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From Sex for Pleasure to Sex for Parenthood: How the Law Manufactures Mothers

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From Sex for Pleasure to Sex for Parenthood: How the Law Manufactures Mothers

Beth A. Burkstrand-Reid

As soon as sperm enter a woman, so do law and politics—or so the decades-long disputes surrounding abortion suggest. Now, however, renewed debates regarding contraceptives indicate that legal and political interference with women’s sexual and reproductive autonomy may actually precede the sperm. This Article argues that women even thinking about having sex are increasingly defined socially and legally as “mothers.” Via this broad definition of who is a “mother,” the State extends its reach into women’s decisionmaking throughout their reproductive lifetimes.

This Article argues that the State simultaneously devalues women’s choices to have sex for pleasure, which this Article calls “desexualization,” and uses medical rituals associated with motherhood, which this Article calls “ritualization,” to persuade women to accept the role of mother. Desexualization and ritualization signal the State's attempt to influence women’s sexual and reproductive decisionmaking not only in the context of abortion, but also in the areas of contraception, pregnancy, and childbirth.

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Introduction

“[B]eing against sex is not good. . . . Sex is popular.”1

Sex is complicated. It can be physical, emotional, violent, tender, for pleasure or for procreation, and any combination of these.2 Arguably, no other act can have so many different meanings and consequences, pregnancy included. But two things are certain: sex is popular, and women, specifically, are sexual beings.3 Perhaps due to its near-universal appeal, sex is also a frequent subject of legal regulation.4 Today, women are regulated—not as sexual beings but as would-be mothers—long before they ever have sex and certainly before they see a fetal image on an ultrasound screen, whether before an abortion or as a milestone on a path to childbirth.5

For women, “[s]ex for pleasure, for fun, or even for building relationships is completely absent from our national conversation.”6 Instead, the national focus is on “morality,” a one-word descriptor for the anxiety that female


2. Sylvia A. Law, Homosexuality and the Social Meaning of Gender, 1988 Wis. L. Rev. 187, 225; see Margo Kaplan, Sex-Positive Law, 89 N.Y.U. L. Rev. (forthcoming Apr. 2014) (arguing that “sexual pleasure has value because of the pleasure it provides and apart from its ability to serve other ends such as emotional bonding or procreation”). Sex for pleasure and sex for procreation are not necessarily disaggregated, though in this Article the intent of sex for pleasure is pleasure itself, not procreation.


5. See infra Part III; see also Beth Burkstrand-Reid, The War on Sex for Pleasure, Huffington Post (May 16, 2012, 1:58 PM), http://www.huffingtonpost.com/beth-burkstrandreid/war-on-women_b_1521804.html (arguing that the “war on sex” targets both women and sex itself).

sexuality provokes in the collective consciousness. Increasingly, the State is the moral arbitrator of women’s sexual choices.

While the dialogue on sexual activity has long focused on abortion, more recent controversies have involved non-abortion reproductive health issues, such as contraception. These debates boil down to one question about every woman: when she has sex, is she acting as a “slut,” by having sex for pleasure, or as a “mother,” by having sex for procreation? The answer to this question has profound legal consequences for contraception policy, abortion rights, and even medical care during pregnancy. This Article argues that for women today, there is no such thing as sex for pleasure under the law: only sex for the purpose of becoming a mother is considered legitimate, and women’s sexual and reproductive health choices are regulated accordingly.

So if you are a woman, are you a “slut” or a “mother”? Given that nearly all women use contraception during their lifetime, there are a lot of “sluts”—women having sex without intending to procreate—out there. This Article argues that the law regulates women’s reproductive choices by re-conceptualizing all sexually active (or potentially sexually active) women as...


8. State Policy Trends: Abortion and Contraception in the Crosshairs, Guttmacher Inst. (Apr. 13, 2012), http://www.guttmacher.org/media/thenews/2012/04/13/index.html (“In the first three months of 2012, legislators in 45 of the 46 legislatures that have convened this year introduced 944 provisions related to reproductive health and rights. Half of these provisions would restrict abortion access.”).


11. See infra Parts II, III.

12. Robert D. Goldstein, Mother-Love and Abortion: A Legal Interpretation 13–16 (1988). This is not to say that puritanical notions of sexuality are new. See generally Gail Collins, America’s Women: Four Hundred Years of Dolls, Drudges, Helpmates, and Heroines (2003) (discussing the history of women, including women and sex).

mothers.\textsuperscript{14} Motherhood is not just a biological status; it is a socially constructed role with built-in behavioral expectations—including some surrounding sexuality—that are imposed on women.\textsuperscript{15}

In the context of abortion care, the State’s use of the law to regulate women’s reproductive choices is clear—focusing solely on abortion is a reductionist view of women, their health, and the State’s role in women’s lives.\textsuperscript{16} By broadly defining “mother” to include all women of reproductive age, the State is able to extend its reach over women’s reproductive lives and autonomous decisionmaking.\textsuperscript{17} Moreover, when a woman is pregnant, the State can assert its authority to prohibit abortion or use its power to regulate the choices of the “mother” in order to protect the fetus.\textsuperscript{18} These are but examples; the State regulates a woman’s entire reproductive lifetime, not simply specific points within it. This blinds us to opportunities to improve women’s health holistically and reduces women’s autonomy.

This Article argues that the law effectively re-characterizes women as mothers by (1) desexualizing women, or advancing the notion that women should only have sex for procreation,\textsuperscript{19} and (2) ritualizing women’s healthcare by viewing and treating women (pregnant or not) as “pre-mothers,” and using the law to impose medical and social practices associated with “good mothers” upon them.\textsuperscript{20} The law embodies both desexualization and ritualization in many aspects of the regulation of women’s sexuality. The presence of desexualization and ritualization in law and policy serves as a warning that the State is reaching into women’s health-related decisionmaking. This Article further argues that desexualization and ritualization can be mobilized as legal

\textsuperscript{14} Cynthia R. Daniels, At Women’s Expense: State Power and the Politics of Fetal Rights 26 (1993) (“In this legal and political discourse, women’s autonomy is traded against (and often traded away) by women’s right to reproductive choice.”). In the case of women who are already parenting, they are re-characte- rized as “mothers” of additional children-to-be, regardless of whether future pregnancy or parenting is desired. These women can still be “sluts” if they have sex for pleasure instead of sex for further procreation.


\textsuperscript{17} See infra Part II.

\textsuperscript{18} See infra Parts II, III.

\textsuperscript{19} For many, this means having sex within marriage, even if that is not the case in practice. Richard A. Posner, Sex and Reason 243 (1992).

\textsuperscript{20} Kimberly M. Mutcherson, Making Mommies: Law, Pre-Implantation Genetic Diagnosis, and the Complications of Pre-Motherhood, 18 Colum. J. Gender & L. 313, 337 (2008).
tools used to transform women into “mothers,” thus making their decisionmaking and their bodies fair game for regulation.

Part I of this Article examines the legal transformation of women into mothers by analyzing the conversion of “women’s health” to “maternal health” in abortion jurisprudence. Subpart A briefly examines the conceptualization of health generally, women’s health, and maternal health. It further details problems posed by the use of “maternal health” in the law as a descriptor for health issues faced by pregnant women. Subpart B argues that abortion jurisprudence is the exemplar for how the law co-opts women’s health and thus transforms even non-pregnant women into mothers.

Part II argues that in both the abortion context and beyond, sexual and reproductive health laws desexualize women, re-characterizing women’s desire to have sex for pleasure as an act of procreation instead, thus facilitating regulation of women’s health far beyond abortion. Subpart A defines desexualization as advancing the notion that women should only have sex for procreation, and examines its development in the law. Subpart B argues that desexualization begins before sex, through stigmatization of sexually active women, as the debate around the Affordable Care Act (“ACA”)—otherwise known as Obamacare—exemplifies. Subpart C uses the emergency contraception controversy to illustrate that once a woman has sex, she is assumed to have consented to the role of “mother,” thus allowing the woman to be legally treated as a mother and her health treated as “maternal health.”

Part III discusses the impact of ritualization in reproductive health law. Specifically, Part III focuses on how ritualization, in combination with desexualization, is mobilized in an attempt to control women’s reproductive decisionmaking. Subpart A defines ritualization as the use of medical experiences related to pregnancy and childbirth to influence the sexual and reproductive decisionmaking of women. Abortion laws mimic the rituals of obstetrical care, for example, as a way of pushing women toward motherhood. Subpart B examines how this ritualization occurs outside of the abortion context, specifically during a continuing pregnancy, an area subject to extensive—but under-examined—legal regulation.

Finally, Part IV theorizes that future laws will employ ritualization and desexualization to reduce women’s reproductive autonomy. Subpart A discusses the current use of desexualization and ritualization in current controversies in contraception regulation and abortion legislation. Subpart B

hypothesizes how future regulation of contraceptives may rest on desexualization and ritualization.

At its core, this Article theorizes that the law re-conceptualizes sexually active women, pushing them toward the role of a lifetime: motherhood. After all, using contraceptives, for example, is “a license to do things in a sexual realm that is counter to how things are supposed to be.” When women resist the role of mother, they face marginalization and stigmatization—and, in some cases, legal control of their decisionmaking.

I. Women’s Health Is Dead. Long Live Maternal Health

In 2006, the Centers for Disease Control and Prevention (“CDC”) recommended that all women of childbearing age take vitamins, abstain from certain behaviors such as smoking and heavy drinking, and monitor their weight, all to prepare for eventual motherhood. In essence, the government indicated that it viewed women as mothers-to-be. Women are transformed into mothers via government actions that are ostensibly designed to protect women’s health. We see this in regulatory contexts such as the CDC recommendations, as well as via various statutes and court decisions: the underlying questions are whose health is most important—the pregnant woman’s or the fetus’—and who gets to make that determination.

A. From Woman to Mother, Women’s Health to Maternal Health

Abortion jurisprudence provides the quintessential example of the legal conceptualization of women as mothers. We see this directly in Supreme Court rhetoric, which emphasizes “maternal” health despite the fact that not all sexually active women are mothers and not all women want to be mothers.

22. Turning women into “mothers” in the law via desexualization and ritualization may be intentional or an unintended result of broader social and legal policies.
23. Charles P. Pierce, Santorum’s War Against Women, Continued, Esquire (Jan. 3, 2012, 3:41 PM), http://www.esquire.com/blogs/politics/rick-santorum-contraception-6632083 (quoting Rick Santorum); see John Bancroft, Editorial: The Pill, Sex, and the Politics of Gender, Medical Aspects of Human Sexuality (Mar. 2002) (“The idea that [the pill] might allow unmarried women to enjoy sex free of fears of pregnancy was anathema to many physicians, and concern that it might ‘let loose’ the sexuality of married women was not far below the surface.”) (on file with Author).
27. Luker, supra note 3, at 193 (“[T]he abortion debate is so passionate and hard-fought because it is a referendum on the place and meaning of motherhood.”).
28. Elizabeth A. Reilly, The Rhetoric of Disrespect: Uncovering the Faulty Premises Infecting Reproductive Rights, 5 Am. U. J. Gender & L. 147, 157–58 (1996) (“[T]he United States Supreme Court has consistently viewed women through their reproductive capacity. Women have been subsumed into their reproductive organs. The woman as an independent person with interests and needs is invisible in the Court’s decisions: instead, law has treated women first and foremost as potential or actual mothers.”).
To understand the differences between health, women’s health, and maternal health, one may visualize a funnel. At the top of the funnel is the broadest category of “health,” a non-sex-specific term referring to “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Further into the narrowing funnel, we reach “women’s health,” which includes sex-specific health issues faced by women in their lifetime, including but not limited to concerns based on women’s unique sexual and reproductive capacity. Below women’s health is an even smaller subset of women’s health—some call it “maternal health”—which specifically relates to pregnancy, birth, and post-partum care. Only some women experience these health issues. Almost one in five women end their reproductive years without having a child, double the percentage in the 1970s.

