediation abortion. Even as the FDA moves to allow the sale of abortion pills at retail pharmacies, there are multiple lawsuits challenging the legality and safety of the drug, potentially threatening its availability.34 One grim Washington Post opinion headline asked recently, “Can medical abortions survive in the post-Roe era?”35 Katha Pollitt’s daydream has never felt more urgent. In the meantime, as this essay goes to print, I will be editing a series of new journal articles along with Lauren MacIvor Thompson for a forthcoming special issue on “Regulating Reproduction in the History of Pharmacy and Drugs,” for History of Pharmacy and Pharmaceuticals. In

my campus office, I keep a stack of PlanCPills.org stickers next to a cup full of free menstrual products, seeking clarity in the past with the help of our colleagues’ scholarship on my shelves.

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