When used in a legal context, the descriptor “maternal health” is often coupled with use of the term “mother” to refer to pregnant women. When these terms are used together, the woman’s health is no longer her own, but is tied up with the demands of motherhood even prior to childbirth. Thus, judicial use of the term “maternal health” when discussing pregnancy and childbirth is particularly problematic. Women’s health is often reduced to maternal health, a transformation with significant implications. Motherhood, after all, is not just a physical condition; it is also a social role. In other words, legal protections of maternal health are not just a means to keeping women healthy; they propel women toward accepting a mothering role. This role requires a woman to

29. World Health Org. [WHO], WHO Definition of Health, http://www.who.int/about/definition/en/print.html (last visited Oct. 8, 2013). Within its general “health” definition, the WHO includes the non-sex-specific concept of “reproductive health,” which concerns the functioning of “reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.” WHO, Health Topics: Reproductive Health, http://www.who.int/topics/reproductive_health/en (last visited Oct. 8, 2013).

30. See U.S. Nat’l Library of Med., Nat’l Insts. of Health, Women’s Health, http://www.nlm.nih.gov/medlineplus/womenshealth.html (last visited Oct. 8, 2013) (“Women have unique health issues. And some of the health issues that affect both men and women can affect women differently. Unique issues include pregnancy, menopause, and conditions of the female organs. Women can have a healthy pregnancy by getting early and regular prenatal care. They should also get recommended breast cancer, cervical cancer, and bone density screenings. Women and men also have many of the same health problems. But these problems can affect women differently.”).


33. See infra Part I.B.

34. See Reilly, supra note 28, at 157–58, 164-65. Abortion jurisprudence frequently contains paternalistic concern for women’s mental health, suggesting, for example, that women who have an abortion will regret their decision. Maya Manian, The Irrational Woman: Informed Consent and Abortion Decision-Making, 16 Duke J. Gender L. & Pol’y 223, 290 (2009).

subrogate her needs—sexual and otherwise—to the needs of her fetus or child.\textsuperscript{36} In reproductive health law, this means that the law focuses primarily on how the medical treatment of her body impacts her ability to fulfill her socially defined role as a mother.\textsuperscript{37}

Abortion jurisprudence often conceptualizes all women as mothers or potential mothers. Such laws push women toward “maternal” roles, even when women are clearly rejecting motherhood, and ignore the importance of sex for pleasure.\textsuperscript{38} Thus, abortion jurisprudence signals that to regulate women’s reproductive autonomy, the law conceptualizes them as mothers. The law does so often by invoking “maternal health” even when a woman attempts to avoid motherhood. This signals desexualization, the notion that women should only have sex for procreation, and ritualization, viewing and treating women (pregnant or not) as “pre-mothers” and using the law to impose medical and social practices associated with “good mothers” upon them.\textsuperscript{39}

\section*{B. Abortion and Motherhood Via Maternal Health}

In \textit{Roe v. Wade}, the germinal case confirming the right to have an abortion in some circumstances, the Supreme Court established a tripartite framework to judge the constitutionality of abortion restrictions.\textsuperscript{40} In the standard itself, the Court vacillates between treating the pregnant woman as a woman or as a mother; its conceptualization of the woman seeking an abortion is dependent upon the point at which she seeks to end the pregnancy.\textsuperscript{41} The woman remains a person separate from the fetus until the end of the first trimester: “For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician.”\textsuperscript{42} The woman is still seen, at this point, as a person experiencing a medical condition—pregnancy—not a woman occupying the socially defined role of mother.\textsuperscript{43}

However, at some point after the end of the first trimester, a “pregnant woman’s” health becomes “maternal health” in the rhetoric of the decision, suggesting that the woman is then a mother: “For the stage subsequent to

\begin{thebibliography}{99}
\bibitem{Mutcherson} See Mutcherson, supra note 20, at 337; infra Parts II, III.
\bibitem{40} 410 U.S. 113, 164–65 (1973).
\bibitem{Id. Roe} Id. Roe did not give women a positive right—the right existed naturally. Robin West, \textit{From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights}, 118 Yale L.J. 1394, 1403 (2009).
\bibitem{Roe} Roe, 410 U.S. at 164 (emphasis added).
\bibitem{But see} But see Lisa C. Ikemoto, \textit{Abortion, Contraception and the ACA: The Realignment of Women’s Health}, 55 How. L.J. 731, 762–64 (2012) [hereinafter Ikemoto, \textit{The Realignment of Women’s Health}] (arguing that abortion has been disconnected from women’s health).
\end{thebibliography}
approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. See Roe, 410 U.S. 164 (emphasis added). The Court’s use of the “mother” descriptor continues through the “stage subsequent to viability” when it says the State “may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” Roe, 410 U.S. at 164–65.

44. Roe, 410 U.S. at 164 (emphasis added). The Court’s use of the “mother” descriptor continues through the “stage subsequent to viability” when it says the State “may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” Roe, 410 U.S. at 164–65.


46. See Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution 42 (1995); Ikemoto, Code of Perfect Pregnancy, supra note 21, at 1285 (stating that reproduction-related regulations “devalue women as persons by characterizing women as wombs”).


48. Roe vests the decision to have an abortion—and how to have that abortion—not with the woman, but largely with her doctor. 410 U.S. at 164–65.

49. Id. at 120.

50. See, e.g., Jack M. Balkin, How New Genetic Technologies Will Transform Roe v. Wade, 56 Emory L.J. 843, 844 (2007); Reilly, supra note 28, at 159–160; see also infra Parts II, III.


came to a head in *Gonzales v. Carhart*, in which the Supreme Court upheld the federal partial-birth abortion ban even though it did not include an exception for the pregnant woman’s health.  

Although the very word choice in the *Roe* decision—the shift from “pregnant woman” to “mother”—showed that pregnant women were considered would-be mothers after the first trimester of pregnancy, *Gonzales* further propelled the conceptualization of all pregnant women as mothers. *Gonzales* explicitly invoked notions of maternal guilt to shame pregnant women seeking an abortion and change their minds.  The majority opinion says:

> Respect for human life finds an ultimate expression in the bond of love the mother has for her child. . . . Whether to have an abortion requires a difficult and painful moral decision. 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.  

The opinion continues:

> It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.  

> These passages emphasize that the Court views women as mothers before childbirth, that the role of “mother” impacts legal rights, and that the Court believes that motherhood should impact the choices women make.  

> It cannot be overemphasized that the metaphysical transformation of pregnant women into mothers in abortion jurisprudence was done to women who were actively attempting to avoid the motherhood role at that time.  

> When stripped to its core, sexual and reproductive health jurisprudence (abortion and beyond) is founded on what this Article labels desexualization.
and ritualization, both of which reinforce the notion, so apparent in abortion jurisprudence, that all women are or will be mothers and should be regulated (and should themselves act) as such. “Desexualization” is the mechanism by which the State expresses its moral disapproval of any type of sexual activity other than sex for parenthood and, as a corollary, treats even the actions of sexually active women (or women considering sexual activity) as tantamount to accepting motherhood. “Ritualization” is the legally sanctioned use of the rituals or rites of passage associated with continuing pregnancies to push women toward accepting motherhood and behaving as “good mothers” even to the detriment of their health or rights. Part II discusses the first of these tools, desexualization, and how it contributes to the law’s manufacturing of mothers.

II. Which Comes First: Sex or Motherhood? Law and Desexualizing Women

There is no doubt that many women enjoy sex, but are they supposed to? Desexualizing women through the law minimizes the importance, or even denies the existence, of women’s desire for sex for pleasure and then re-characterizes women’s sexual actions as implicit acceptance of motherhood. It is the age-old division of women into Madonnas and whores.

Although the right of women to access contraceptives was recognized decades ago, regulation of and access to contraceptives have again emerged as legal issues. Two examples of this are the controversy surrounding contraceptive coverage in the ACA, and the regulation of oral emergency contraceptives, also called the morning-after pill, or referred to by the brand names “Plan B” or “Plan B One-Step.” In both contexts, women are desexualized, their desire to have sex for pleasure is delegitimized, and sexual


60. Rosenbury & Rothman, supra note 1, at 809. But see Martha Chamallas, Consent, Equality, and the Legal Control of Sexual Conduct, 61 S. Cal. L. Rev. 777, 838 (1988) (“A list of acceptable inducements [to sex] would surely include procreation, emotional intimacy, and physical pleasure. Of these three inducements, procreation probably plays a less significant social role today than either intimacy or pleasure.”).

61. Stevi Jackson & Sue Scott, Sexual Skirmishes and Feminist Factions: Twenty-Five Years of Debate on Women and Sexuality, in Feminism and Sexuality: A Reader 3 (Stevi Jackson & Sue Scott eds., 1996).

62. See infra Parts II.B, C; see also Page, supra note 47, at 21 (asserting that some anti-abortion groups equate contraceptives and abortion).


64. See infra Part II.C.
activity is re-characterized as an affirmative step toward motherhood. And, once again, any act that casts a woman as a “mother” expands the State’s ability to intervene in her choices.

**A. Defining Desexualization**

A core aspect of conceptualizing women as mothers in the law is viewing them—and treating them legally—as people who should engage in sexual activity for the purpose of parenthood, not pleasure; this is desexualization. Desexualization consists of two actions: (1) shaming sex for pleasure and (2) reinforcing a norm that sex should be for the purpose of procreation or, for women more specifically, motherhood.

In society, motherhood and sexuality are in opposition. A woman’s success as a mother is defined in part by perceptions about her sexuality; some studies find that a less sexual mother is deemed to be a better mother. The legal question, then, is when does a woman actually become a mother: upon a child’s birth or sometime before? Abortion jurisprudence demonstrates that the law labels a woman as a mother and her health “maternal” well before birth. But as the debates raging about contraceptives show, a woman may be conceptualized as a mother even before sex.

The path to the desexualization of women in the law has been circuitous. For example, the Supreme Court has not been entirely prudish when it has confronted the issue of contraception, but that does not mean that it openly accepts sex for pleasure. Early on, members of the Court in Poe v. Ullman signaled that they recognized the importance of marital intimacy. The Court

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65. Reilly, supra note 28, at 204 (describing “the assumptions that women are morally responsible only when fulfilling traditional expectations of the mother-role”). “Desexualization” is used in many ways. See, e.g., Charles Winick, Desexualization in American Life 1–2 (1995) (recognizing that “changes were occurring in the social and sex roles, social structure, and popular culture” in the 1960s, when the book was written); Montemurro & Siefken, supra note 6, at 385 (using desexualization to refer to changes mothers experience post-partum); Wouters, supra note 59, at 726–28 (discussing desexualization in history, when sex was a duty and not for pleasure); see also Ellison v. Brady, 924 F.2d 872, 880 (9th Cir. 1991) (Title VII); Elizabeth F. Emens, Intimate Discrimination: The State’s Role in the Accidents of Sex and Love, 122 Harv. L. Rev. 1307, 1401 (2009) (Disability); Anthony C. Infans, The Internal Revenue Code as Sodomy Statute, 44 Santa Clara L. Rev. 763, 777 (2004) (Same-sex relationships); Morvareed Z. Salehpour, Election 2008: Sexism Edition: The Problem of Sex Stereotyping, 19 UCLA Women’s L.J. 117, 134–35 (2012) (Politics).


67. Montemurro & Siefken, supra note 6, at 385; Friedman et al., supra note 66, at 796–99.


69. Page, supra note 47, at 30 (“[C]hildren are an intended purpose of intercourse, and parents should therefore act to responsibly care for and protect their pre-born children.”).

took a step toward recognizing the importance of sex for pleasure in *Griswold v. Connecticut*, which confirmed that married persons had the right to use contraceptives. The *Griswold* Court said that “intimacy” had a role in the lives of married couples (and thus in the lives of married women) but, as the decision did not dwell on sex itself, the precedent focused on relationship building rather than pleasure. By focusing on the marital relationship, *Griswold* also impliedly served a shaming function against sexually active people who were not married.

Later, in *Eisenstadt v. Baird*, the Court jumped into law and sexuality with both feet by confirming that “whatever the rights of the individual to access to contraceptives may be, the rights must be the same for the unmarried and the married alike.” But again, the right did not focus on sex for pleasure. The Court’s discomfort with sexuality lingered in tone, calling sex by the euphemism “the physical act.” Shaming was not overt, but the Court’s discomfort with sexual activity was.

The inevitable successor to the contraception cases—abortion jurisprudence—shows how the seed of the Court’s discomfort with sexuality grew into desexualization and, eventually, would be expressed in legislation and jurisprudence. *Roe* obscured the significance of physical intimacy by implicitly shaming sexually active women who were not married. Women seeking an abortion were pushed toward accepting the role of mother.

*Roe’s* companion case, *Doe v. Bolton*, further cast women having sex outside of marriage as sexually suspect. In *Doe*, the Court went out of its way to establish that the “situation did not involve extramarital sex and its product,”

72. *Id.* at 482 (“This law, however, operates directly on an intimate relation of husband and wife and their physician’s role in one aspect of that relation.”); *see Law, supra* note 2, at 226; *see also* *Lawrence v. Texas*, 539 U.S. 558, 565 (2003) (“*After Griswold*, it was established that the right to make certain decisions regarding sexual conduct extends beyond the marital relationship.”).
73. *Griswold*, 381 U.S. at 498–99 (Goldberg, J., concurring) (“Finally, it should be said of the Court’s holding today that it in no way interferes with a State’s proper regulation of sexual promiscuity or misconduct.”).
76. The Court acknowledged, however, that sex for pleasure happened. *Id.* at 452–53 (“To say that contraceptives are immoral as such, and are to be forbidden to unmarried persons who will nevertheless persist in having intercourse, means that such persons must risk for themselves an unwanted pregnancy, for the child, illegitimacy, and for society, a possible obligation of support.”); *see also Lawrence*, 539 U.S. at 578.
78. *Roe v. Wade*, 410 U.S. 113, 120 (noting that Roe was not married); *id.* at 164 (stating the abortion decision “must be left to the medical judgment of the pregnant woman’s attending physician”).
79. *Id.* at 120, 164–65. *But see* *Posner, supra* note 19, at 333 (discussing the *Roe* decision as one supporting “morally indifferent sex”); *see Courtney Megan Cahill, Abortion and Disgust*, 48 Harv. C.R.-C.L. L. Rev. 409, 442 (2013) (discussing how abortion stigma relates to “shame associated with conduct that defines deeply rooted beliefs about women’s social and biological roles”).
implying that women who do not transgress that boundary are somehow more worthy of constitutional protection than those who do. The Court’s decision exemplifies how motherhood is treated as a “social institution,” one that facilitates the control of women: in this case, their sexuality.

Planned Parenthood v. Casey further retreated from Eisenstadt’s limited recognition of sex for pleasure. Although Casey recognizes that intimate decisionmaking relies to some degree on the availability of abortion, the decision, in part, grounded women’s right to choose abortion in their ability to succeed as workers. Sex and pregnancy were, at least in part, treated as economic issues and, at least impliedly, not issues of pleasure. Casey abandoned Roe’s trimester framework in favor of the amorphous “undue burden” standard. In Casey, the State interest in women’s health begins to become a veil for a more politicized interest—the pre-viable fetus. This interest in the pre-viable fetus further catapulted women toward motherhood.

The government’s ability to directly regulate sex was arguably curtailed by Lawrence v. Texas, in which the Supreme Court struck down a Texas sodomy statute, but Lawrence may have had as much—if not more—to do with preserving an individual’s interest in building intimate relationships than in an individual’s interest in sex in and of itself. Even as it discussed Casey, Lawrence tied the right to engage in homosexual conduct to “persons in a homosexual relationship.”

Gonzales, however, the relationship at issue turned from one between adults to one between the pregnant woman and her fetus, directly implicating motherhood. Gonzales linked women’s sexuality to the rights of the fetus and thus propelled women toward motherhood. Gonzales imbues the sexual act itself

81. Friedman et al., supra note 66, at 783.
82. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 856 (“The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.”).
83. Id.
84. Id. at 878–79 (retaining Roe’s life and health exceptions, using both “woman” and “mother,” and reaffirming Roe’s viability-related holding).
86. Casey, 505 U.S. at 878 (“To promote the State’s profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman’s choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. These measures must not be an undue burden on the right.”).
87. Lawrence v. Texas, 539 U.S. 558, 567 (2003) (“The statutes do seek to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals. This, as a general rule, should counsel against attempts by the State, or a court, to define the meaning of the relationship or to set its boundaries absent injury to a person or abuse of an institution the law protects.”); Kaplan, supra note 2 (arguing that Lawrence was less about sex and more about relationships).
88. Lawrence, 539 U.S. at 573–74 (emphasis added).
with the intent to parent: it warns women, addressing them as mothers, that they may regret ending “the infant life they once created and sustained” and cautioned that the woman’s health may suffer from a decision to abort. This so-called “fetal personhood” rhetoric implies that, once conceived, a fetus is a separate person with rights, thus, it has a mother. Women are told that they “should become instantaneously ‘motherly’ from the moment of conception.” This contributes to what some call “maternal-fetal conflict,” the purported clash of rights between a pregnant woman and the fetus. Thus, women remain desexualized, purportedly destined to be mothers and expected to behave as such. If the State “couldn’t stop growing numbers of women from climbing into the sexual driver’s seat, they could at least make the women’s drive more dangerous—by jamming the reproductive controls,” and courts facilitate that move.

B. Sluts or Mothers: “Pre-Pregnant” Women, Desexualization, and Obamacare

Sex conjures notions of unbridled passion but also of unconstrained power, especially when it comes to women having sex for pleasure. By using contraceptives, sexually active women gain some measure of legal autonomy by exhibiting power over their bodies and lives. However, there is a growing backlash against access to contraceptives, which reflects the view that “real women have babies”: they do not have sex for pleasure, which requires contraceptives; they only have sex for procreation, which does not. As these laws become more entrenched, women will continue to be desexualized through contraception policy, litigation, and regulation.

90. Id. Researchers have questioned the Court’s implication that women who have an abortion suffer from mental health problems as a result. See Vignetta E. Charles et al., Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence, 78 Contraception 436, 445–49 (2008) (finding that high-quality research has suggested few if any negative mental health differences between women who have and have not had abortions).
96. Cossman, supra note 70, at 24–25 (stating that “patrolling the borders” of when sex is and is not legitimate still took place after Roe); Klein, supra note 7, at 3; Friedman et al., supra note 66, at 783 (“As long as a woman’s sexuality remains in the family sphere and is channeled to procreation, it receives full legitimacy. When her sexuality is ‘uncontrolled’ it is seen as illegitimate and is criticized and penalized.”).
97. Valenti, supra note 25, at 151–52.
 Ninety-nine percent of sexually active women use contraception at some point in their lives, making its use “virtually universal” in the United States. More specifically, a survey of women conducted between 2006 and 2008 found that eighty-two percent of women have used oral contraceptives and ten percent have used emergency contraceptives—more than double the proportion of women who had used emergency contraceptives in 2002. According to the Guttmacher Institute, the “typical American woman” who wants two children must use some mechanism of contraception for three decades. The connection between contraception and women’s health, broadly defined, is clear: contraceptives reduce maternal mortality and improve maternal-fetal outcomes by preventing unplanned pregnancies. Contraceptives also have numerous other health benefits for women, including protection against certain cancers.

The morality of contraception—or of sex for pleasure—resurfaced dramatically recently due to the ACA mandate requiring “women’s preventive health care”—such as mammograms, screenings for cervical cancer, prenatal care, and other services—generally must be covered by health plans with no cost sharing” including “[c]ontraceptive methods and counseling.” This mandate infuriated some employers and state governments, which alleged that the mandate violated religious freedom by forcing some employers not qualified for a religious exemption under the ACA to cover health services—such as contraceptives—that conflict with their faith. Implicit in the

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98. Mosher & Jones, supra note 13, at 5 (stating that nearly one hundred percent of sexually active women ages fifteen to forty-four surveyed from 2006 to 2008 who have ever had intercourse with a man have at some point in their lifetime used contraceptives, natural or artificial).

99. Id.


102. Boston Women’s Health Book Collective, Our Bodies, Ourselves 225 (2011) [hereinafter Our Bodies, Ourselves].


objections is the notion that sex for pleasure should not be subsidized, suggesting that sex for procreation is the only appropriate type of sex. President Obama later offered compromises concerning the contraception mandate, attempting to assuage employers’ concerns, though those compromises did little to avert litigation over the validity of the ACA.

On one hand, the ACA contraception mandate can be seen as the quintessential government recognition that women do have sex for pleasure—and should be able to have sex for pleasure—without suffering from undesired consequences. The pushback on the ACA by other government actors, employers, media pundits, states, and individual lawmakers, however, emphasizes the vast the disapproval of women’s non-procreative sexuality.

One prime example: Sandra Fluke.

Fluke, then a law student at Georgetown University, was scheduled to testify before Congress on the importance of contraceptive coverage but was refused by the United States House Committee on Oversight and Government Reform. She later testified before a panel of House Democrats. Her testimony was followed by comments from media personality Rush Limbaugh:

What does it say about the college coed Susan Fluke [sic], who goes before a congressional committee and essentially says that she must be paid to have sex? What does that make her? It makes her a slut, right? It makes her a prostitute. She wants to be paid to have sex. She’s having so much sex she can’t afford the contraception. She wants you and me and the taxpayers to pay her to have sex. What does that make us? We’re the pimps.

By lobbying for contraceptive coverage, Fluke was “happily presenting herself as an immoral, baseless, no-purpose-to-her life woman,” attending an elite law school and becoming a lawyer was not a legitimate life purpose for a

HHS Mandate Information Central, Becket Fund for Religious Liberty, http://www.becketfund.org/hhsinformationcentral/ (last visited Sept. 8, 2013) (identifying 67 cases and more than 200 plaintiffs). The type of contraceptive objected to varies. FAQs: Becket Fund’s Lawsuits Against HHS, Becket Fund For Religious Liberty, http://www.becketfund.org/faq/#faq15 (last visited Oct. 23 2013) (“Although many of these institutions do not have objections to traditional contraception, all are opposed to abortion-inducing drugs, such as the ‘morning after pill’ and ‘week after pill.’ “)

105. Certainly, some women who use contraceptives are already mothers in that they have given birth to children. The analysis applies to these women, too, as they may be attempting to prevent additional pregnancies.


109. Id.

woman, and, if there was any legitimacy in that endeavor, the potential of any woman to have non-procreative sex overshadowed her accomplishments. Fluke was forced into the role of mother-in-waiting because she was assumed to be sexually active. And, the only legitimate “purpose to her life,” if she had sex, would be to procreate.

Limbaugh may have been the most famous talking head to address the contraception mandate, and his comments were histrionic at best, but he is far from the only prominent person to publicly decry the law. Company after company, school after school, state after state, and lawmaker after lawmaker fought contraceptive coverage, even directly challenging the value of sex for pleasure. Former presidential candidate Rick Santorum, the state of Nebraska, Hobby Lobby, and Domino’s Pizza are just a few.

Regardless of whether the asserted sexual authority of the religious right trumps the autonomy of women as the ACA winds its way through the courts, any failure to cover contraceptives—and, therefore, recognize sexuality—contributes to women’s desexualization in society. These attacks thus buttress entrenchment of desexualization by the State by eliminating resources that would allow women the ability to avoid or delay motherhood. This is the essence of desexualization.

The ACA controversy demonstrates that desexualization and its relationship with law and public policy begins long before pregnancy. But the contraception mandate controversy is merely a gateway to how law and policy express desexualization. Desexiousalization intensifies as a tool for transforming women into mothers when women have already had sex and are dealing with a potential consequence: pregnancy.

112. Becket Fund for Religious Liberty, supra note 104 (detailing lawsuits filed over the ACA mandate); Irin Carmon, Rick Santorum is Coming for Your Birth Control, Salon (Jan. 4, 2012, 6:30 PM), http://www.salon.com/2012/01/04/rick_santorum_is_coming_for_your_birth_control.
114. Preventative care is sometimes referred to as “[p]reconception and interconception care,” which are “health care services and supports that are provided prior to a pregnancy . . . designed to assure that women are healthy before conception in order to improve pregnancy-related outcomes.” Carolyn Mullen, The Affordable Care Act and Preconception Health, Pulse 9–10, Nov. 2011, available at http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Documents/Pulse_November11.pdf.
C. Motherhood the Morning After

Women trying to avoid pregnancy can use pre-intercourse contraceptives, some without a prescription and some, including oral contraceptives, with a prescription. There are also oral, post-coital contraceptives, sometimes called emergency contraception, the morning-after pill, or the brand names “Plan B” or “Plan B One-Step.” Recently, some emergency contraceptives were made available without a prescription, but availability was restricted on the basis of age. Efforts to make some emergency contraceptives available without a prescription and without age restrictions carried on for years and only recently achieved some success.

Emergency contraception does not implicate motherhood or maternal health: there is no “mother” involved. The concept of “maternal” health generally, and abortion more specifically, should have no bearing on the regulation of emergency contraceptives, which prevent—not end—pregnancy. Yet as the controversies surrounding the availability of emergency contraceptives show, engaging in intercourse may signal that a woman has accepted the role of mother, even as she tries to prevent motherhood.

Similar to pre-coital contraceptives, emergency contraceptives prevent pregnancy by stopping ovulation. Emergency contraceptives must be taken

115. Planned Parenthood, Birth Control Pills, http://www.plannedparenthood.org/health-topics/birth-control/birth-control-pill-4228.htm (last visited Oct. 6, 2013) (reporting that pills cost as much as $50 per month and a medical exam prior to getting them, at a cost of up to $250, may be necessary).


117. See News Release, Food & Drug Admin., FDA Approves Plan B One-Step Emergency Contraceptive for Use Without a Prescription for All Women of Child-Bearing Potential (June 20, 2013), available at http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm358082.htm [hereinafter FDA Approves Plan B One-Step Without Prescription] (saying Plan B One-Step was approved in 2009 for use by women age seventeen and over; the age was lowered to fifteen in April 2013).


119. See Mother Definition, supra note 10.


121. FDA Approves Plan B One-Step Without Prescription, supra note 117 (“The product contains higher levels of a hormone found in some types of daily use oral hormonal contraceptive pills and works in a similar way to these contraceptive pills by stopping ovulation and therefore preventing pregnancy.”). For general
quickly after intercourse in order to maximize efficacy. Although some antireproductive-rights advocates argue that emergency contraceptives may prevent a fertilized egg from implanting in the uterus, scientists say there is no evidence that emergency contraceptives function in that capacity. In other words, studies—and the Food and Drug Administration (“FDA”)—contend that emergency contraceptives do not end an established pregnancy. Still, some argue that emergency contraceptives are abortifacients. For example, the American Right to Life organization says that “the greatest danger of the ‘Morning After Pill’ is that it is designed to kill a child.”

In addition to the initial, prescription-only status of emergency contraceptives, access to the medications has been restricted in other ways. The federal government, until recently, restricted availability based on age. Additionally, pharmacists—and perhaps even others—may be allowed to refuse to dispense emergency contraceptives.

The sexuality of young women is perhaps the most feared sexuality of all as, in most cases, it is overtly sex for pleasure. It can also have massive, unintended ramifications in terms of unplanned pregnancy.


122. Pam Belluck, Abortion Qualms on Morning-After Pill May Be Unfounded, N.Y. Times (June 5, 2012), http://www.nytimes.com/2012/06/06/health/research/morning-after-pills-dont-block-implantation-sciente-suggests.html?pagewanted=all&_r=0 (asserting that the debate over how emergency contraceptives work has been largely resolved and that it is not an abortifacient, but discussing contrary views).


124. Id.; Belluck, supra note 122.

125. See FDA Approves Plan B One-Step Without Prescription, supra note 117 (“Plan B One-Step will not stop a pregnancy when a woman is already pregnant and there is no medical evidence that the product will harm a developing fetus.”); Belluck, supra note 122 (citing Mayo Clinic physicians, National Institutes of Health, and International Federation of Gynecology and Obstetrics officials as saying emergency contraception does not work post-fertilization).


128. See generally Sinikka Elliott, Not My Kid: What Parents Believe About the Sex Lives of Their Teenagers (2012) (discussing the disconnect between actual sexual activity and parental perceptions of it); Amy T. Schalet, Not Under My Roof: Parents, Teens, and the Culture of Sex (2011) (comparing U.S. attitudes toward teen sex with other countries); Deborah L. Tolman, Dilemmas of Desire: Teenage Girls Talk about Sexuality (2002) (discussing fear over girls’ sexuality); Valenti, Purity Myth, supra note 6 (discussing the harm girls face from lacking a comprehensive understanding of sexuality); In Brief: Fact Sheet, Facts on American Teens’ Sexual and Reproductive Health, Guttmacher Inst. (June 2013), http://www.guttmacher.org/pubs/FB-ATSRH.html (reporting that fewer than two percent of adolescents
In 2011, Department of Health and Human Services Secretary Kathleen Sebelius refused to follow the guidance of FDA staff, who recommended that Plan B One-Step be made more widely available to young women without a prescription. 130 She rejected the recommendations of her own agency and said that there was insufficient proof that young women could understand how to use the drug or the consequences of its use.131 Ultimately, her actions were called “obviously political” by a federal district court judge, who ordered the FDA to “make levonorgestrel-based emergency contraceptives available without a prescription and without point-of-sale or age restrictions.”132

Eventually, after the Second Circuit denied in part the government’s request for a stay pending appeal, the Obama administration capitulated: Plan B One-Step was made available without a prescription or point-of-sale restrictions regardless of a woman’s age (assuming that a woman can afford it and is not otherwise obstructed from accessing it).133 Obstructions, however, are likely;

younger than twelve are sexually active, sixteen percent by age fifteen, one-third by age sixteen, and that 750,000 teens between fifteen and nineteen years old get pregnant each year. A minor’s right to access contraceptives has long been controversial, as is seen in the fragmented decision in Carey v. Population Control Servs. Int’l, 431 U.S. 678 (1977), and discussed in Angela Patterson, Carey v. Population Services International: Minors’ Right to Access Contraceptives, 14 J. Contemp. Legal Issues 469 (2004); see also State Policies in Brief, Minors’ Access to Contraceptive Services, Guttmacher Inst. (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf.

129. Teen Pregnancy Prevention, Nat’l Conference of State Legislatures, http://www.ncsl.org/issues-research/health/teen-pregnancy-prevention.aspx (last visited Oct. 6, 2013) (“Teenage mothers are less likely to finish high school and are more likely than their peers to live in poverty, depend on public assistance, and be in poor health. Their children are more likely to suffer health and cognitive disadvantages, come in contact with the child welfare and correctional systems, live in poverty, drop out of high school and become teen parents themselves. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, the annual public cost of teen childbearing—due to higher costs of public health care, foster care, incarceration and lost tax revenue—is nearly $11 billion.”).


133. Tummino v. Hamburg, No. 13-1690, 2013 WL 2435570, at *1 (2d Cir. June 5, 2013) (“Insofar as the district court order requires Appellants to immediately provide over-the-counter access to the one-pill variants of emergency contraceptives, a stay, pending appeal, is granted. Insofar as the order mandates immediate over-the-counter access to the two-pill variants of emergency contraceptives, a stay is denied because the
despite the non-prescription status and lack of age restrictions for Plan B One-Step, pharmacists have already said they may continue to keep it behind the counter and limit access by age.\textsuperscript{134}

From a policy perspective, the regulation of emergency contraception for minors exposes a paradox. If we break down desexualization, we see that it involves two steps: (1) a shaming of sex for pleasure, and (2) a push toward motherhood. The first move of desexualization may seem appropriate when it comes to young women.\textsuperscript{135} However, taking the second step and pushing young women toward motherhood is counterintuitive. Once unprotected sex has occurred, opponents of non-prescription emergency contraceptives for younger women appear to fear the possibility of promiscuity among young women more than they fear teen pregnancy, even though studies show the availability of emergency contraceptives does not increase sexual activity.\textsuperscript{136} This is remarkable; once they have sex, young women were—and arguably still are—pushed toward motherhood seemingly as a punishment either for failure to use contraceptives or for being sexually active at all.\textsuperscript{137} This is desexualization. Whether young or not, women are not to have sex for pleasure and, if they do, they are deemed to have accepted the role of mother, no matter their age.

Government actions to limit the availability of emergency contraceptives propel women toward motherhood and do so without providing health information related to pregnancy. Sebelius, for example, said that young girls might not understand the Plan B One-Step label, justifying limitations on its availability.\textsuperscript{138} Her actions suggested that young women could not make good


\textsuperscript{135} \textit{But see} Valenti, \textit{Purity Myth}, supra note 6, at 9–10 (arguing that the focus on virginity discourages girls from safe expressions of sexuality).


\textsuperscript{137} \textit{See} supra note 136. \textit{See generally} Valenti, \textit{Purity Myth}, supra note 6 (discussing how girls are taught to fear their sexuality).

\textsuperscript{138} \textit{Compare} Hamburg Statement, supra note 131 (“[Plan B One-Step] was safe and effective in adolescent females, that adolescent females understood the product was not for routine use, and that the product would not protect them against sexually transmitted diseases. Additionally, the data supported a finding that adolescent females could use Plan B One-Step properly without the intervention of a healthcare provider.”), \textit{with} Sebelius Statement, supra note 130 (“the actual use study and the label comprehension study
health decisions related to contraception, but at the same time, young women’s ability to make good health decisions related to pregnancy—which carries with it health risks, too—were not discussed in her statement, thus undermining any argument that the Plan B One-Step restriction was intended as a health protection.\textsuperscript{139} Her invocation of girls’ health to deny access to emergency contraceptives was particularly disingenuous given that the drug was still available to girls by prescription.\textsuperscript{140} According to prominent physicians, “[a]ny objective review makes it clear that Plan B is more dangerous to politicians than to adolescent girls.”\textsuperscript{141} We will see this misleading use of women’s health against women’s autonomy again in the context of abortion and cesarean sections.\textsuperscript{142}

Moreover, some states have enacted laws that allow some healthcare providers to deny women access to reproductive health services.\textsuperscript{143} These laws were first passed in response to Roe and allow medical providers, among other actions, to refuse to dispense drugs that may conflict with their moral or religious beliefs.\textsuperscript{144} Changes in the way that emergency contraceptives are dispensed may lessen the potential impact of pharmacist refusal. However, opportunities for pharmacists and other employees of retailers that sell Plan B One-Step to obstruct access will undoubtedly still exist.\textsuperscript{145} Refusing to dispense emergency contraceptives is tantamount to declaring a sexually active woman to be “pregnant,” and thus a mother, the instant she has sex.\textsuperscript{146} Women are explicitly desexualized through these clauses. When healthcare providers refuse to dispense emergency contraceptives, they push women toward motherhood, often with State support.\textsuperscript{147}

\textsuperscript{139} See generally Heidi Murkoff & Sharon Mazel, What to Expect When You’re Expecting (2008) (discussing various health risks women face when pregnant).
\textsuperscript{142} See infra Part III.
\textsuperscript{144} Id.; see Burkstrand-Reid, The Invisible Woman, supra note 51, at 114–22.
\textsuperscript{145} Kim, supra note 134.
\textsuperscript{146} Id. See Pharmacy Refusals 101, Nat’l Women’s Law Ctr. (Apr. 24, 2012), http://www.nwlc.org/resource/pharmacy-refusals-101 (“In Milwaukee, Wisconsin, a mother of six went to her local Walgreens with a prescription for emergency contraception. The pharmacist refused to fill the prescription and berated the mother in the pharmacy’s crowded waiting area, shouting ‘You’re a murderer! I will not help you kill this baby . . . ’ She subsequently became pregnant and had an abortion.”).
\textsuperscript{147} Some people even feel so strongly that all sex is procreative that they think women who are sexually assaulted should welcome the role of motherhood even if it is—literally—forced up on them. John Avlon, GOP Policy is the Scandal, Not Just Akin’s Comments, CNN (Aug. 21, 2012), http://www.cnn.com/2012/08/21/opinion/avlon-akin-gop/index.html; Mark Memmott, “God Intended”
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Whether expressed by a private employer or by a government official, desexualization is identifiable in the law. When it came to the ACA, we saw desexualization by public and private actors challenging the mandated coverage of contraceptives. In terms of emergency contraception, we see desexualization in the actions of regulatory officials. In both contexts, desexualization is used to propel women toward motherhood. As a consequence, women are impliedly told prior to intercourse that sex is only sanctioned if it is done for the purposes of becoming a parent, thus further facilitating the legal regulation of sexual and reproductive decisionmaking.

III. The Curious Disappearance of the Pregnant Woman: Using Rituals to Promote Motherhood

Motherhood is treated as a “female rite of passage” that marks a woman’s value and status. For a woman, rejecting motherhood is tantamount to rejecting her core societal role. Using contraceptives is counter to the role women are supposed to play.

Whether a woman seeks to end a pregnancy or to continue it, desexualization continues through the regulation of women’s sexual and reproductive health. After all, a less-sexual woman may be seen as a better mother. But being pregnant does not necessarily mean that one will become a “mother,” let alone the good, all-sacrificing mother that society demands. Manufacturing mothers after conception also requires what this Article calls ritualization: first, making pregnant women seeking an abortion participate in the same medical rituals that women continuing pregnancies are directed to undertake, and second, for women who decide to continue their pregnancy, using their participation or lack of participation in certain rituals to indicate whether they will be “good mothers.” Desexualization and ritualization work in tandem in reproductive health law to cast women as mothers.


150. Id. at 231.

151. Robbie E. Davis-Floyd, Birth as an American Rite of Passage 61 (2003).

152. Friedman et al., supra note 66, at 796–99.
A. Locating and Defining Ritualization

“Good motherhood” is derived from a cultural script telling women how to be mothers.153 This script requires women to relegate their sexuality to the periphery.154 Rituals bring women into the norms of pregnancy and motherhood.155 Women may be coerced into participating in what are typically treated in continuing pregnancies as bonding rituals associated with “good motherhood.”156 In the context of abortion, by requiring women to interact with providers multiple times or see an ultrasound, the law tries to compel them to accept the role of mother.157 Likewise, women are told by society and the legal system that to be a “good mother” they must participate in a medicalized birth and may be legally punished if they do not.158

This Part examines how ritualization underpins the regulation of pregnant women’s sexual and reproductive health decisionmaking and thus undermines women’s autonomy once a woman is pregnant.159 Ritualization occurs both in the context of abortion and in the context of a continuing pregnancy, from prenatal care to childbirth. In both, we see examples of how Roe and its progeny have been mobilized to facilitate the State’s purported interest in “maternal” health and fetal life, which thinly veils how the law pushes women toward motherhood.160

153. McMahon, supra note 149, at 27.
154. Montemurro & Steffen, supra note 6, at 366; Tardy, supra note 6, at 462–63.
155. Lisa M. Mitchell, Baby’s First Picture: Ultrasound and the Politics of Fetal Subjects 174 (2001); Geoffrey P. Miller, The Legal Function of Ritual, 80 Chi.-Kent L. Rev. 1181, 1181, 1189–90 (2005) ("Rituals . . . speak to people’s core emotions and reveal values that a society holds dearest. Because their expression is conventional and obligatory, they join the individual in solidarity with the group. . . . Rituals are enacted at key transitions in a person’s life when he or she is likely to be receptive to influences on identity. These transitions include life crises such as . . . pregnancy, parenthood, or death of a loved one. People are likely to be more receptive to influence in these situations because the circumstances tend to be charged with emotion and because these are occasions where identities are changing.").
156. See generally Carol Sanger, Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice, 56 UCLA L. Rev. 351, 382–83 (2008) [hereinafter Sanger, Seeing and Believing]. There are countless rituals in the medicalized birthing process today. Davis-Floyd, supra note 151, at 73–153 (listing, for example, the use of wheelchairs, separation from partners, use of hospital gowns instead of personal clothing, enemas, hospital beds, and fasting).
159. Using abortion jurisprudence to directly or implicitly justify intervention in women’s reproductive lives is a “serious distortion” of Roe. Janet Gallagher, Prenatal Invasions & Interventions: What’s Wrong with Fetal Rights, 10 Harv. Women’s L.J. 9, 15 (1987); see Kim Shayo Buchanan, Lawrence v. Geduldig: Regulating Women’s Sexuality, 56 Emory L.J. 1235, 1291 (2007) (“[T]he courts of appeals of two circuits have imported the ‘undue burden’ standard to adjudicate the equal protection rights of pregnant women in cases that have nothing to do with any countervailing state interest in protecting fetal life.").
The number and type of abortion-related laws are extensive and continue to increase.\textsuperscript{161} Some of these laws contain an insidious aspect: they replicate the rituals of prenatal care but with the goal of stopping women from exercising their right to have an abortion. Examples of common abortion laws that both limit access to abortion care and replicate prenatal care are forced ultrasounds, biased counseling, and mandatory delay laws, which operate together to ritualize abortion services.

1. Forced Ultrasounds\textsuperscript{162}

Perhaps the most powerful ritual in a continuing pregnancy is displayed on a screen and subsequently carried in the pockets and purses of mothers-to-be. This is the ultrasound, the first visual representation of a fetus.\textsuperscript{163} Ultrasounds have become a rite of passage for a pregnant woman.\textsuperscript{164} This prenatal ritual is one of many legal tools that anti-reproductive-rights advocates use to push women seeking abortions toward motherhood.\textsuperscript{165}

Ultrasound use is virtually unregulated in the United States, and the research on the safety and efficacy for both the pregnant woman and fetus is limited.\textsuperscript{166} Even in a continuing pregnancy, ultrasounds are medically indicated only in limited circumstances.\textsuperscript{167} Ultrasounds in a continuing pregnancy can be used to confirm that the pregnancy is viable, determine the date of gestation and the number of fetuses, and to determine whether there may be problems with the fetus.\textsuperscript{168} During the ultrasound process, women may hear a fetal heartbeat and may leave their provider’s office with a printout of a bean-sized image to share with friends and family.\textsuperscript{169} Despite the popularity of this ritual,
The ultrasound process and resulting “picture” are misleading; especially early in pregnancy, it is likely that “the ultrasound image has been magnified and the heartbeat amplified.” Studies show that most couples need help even interpreting the fetal image. So why is that black-and-white printout so powerful? Quite simply: the act of holding that picture defines the holder—a parent.

There are limited medical reasons to require an ultrasound for a first-trimester abortion. Some providers perform ultrasounds voluntarily, however, while others are forced by law to either perform them or to give information about them prior to providing an abortion. Regardless of whether the ultrasound is mandated by law or performed at the direction of the provider, ultrasounds push women toward motherhood.

Some states do not require a provider to perform an ultrasound but require providers to offer to display the ultrasound screen if one is performed. In some states, the law forces a woman seeking an abortion to have an ultrasound—regardless of her or the provider’s wishes—and may require the provider to offer to show the image to the woman. State laws with the most “force” require providers to perform an ultrasound, display the image, and describe what is on the screen, presumably on the patriarchal assumption that women having an abortion have not thought their choice through.

Ultrasound laws are often veiled in medical terms and are described as a type of “informed consent.” Informed consent in medicine, generally, is

or see your baby kick on the ultrasound screen.”); Kukla, supra note 25, at 70–74 (describing ultrasounds as being “social” events).


171. Mitchell, supra note 155, at 5.

172. 10 Ways to Bond With Your Bump, Babycentre (last updated Oct. 2011), http://www.babycentre.co.uk/a1049630/10-ways-to-bond-with-your-bump#ixzz2GwTNBrxGD (“Having a picture of your baby’s scan on your phone or on your fridge door is a constant reminder that your bump is home to a little person.”).


179. See, e.g., Tex. Med Providers Performing Abortion Servs., 667 F.3d at 582; La. Rev. Stat. Ann. § 40:1299.35.2(D)(2)(d) (requiring women to fill out a form indicating that they’ve been given the opportunity
designed to be a health protection for patients, but the use of ultrasounds and the required dialogue surrounding their use prior to abortion is intended to push women toward motherhood. Even if forced ultrasounds are constitutionally permissible, their purported constitutionality does not make them any more medically necessary or any less political.

Mandating ultrasounds in the context of abortion care uses a major ritual of a continuing pregnancy in an attempt to trigger “maternal” bonding, prompt “maternal” guilt, and prevent abortion. The very process of getting an ultrasound is part of the ritual of a continuing pregnancy: the cleaning of the stomach, the movement of the ultrasound wand, lying down on what may feel like a delivery table, lights dimmed and screen bright. It is in similar circumstances when, later in a continuing pregnancy, women may find out the sex of the baby and have the first glimpse of fetal body parts and the twists and turns of the fetus in utero. As such, the law tries to turn them into mothers; ultrasounds put the pregnant woman in a place very similar to where she might be in a much later point in pregnancy, one at which, hypothetically, she has accepted motherhood. It is a thinly “veiled attempt to personify the fetus and dissuade a woman from obtaining an abortion.”

2. Biased Counseling/Informed Consent and Mandatory Delay/Waiting Periods

While the use of forced ultrasounds may be the most obvious way that a ritual of continuing pregnancy is used to push women seeking an abortion into motherhood, ritualization is used in other ways in the context of abortion. Although more subtle, some counseling and informed consent provisions regulating abortion also signify ritualization and further thrust women toward motherhood.

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to see the “unborn child” and listen to a heartbeat); Sonia M. Suter, Bad Mothers or Struggling Mothers?, 42 Rutgers L.J. 695, 700 (2011).
180. Suter, supra note 179, at 700.
182. Sanger, Seeing and Believing, supra note 156, at 382–83.
183. Mitchell, supra note 155, at 3; Michelle Chen, It's Not Just Forced Ultrasound: Abortion Rights Under Assault, Salon (Oct. 21, 2012, 12:00 PM), http://www.salon.com/2012/10/21/its_not_just_forced_ultrasound_abortion_rights_under_assault. Furthermore, given the high percentage of women having abortions who are already mothers, by replicating the ultrasound ritual, the law has compelled women to experience a significant ritual in “maternal” healthcare and “motherhood,” one which they may be familiar with as biological mothers. Lauren Sandler, The Mother Majority: Women with Children Have More Abortions than Anyone Else, and By an Increasingly Wide Margin. So Why is the Topic Taboo?, Slate (Oct. 17, 2011, 4:34 PM), http://www.slate.com/articles/double_x/doublex/2011/10/most_surprising-abortion_statistic_the_majority_of_women_who_termination.html.
185. Chiné Turner Richardson & Elizabeth Nash, Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials, 9 Guttmacher Pol'y Rev. 4 (2006) (“In some cases, the state goes so far as to include information that is patently inaccurate or incomplete, lending credence to the charge that states’
The State may express anti-abortion viewpoints by forcing medical providers to convey information that goes beyond traditional informed consent requirements. 186 Thirty-five states require that women receive some type of counseling prior to having an abortion; twenty-seven specify what the information must include, and that information is often biased or inaccurate. 187 These laws are often described as “informed consent” laws, a label that disingenuously implies that they replicate the counseling that takes place before all medical procedures when, in fact, the information provided goes far beyond that. This is why pro-choice advocates sometimes call them “biased counseling” laws. 188 For example, South Dakota forces providers to give misleading information that says having an abortion puts women at increased risk of committing suicide. 189 Wisconsin requires that the materials offered to a woman include “[photographs, pictures or drawings, that are designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at 2-week gestational increments.” 189 Some states even provide inaccurate information on the impact an abortion can have on future fertility, 191 and the discredited theory that there is a link between abortion and breast cancer. 192

To understand how biased counseling constitutes ritualization at the time of an abortion, one must first understand how health care is delivered during a

abortion counseling mandates are sometimes intended less to inform women about the abortion procedure than to discourage them from seeking abortions altogether.”.

186. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 882–83 (1992) (“If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible . . . [R]equire that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden.”).

187. State Policies in Brief: Counseling and Waiting Periods for Abortion, Guttmacher Inst., http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (last visited Oct. 6, 2013) [hereinafter Counseling and Waiting Periods for Abortion]. Counseling may be oral or written, in person or not. Id; see Caroline Mala Corbin, The First Amendment Right Against Compelled Listening, 89 B.U. L. Rev. 939, 1000–11 (2009) (arguing that women have a right to not listen to abortion-related counseling).


189. Planned Parenthood Minn., N.D., & S.D. v. Rounds, 686 F.3d 889, 905 (8th Cir. 2012); Spurious Science Triumphs as U.S. Court Upholds South Dakota “Suicide Advisory” Law, Guttmacher Inst. (July 27, 2012), http://www.guttmacher.org/media/inthenews/2012/07/27/index.html (quoting the American Psychological Association as saying, “the best scientific evidence indicates that the relative risk of mental health problems among adult women who have an unplanned pregnancy is no greater if they have an elective first-trimester abortion than if they deliver the pregnancy”).


191. Counseling and Waiting Periods for Abortion, supra note 187 (listing Arizona, Kansas, North Carolina, South Dakota, Texas, and West Virginia).

192. Id. (listing Alaska, Kansas, Mississippi, Oklahoma, and Texas).
typical pregnancy. In an ideal prenatal care setting, when a woman chooses to continue a pregnancy, her interaction with a medical professional begins immediately. In addition to confirming the pregnancy, the first visit typically involves the taking of a medical history, a physical exam, some laboratory tests, a lot of talk about what is to come in the next several months, and ways for the pregnant woman to stay healthy during the pregnancy.  

Biased counseling laws are an attempt to replicate that prominent ritual of pregnancy: visits to a trusted healthcare provider. But abortion “informed consent” statutes do nothing of the kind; they twist the woman’s medical confidant into an ideological advocate, whether or not the provider agrees. As a consequence, a woman’s trust in her provider is used against her.

Admittedly, when a pregnancy is to be terminated, a woman’s relationship with the provider is more truncated than the relationships women have with their providers in an ongoing pregnancy. Nonetheless, by requiring biased counseling, the State pushes healthcare providers to exert power over a woman seeking to end a pregnancy. The power a practitioner has over a pregnant woman, whether she is ending or continuing her pregnancy, is immense and is badly misused when counseling is biased, especially when that provider is forced to provide erroneous health information. But biased counseling is not the only example of ritualization in pregnancy. Mandatory delay laws, which require time to pass between an initial consultation and the abortion, also mimic the care provided in a wanted pregnancy.

Monthly visits to a medical provider are one of the rituals of an ongoing pregnancy. The wait between each visit provides time for the pregnant woman (transformed into a mother) to bond with the fetus and to contemplate motherhood. This process is mirrored to a limited extent by laws that mandate delay between a woman’s decision to have an abortion and the procedure itself. In twenty-six states, a woman has to wait one or more days between the time she seeks an abortion and the time an abortion is performed,

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195. Richardson & Nash, supra note 185.
196. La. Rev. Stat. Ann. § 40:1299.35.6(A)(4)(c) (“The vast majority of all abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for postsurgical care. In most instances, the woman’s only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision.”).
198. Vandewalker, supra note 188, at 6–33.
199. See generally Murkoff & Mazel, supra note 139 (describing monthly prenatal visits).
and several states mandate two visits to the abortion provider.\textsuperscript{201} A woman terminating a pregnancy is required to take the time to think about and bond with her “unborn child,” as if she had not already seriously considered her decision to have an abortion before going to visit her provider.

Forced ultrasounds, biased counseling, and mandatory delay laws replicate rituals that take place during the process preceding childbirth for the purpose of making women accept the role of mother, and thus impede women’s access to abortion. The information presented to the woman—via ultrasound, orally, or in writing—is designed to create a hierarchical relationship with a medical professional who then may be required to provide information designed to induce women to feel like a mother through these rituals and create feelings of guilt about choosing not to be a mother. If a woman does not change her mind, she is rejecting “a five-thousand-year-old tide of conditioning, of social agendas propounded by churches and other male-dominated institutions, that say that a woman’s primary purpose is to have children and to serve her children and her husband.”\textsuperscript{202}

B. The Patient Mother

One might think that once a woman accepts the responsibility of childbirth, the State would cease to intervene. But “choice” is not just about abortion. Pregnancy and the birth process are filled with a vast number of options regarding how birth will take place.\textsuperscript{203} And the law frequently influences what choices women make as mothers, as we see through the ritualized practices in the ongoing pregnancy.

In the context of childbirth, ritualization involves a woman engaging the rituals of a medicalized pregnancy and birth process, primarily the rituals involved in standard obstetric care and hospital birthing.\textsuperscript{204}

By ‘medicalizing’ birth, i.e. separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman’s state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must equally be altered. The result is that it is no longer possible to know what births would have been like before these manipulations. Most health care providers no longer know what

\textsuperscript{201} Counseling and Waiting Periods for Abortion, supra note 187. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 885–87 (1992) (upholding a twenty-four hour waiting period). Although some states require a mandatory delay of less than twenty-four hours, the practical impact of the delay is likely to make the woman have to return to the provider the following day.

\textsuperscript{202} Christiane Northrup, Women’s Bodies, Women’s Wisdom: Creating Physical and Emotional Health and Healing 388 (2010).

\textsuperscript{203} Murkoff & Mazel, supra note 139, at 21–31.

\textsuperscript{204} This Article asserts that ritualization is reflected in the broader trend of medicalization, the “process of turning . . . people into patients . . . It leads people to have too much treatment—and some of them are harmed by it.” H. Gilbert Welch, Opinion, The Medicalization of Life, L.A. Times (Mar. 15, 2010), http://articles.latimes.com/2010/mar/15/opinion/la-oe-welch15-2010mar15.
‘non-medicalized’ birth is. The entire modern obstetric and neonatological literature is essentially based on observations of ‘medicalized’ birth.\textsuperscript{205} Although women can give birth in a variety of settings, they do so overwhelmingly in hospitals and with physicians, though options for other birth attendants exist.\textsuperscript{206} In the United States there is a “veritable mandate” that babies be born in hospitals—and nearly all are.\textsuperscript{207} This is due, in part, to the increasing number of medical technologies that are presented as necessary for a safe labor process: fetal monitors and intravenous medicines, among other interventions, are part of the birth ritual.\textsuperscript{208} Given all of the technology now available for use during the labor process, its use is expected; women who refuse modern locations, modern interventions, or who forsake “scientific” (that is physician) advice risk being seen as selfish, the hallmark of a “bad mother.”\textsuperscript{209}

Some degree of medicalization within the narrow relationship between a pregnant woman and her practitioner is expected. But our legal regime may go above and beyond the typical provider-patient relationship by dictating where, how, and with whom women may labor.\textsuperscript{210} Why do we see ritualization in the law and social dictates regarding what constitutes a good pregnancy and birth?\textsuperscript{211} Is it a symptom of industrialization and our societal obsession with new technologies?\textsuperscript{212} Is it a sign not only of State intervention but also our lawsuit-happy society, with doctors choosing to intervene rather than assume legal risk?\textsuperscript{213} Or might the State’s push to use the rituals of medicalized birth reflect a distrust of women’s reproductive capacity, a view “of the female body as an inherently defective machine?”\textsuperscript{214} The answer is unknown.

\begin{itemize}
\item \textsuperscript{206} Joyce A. Martin et al., Dep’t of Health & Human Servs., Births: Final Data for 2011, 62 Nat’l Vital Statistics Reports 1, 12 (2013).
\item \textsuperscript{207} Heather Joy Baker, “We Don’t Want to Scare the Ladies:” An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process, 31 Women’s Rights L. Rep. 538, 553 (2010); see supra note 206.
\item \textsuperscript{208} Murkoff & Mazel, supra note 139, at 362–99.
\item \textsuperscript{209} See Kulka, supra note 25, at 74 (discussing “birth as a maternal achievement test”); Baker, supra note 207, at 553. See generally Susan Goldberg, \textit{Medical Choices During Pregnancy: Whose Decision is it Anyway?}, 41 Rutgers L. Rev. 591 (1989) (discussing efforts to compel pregnant women to undergo treatments against their wishes). Blaming the woman for all ills that befall her baby is not new; for example, people used to believe that “if you looked at ugly things, you’d have an ugly baby.” Tara Parker-Pope, \textit{Lessons from the History of Childbirth}, N.Y. Times (Well) (Feb. 5, 2010, 10:28 AM), http://wellblogs.nytimes.com/2010/02/05/the-history-of-childbirth. For a discussion of the “bad mother” in law, see generally Marie Ashe, \textit{The “Bad Mother” In Law and Literature: A Problem of Representation}, 43 Hastings L.J. 1017 (1992).
\item \textsuperscript{210} The tort system may impact obstetrical practice. Sheila Kitzinger, The Complete Book of Pregnancy & Childbirth 56 (2011); Davis-Floyd, supra note 151, at 48.
\item \textsuperscript{211} Jennifer Block, Pushed: The Painful Truth About Childbirth and Modern Maternity Care 6 (2007); Davis-Floyd, supra note 151, at 48.
\item \textsuperscript{212} Block, supra note 211, at 6, 39–40.
\item \textsuperscript{213} Id. at 43; Davis-Floyd, supra note 151, at 48.
\item \textsuperscript{214} Davis-Floyd, supra note 151, at 72.
\end{itemize}
The State controls pregnancy and labor by propelling pregnant women toward a birth marked by a standard set of medical rituals. Specifically, it adopts laws and allows legal interventions that (1) limit what type of medical professional can attend childbirth, (2) limit the locations of birth labor, and (3) limit the methods women use to give birth. All of these exemplify how women are expected to participate in the ritualization of pregnancy, the propulsion of those women toward “good motherhood,” and the consequences to women who do not participate in these rituals.  

1. Attending Birth

Among the most important decisions a woman approaching childbirth can make is the choice of who, if anyone, will provide medical attention to her and the child at birth. This choice is circumscribed by legal restrictions limiting the number of acceptable choices available to a “good mother.”

In medicalized birth the doctor is always in control while the key element in humanized birth is the woman in control of her own birthing and whatever happens to her. No patient has ever been in complete control in the hospital—if a patient disagrees with the hospital management and has failed in attempts to negotiate the care, her only option is to sign herself out of the hospital. Giving women choice about certain maternity care procedures is not giving up control since doctors decide what choices women will be given and doctors still have the power to decide whether or not they will acquiesce to a woman’s choice.

More than eighty-six percent of all hospital births are attended by physicians, who are often criticized as being proponents of medicalized birth. A recent trend in birth choice in the United States is to eschew the services of a physician and use alternative providers—midwives—to facilitate a kinder, more gentle birth. There are several types of midwives, and each has different legal status, degree of legal regulation, educational requirements, and type of organization. Even though many Certified Nurse Midwives, one type of midwife, practice in hospitals, they are seen by some as a viable alternative to the medicalization of birth. Still, many fewer hospital births are attended by midwives as compared with physicians, even though studies

216. Wagner, supra note 205, at 826.
217. Martin et al., supra note 206, at 12; Block, supra note 211, at 263.
218. This is not to say that all physicians subscribe to a medicalized view of birth, or that all midwives do not. Gaskin, supra note 166, at 305–07.
219. For detailed information on the types of midwives, see Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives, Am. Coll. of Nurse-Midwives (Mar. 2011).
220. Martin et al., supra note 206, at 12–13.
222. Martin et al., supra note 206, at 12.
suggest that births attended by midwives (as well as births at home) are as safe as or safer than physician-assisted births for women with uncomplicated pregnancies. But midwives face a patchwork of legal regulations.

In midwifery-related jurisprudence, Roe has been used by courts as both sword and shield against pregnant women. For example, one court wrote that Roe and its progeny provide no privacy protection for women wanting midwives, thus limiting access to such providers: “The right to privacy which protects a woman’s choice to have an abortion has never been interpreted to guarantee a woman the right to choose the manner and circumstances in which her baby is born.” Another court used Roe to find a legitimate state interest in regulating midwifery and limiting access to midwives. Thus, once the woman has had sex that leads to procreation, ritualization of birth seals the deal: as a mother-to-be she is desexualized and pregnancy and birth rituals further entrench her in her socially and legally defined role as a mother.

As discussed previously, Roe’s applicability to women’s health issues outside of the abortion context—including midwifery—is questionable. This is, in part, because it is unclear what parts of Roe are essential holdings and what parts are dicta. Roe states that it is permissible to regulate the qualifications of the abortion provider, the location of the procedure, and the applicable licensing requirements, but this approval is given in the context of abortion services, and it does not speak to any extension of the holding outside of that factual context. Nonetheless, some in the midwifery community appear to concede that an expansive reading of Roe supports arguments to curtail or regulate midwifery.

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224. For detailed information, see Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives, supra note 219. Additionally, midwives may have difficulty with insurance reimbursement, finding physicians willing to supervise their practice, or getting hospital privileges. Susan Corcoran, To Become a Midwife: Reducing Legal Barriers to Entry into the Midwifery Profession, 80 Wash. U. L.Q. 649, 651 (2002).


229. One person in the midwifery community said that “[i]n short, if a state can require persons performing abortions to be licensed doctors, then a state can require that persons assisting births be licensed doctors, nurses or midwives as well. This is why midwifery proponents should never argue that Roe v. Wade supports a mother’s right to choose her manner and place of giving birth. . . . Because midwifery involves the birth of a child after viability, assisted by a nonphysician, Roe v. Wade is not good precedent for a privacy argument.” Erik L. Smith, Midwifery and the Constitution, 65 Midwifery Today 33, 35 (2003). For an examination of Roe’s impact in other non-abortion contexts, see generally Susan Behuniak-Long, Roe v. Wade: The Impact of An Outdated Decision on Reproductive Technologies, 8 Pol’y Studies Rev. 368 (1989).
Restrictions on midwifery are based on the ritualized treatment of labor as a medical condition. As in abortion jurisprudence, even before birth, women are treated as mothers whose first priority is their baby, not as women who can make autonomous healthcare decisions. Legal barriers to midwifery have the attendant consequence of driving women into the traditional healthcare system, where technology is omnipresent and where “good mothers” take advantage of it. These medicalized rituals are a welcome aspect of birth for some women, yet for those who seek an alternative path to childbirth, even one that has been shown to be safe for mother and fetus, rejection of prescribed rituals opens the door to further legal limits on reproductive autonomy, such as where the birth can take place and what type of birth—vaginal or cesarean—will occur.

2. Locating Birth

The location of birth is closely linked to who attends birth. Again, the location of birth triggers the State’s interest in “maternal” health as conceptualized in abortion regulation and, thus, ritualization is present. And again, this regulation of “motherhood” takes place before a woman actually becomes a mother.

Although nearly one hundred percent of births took place in a hospital in 2011, not all women want hospital births; some women seek to give birth at a birthing center or even at home. Birthing centers are typically locations where women are often attended by midwives in a setting that is less medicalized than hospitals. Home birth is controversial; a 2012 study goes as far as to propose that countries should establish home birth support, as “there is no strong evidence . . . to favour either planned hospital birth or planned home birth for low-risk pregnant women.” But the legal ramifications of giving birth at home can be dramatic for both the pregnant woman and any medical professional who may help her.


233. See Spence, supra note 221, at 92–93 ("Reproductive justice demands that all pregnant people have an equal opportunity to make and exercise decisions about their care, including out-of-hospital birth. While no state regulates the location where a woman must give birth, all states have the power to license and regulate health professionals who attend birth as a component of state police power.").

234. Martin et al., supra note 206, at 12.

235. Murkoff & Mazel, supra note 139, at 23.


237. Anna Hickman, Born (Not So) Free: Legal Limits on the Practice of Unassisted Childbirth or Freebirthing in the United States, 94 Minn L. Rev. 1651, 1653–54 (2010); NFOM Frequently Asked
Birth outside of hospitals is constrained. For example, there is a significant economic barrier for women wanting home birth; even professionals who can attend such births legally are often not covered by private insurance, forcing the costs onto the pregnant woman. Moreover, women can be prosecuted for their birth choice, the ultimate retribution for rejecting the traditional ritualization of birth, and some of these cases cite Roe in their analyses of women’s reproductive rights in the context of home birth. Whether one agrees with the pregnant woman’s decision or not, at a minimum, the very existence of criminal prosecution may have a chilling effect on this form of non-medicalized childbirth, limiting a woman’s choices. This may have the consequence of solidifying the ritual of the hospital birth.

The regulation of midwives and birth locations goes much further than the women’s health regulation contemplated in Roe: by the point of labor, the woman has already accepted her maternal role and the inevitability of birth is no longer a concern. Still, the State influences pregnant women’s choices regarding how a pregnancy should progress and thus dictates whether a pregnant woman is acting as a “good mother” when she makes those choices.

The relationship between laws related to midwifery, home birth, and labor regulates women’s birth choices and serves to promote a certain ritualized form of childbirth, regardless of a woman’s choices: a medicalized birth. At the point of birth, women are heavily invested in the management of their own birth process, hence the emergence of so-called birth plans in which women express in writing their desires regarding how, where, and with whom childbirth is to proceed, the ultimate expression of reproductive management. Yet despite these private documents, purported State interests may trump a woman’s desires. When the regulations concerning where and with whom birth may occur are read together, it appears that the State is invested in the ritualization of a medicalized birth, just as it was invested in a...
ritualized abortion process. But ritualization goes further—all the way to labor and delivery, which, if medical orders are not followed, may result in court-ordered medical intervention.

3. Accomplishing Birth

In some circumstances, labor does not culminate in vaginal birth; rather, a baby may be born by cesarean section, a procedure by which the baby is removed from the woman via an incision into her uterus. Once uncommon, the percentage of cesareans in the United States was almost thirty-three percent in 2011, more than double the estimated maximum safe percentage of cesarean births set by the World Health Organization and United States health agencies; many cesarean sections, therefore, are likely unnecessary. Cesarean sections are not without risk: many minor complications, such as infection, are possible and, most significantly, cesarean birth presents higher maternal death rates than vaginal delivery.

Cesarean sections are becoming a cornerstone of ritualized birth: not having one can exemplify bad “motherhood.”

As long as she has formally consented to Cesarean surgery, the case is assumed to be an easy one: her decision should be effectuated. When she has refused, however, the question becomes whether the state can override that choice. Conventional legal analyses thus pose questions such as: 1) Does the right to decide whether to procreate necessarily imply a right to decide how to procreate? 2) Does the state’s interest in the life and health of a full-term fetus outweigh the woman’s right to refuse medical treatment? 3) Does the duty of a parent to rescue a child in danger extend to a mother carrying a full-term fetus? Does it apply even when the rescue involves a risk of death to the mother?

Discussing what type of birth constitutes ritualization is complex. Certainly the high rate of cesarean sections suggests that, increasingly, the correct ritual in terms of medicalization and being a “good mother” may be a cesarean section in some circumstances. Legal decisions have made clear that in some cases, the State thinks “mother” does not know best when it comes to birth choice. In the context of abortion, for example, the Casey Court says, “[n]or can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision.” Imagine, then, any court’s reaction to a mother-to-be deciding against having a cesarean section when told to have one by a medical professional.

244. Martin et al., supra note 206, at 13.
246. Gaskin, supra note 166, at 288–89.
247. Ehrenreich, supra note 37, at 497.
In several cases, laboring or critically ill women have been forced to have a cesarean section by court order. In one example, a pregnant woman was forcibly restrained and drugged under the watch of a horrified partner when she refused a cesarean section in favor of a vaginal delivery. Other women have gone into hiding to avoid State-compelled cesarean sections, and refusal to have a cesarean, even when the child is subsequently born healthy, has been considered in abuse and neglect proceedings.

In compelled cesarean section cases, the law that is supposed to protect women’s reproductive choices, at least in the context of abortion, Roe, may actually be used against women when they choose a birth strategy that is contrary to the provider’s suggestions. Again, on its surface, Roe’s simultaneous interest in “maternal” health and fetal life may seem applicable in situations where a court forces a woman to have a cesarean section—especially given the proximity of the woman to motherhood. Seemingly, if a woman aborting a fetus is “maternal” in Roe, so too would be a woman approaching birth. However, courts forcing women to have cesarean sections use Roe to amplify the woman’s function as mother and the necessity of State intervention because of her failure to assume a maternal role for the benefit of the fetus. Whether sex was initially for pleasure or procreation, once pregnant, the woman is viewed as a mother and is expected to participate in the rituals surrounding that role accordingly. That is what a “good mother” does.

The expanded use of cesarean sections exemplifies shifts in how society sees childbirth, shifts that can “evolve into normalized practices, not only normalizing the obstetrical interventions but also their underlying assumptions about women’s emotional and physiological insufficiency in labor and delivery.” Thus, in the context of forced cesarean sections, the law may not only reflect judgments of the labor-related decisions women make, but also the physical capacity of women to labor without paternalistic direction from the State.

IV. The Future of Women’s Health Regulation?

Desexualization and ritualization have served both as signals and, arguably, tools of State intervention in women’s health, but how might


252. Paltrow & Flavin, supra note 160, at 325.

253. Id. Another argument is that the State interest in maternal health is so strong that it overwhelms the woman’s interest in autonomy. This, however, is not borne out in case law, which focuses on fetal health. See generally Burkstrand-Reid, The Invisible Woman, supra note 51 (discussing the minimization of the health risks of cesarean sections).

254. Bergeron, supra note 162, at 486.
desexualization and ritualization be used in the future? To an extent, these concepts rely on one another to function. While desexualization is the means by which sex is defined as solely procreative, ritualization further redefines the woman who took part in sex as a mother by treating her as one, regardless of whether she intends to carry the pregnancy to term. A woman’s choice to have sex for pleasure can be devalued via desexualization, and that disapproval may be reinforced via ritualization or a woman can be subjected to ritualization as a means of devaluing her sexual choices.

Reproductive health choices in the areas of contraception, abortion, pregnancy, and birth suggest that accepting even a constructive State interest in women’s reproductive health may come with a cost: the loss of autonomy concerning personal health decisionmaking. That cost may increase as State intervention increases. For example, given the State’s ostensible efforts to “protect” maternal health at present, might the next step be to protect potential maternal health and to intervene more aggressively in women’s sexual choices earlier in or prior to pregnancy? If so, desexualization and ritualization in reproductive health law may boost any effort to “protect” women’s health, which emphasizes why protections should be carefully scrutinized. Nonetheless, women need the law to recognize the inherent importance of women’s health but must also deal with the negative consequences of what that recognition can mean for their autonomy.

A. Desexualization and Ritualization Going Forward

Whether desexualization and ritualization are tools affirmatively used to manufacture mothers or to simply serve as signals that state involvement in women’s health is present, they raise an important question: to what extent do we want the State to be involved in regulating, or protecting, women’s health generally and women’s reproductive health specifically? Two examples of the potential application of desexualization and ritualization, one in the context of contraception regulation and a second in the context of abortion legislation, show that the answer to this question is not obvious.

Contraception is one example of an area of reproductive health regulation in which we may see more desexualization and ritualization. As previously discussed, current controversies surrounding contraceptive coverage and emergency contraceptives show that expanding the availability of contraceptives is a political landmine. For example, future legislation might seek to force women to read and sign a state-authored ‘informed consent’

255. Although not discussed in this Article, conceptualizing women’s health as maternal health may also impact women’s rights in relation to assisted reproductive technology. See generally Burkstrand-Reid, The More Things Change, supra note 68; Jack M. Balkin, How New Genetic Technologies Will Transform Roe v. Wade, 56 Emory L.J. 843 (2007).

256. See infra Part IV.B.
document akin to those used in the context of abortion at the time they receive contraceptives—emergency or otherwise. Documentation could appear on a receipt or even the electronic keypad when you swipe your card at checkout. Such a regulation would be yet another way to desexualize women who have sex for pleasure by putting them through a ritual of motherhood in the form of a pseudo-medical “consultation” via the reading of state-authorized “medical” information. Moreover, such a law would mirror ones already approved by courts in the context of abortion. But dismissing the utility of such a regulation out of hand may ignore a hypothetical benefit. Certainly adding an informed consent requirement could, if the information was accurate and apolitical, protect women’s health to some limited extent by informing women as to the safety and efficacy of the medication. However, the implication of forcing a woman to read such “informed consent”-type information is that a woman would not otherwise read about the medication or consider the risks inherent in taking such medication.

As the contraception hypothetical shows, legal intervention in women’s health has costs, such as the loss of autonomy, and potential benefits, such as the provision of medical knowledge, if executed apolitically. Thus, desexualization and ritualization may not necessarily be harmful in every context. At a minimum, however, their presence should counsel further consideration of how a law with them operates.

The presence of both the benefits and detriments of desexualization and ritualization are also seen in the context of abortion. Prior to Gonzales, reproductive rights jurisprudence mandated exceptions to abortion restrictions when a pregnant woman’s life or health was in danger, but the status of the health requirement is now uncertain. Since Gonzales, activists have decried the shrinking of so-called “health exceptions” in abortion law. Efforts to reinvigorate them, however, may come with both benefits and costs.


258. This is not to say that such a law would meet regulatory or constitutional requirements. See, e.g., John Schwartz, Oklahoma Judge Blocks Law Limiting Morning-After Birth Control, N.Y. Times, Aug. 19, 2013, at A11.

259. See supra Part III.A.2.

260. Our Bodies, Ourselves, supra note 102, at 226 (saying that birth control pills increase the risk of blood clots, and outlining which women should not use the pill); see Plan B One-Step Product Leaflet, What You Need to Know (package insert listing possible side effects including changes in menstruation, abdominal pain, and nausea). Emergency contraceptives in particular are safe under most circumstances. Id. at 251–53 (noting that some medications may interfere with some emergency contraceptives).


Recently, controversy has arisen over abortion bans passed under the guise of preventing “fetal pain” during an abortion procedure: these laws are often called “Pain-Capable Unborn Child Protection” acts. Fetal pain bans dramatically restrict abortion at and after the twentieth week post-fertilization and contain extremely circumscribed exceptions for women’s health; this effort “indefensibly jeopardizes” women’s health, according the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists. Courts have struck down some fetal pain-based bans, but they remain in effect in several states.

Deseualization and ritualization are present in fetal-pain-based abortion bans. Women are turned into mothers by virtue of the fact that they are pregnant (ostensibly proving that sex was for procreation), they have carried the pregnancy for a long period of time, and, when they want to terminate the pregnancy, they are expected to subrogate their own health needs for the needs of the fetus.

Fetal-pain-based bans are a prime example of the law’s eroding protection of women’s health. The American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists decried one fetal pain based-ban as “fail[ing] entirely to protect women for whom pregnancy poses serious health risks.” Certainly, the lack of adequate health exceptions in these laws has been a call-to-arms for pro-choice advocates.


264. Twenty weeks post-fertilization is the equivalent of twenty-two weeks after the woman’s last menstrual period. State Policies on Later Abortions, supra note 263. For an example of a fetal pain ban health exception, see Okla. Stat. tit. 63 § 1-745.5 (prohibiting the performance of an abortion if “the probable postfertilization age of the woman’s unborn child is twenty (20) or more weeks, unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function”).


266. See, e.g., Isaacson v. Horne, 716 F.3d 1213 (9th Cir. 2013); McCormack v. Hiedeman, 900 F. Supp. 2d 1128 (D. Idaho 2013); State Policies on Later Abortions, supra note 263.


268. ACOG Amicus, supra note 265, at 14–16.

269. Id. at 8.
advocates. The situations of women seeking an abortion at and after twenty weeks suggests that, when it comes to women’s health, these laws should be revisited to allow these abortions under a broader set of health-related circumstances. But fetal pain bans demonstrate something else: in addition to focusing on the fetus, “protecting” women’s health is used by states to justify reproductive health regulations when the true legislative goal is to restrict women’s reproductive rights. Case in point: the argument made in one case that later-term abortions pose greater health risks to pregnant women than do earlier abortions, thereby justifying the ban. These types of arguments are disingenuous at best. Every complication associated with abortion is more common in women carrying a pregnancy to term and giving birth: a “woman’s risk of death associated with childbirth was approximately 14 times higher than that associated with abortion.” The State’s purported interest in women’s health was mobilized against women, not for them.

While health exceptions to abortion regulations have generally been seen as provisions that protect women, the ritualization and desexualization present in a wide area of women’s reproductive health law suggest that a broader health exception may also lead to further government assertions of a State interest in “health” in non-abortion contexts. Including a mental-health based health exception, for example, would require a definition of “mental health” which could be exported to other, non-abortion law and used to truncate women’s rights to make their own decisions later in pregnancy or even in non-reproductive-health contexts. Health protection may come with a price. It may very well be a price worth paying, but that decision should take into account the history of health protection and current law and politics before it is made.

B. Abandoning the State’s Purported Interest in Reproductive Health

When it comes to legal regulation related to women’s reproductive health, women are in the quintessential double-bind. Most people would agree that


272. McCormack v. Hiedeman, 900 F. Supp. 2d 1128, 1150 (D. Idaho 2013) (refusing to give credence to the argument that the ban was enacted to preserve women’s health and citing the title of the legislation in question, the “Pain-Capable Unborn Child Protection Act”).

273. ACOG Amicus, supra note 265, at 14–16 (noting that abortion is “far safer than the only available alternative—i.e., carrying a pregnancy to term and giving birth”).

274. Id.; McCormack, 900 F. Supp. 2d at 1150.

275. ACOG Amicus, supra note 265, at 14–16.

276. Martha Chamallas, Introduction to Feminist Legal Theory 10–11 (3d ed. 2013); Chamallas, supra note 60, at 862 (“The feminists’ twin focus on freedom and equality means that no one legal stance—
the real issue is not whether the State should take any action to protect women’s health. For example, few would argue that more work is not needed to lower maternal mortality. Pregnant women are at an especially high risk in the United States as compared with the rest of the developed world. Amnesty International calls the United States’ maternal mortality rate “shocking.” Nonetheless, maternal fetal health funding is under attack. The issue is not whether but how and when the State should act.

Neither wholesale acceptance of State intervention in women’s health nor the wholesale rejection of State intervention in women’s bodies comes without a cost. Calling on the State to protect women means that laws and jurisprudence will contain language that allows them to do so, and, as this Article shows, language that “protects” women’s health can be used by the state to intervene in their ability to make autonomous health decisions. Desexualization and ritualization can both signify and propel this problem. The goal, then, should be to develop health regulations that are designed to maximize health outcomes with a minimal degree of legal interference and avoid the legal manufacturing of mothers through desexualization, ritualization, or both.

One way for the State to improve women’s health during their reproductive years is to abandon desexualization and recognize that women are entitled to have sex for pleasure. By abandoning desexualization, the State can improve the availability and use of contraceptives, for example, which is only part of a larger legal regime that protects the ability of women to make real choices about whether and when to have children. Increased availability of contraceptives will both benefit women’s health and save the government money by preventing unplanned pregnancies.

interventionist or noninterventionist—can ever be presumptively correct without careful analysis of the power relationships at play in a particular regulatory context.”).


Abandoning ritualization in a continuing pregnancy also holds promise for improving health outcomes because doing so would require abandoning laws that nominally, at best, protect women’s health but diminish their reproductive choices. In the context of abortion services, abandoning ritualization would require major changes in the way we view abortion, moving it from a shameful act of maternal avoidance to an act of reproductive health management. Moving away from medical rituals in abortion care and diversifying birth choices in continuing pregnancies may actually improve health outcomes by allowing women to freely make reproductive choices that are most suitable for their situation.

Ridding laws of desexualization and ritualization will require major changes in how we view women and reproduction on political, legal, medical, and societal levels. That will be neither easy nor immediate. Until then, by examining law and policy for the presence of ritualization and desexualization, one can determine (1) what is the true goal of a law passed; (2) the potential that the control over the woman exerted in the law or policy could be exported to or co-opted by other areas of law; and (3) whether that potential is worth the risk given the importance of a health-related goal.

Conclusion

Desire motivates consensual sex. It motivates every action related to pregnancy, be it to have sex, to prevent pregnancy, to bring pregnancy about, or to control its progress and end. There can be no child without a woman. This fact makes women simultaneously the most powerful and the most vulnerable individuals subject to State regulation. We cannot escape the fact that women are essentialized by society and by the law specifically; they are pushed to act like mothers regardless of whether they have children.  

Society focuses myopically on abortion as the defining concern in women’s health. By looking at abortion, contraception, and birth-related care, we see that desexualization and ritualization underlie State attempts to control women’s reproductive autonomy in a variety of contexts and that “health” is increasingly used as a political tool instead of a medical end.

284. Paltrow, supra note 16.