

Autonomy, Birth Control, and Intersectionality: Women's Ability to Control their Own Bodies

Research Thesis

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Table of Contents

Abstract	3
Acknowledgements	4
Introduction	5
Chapter 1: Defining Women’s Autonomy	7
Chapter 2: History of Birth Control	17
Chapter 3: Obstacles to Autonomy: The Issue with Informed Consent	28
Chapter 4: Improving Relational Autonomy for Birth Control Users	40
Conclusion	47
References	49

ABSTRACT

This paper explores the role of autonomy within the context of birth control. It is generally accepted that having autonomy is good, and lacking autonomy is bad. Further, it is also generally accepted that birth control increases women's autonomy. Autonomy has a central role in bioethics, especially as new reproductive technologies, including new forms of birth control, become available. However, a closer analysis of the mainstream definition of autonomy reveals that autonomy is not a gender-neutral concept but is in fact gendered to favor male individuals and is thus exclusionary and dangerous for women and minority groups. Moreover, mainstream definitions of autonomy fail to acknowledge the impact of larger systems of racism, sexism, and patriarchy. In this thesis, I criticize the way mainstream masculine definitions of autonomy continue to limit the way we conceptualize autonomy for patients using birth control. I ask two central questions: (1) How can autonomy for birth control users can be improved without centering masculine conceptions of autonomy, and (2) For which groups of women does autonomy increase with use of birth control, if at all? Through the analysis of the definitions of autonomy, the history of birth control, and of informed consent, I argue that birth control has never had the same impact on autonomy across different groups of women historically and currently. To ensure women have equitable control over their bodies and lives, a feminist relational autonomy approach must be integrated into both the processes of informed consent and the medical systems wherein informed consent acts.

Keywords: autonomy, birth control, feminist relational autonomy, bioethics

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INTRODUCTION

Having control over one's own reproduction has been centered in conversations of women's autonomy.¹ Few would disagree that birth control increases autonomy, as having more control over one's body is generally a good thing. In this thesis, I take on an uncommon position and argue that birth control users are limited by mainstream masculine definitions of autonomy. Using a masculine definition and measurement system to affirm or deny autonomy is particularly disadvantageous to women² across race and class because it fails to acknowledge and accommodate for larger systems that act on women differently than men, such as gender, race, patriarchy, social roles, etc. Moreover, while the link between women's autonomy and birth control has generally been close, whether or not this relationship is a positive one or negative one proves variable between different groups of women. The assertion that "birth control increases autonomy" is an uncomplicated observation of the relationship between birth control and autonomy, and my research aims to understand this relationship within the U.S., and seek ways to improve it using a feminist relational autonomy approach.

In Chapter One: Defining Women's Autonomy, I address what autonomy should look like for women based on a relational autonomy approach. I criticize mainstream masculine definitions of autonomy and argue that the feminist definition of relational autonomy is better because it is more intersectional and thus results in better outcomes for all women, especially BIPOC³ and poor women. In Chapter Two: History of Birth Control, I summarize the historical differences between the relationship of birth control and autonomy for different groups of

¹ Note that these dominant conversations of reproduction and autonomy center White, cisgender, heterosexual women, and are exclusive to other identities.

² I acknowledge that using the term "woman" can be assumptive of homogeneity and can be exclusive to non-binary and transgender people. Unless stated otherwise, the word "woman" used in this thesis is intersectional and is meant to include female-sexed individuals, any person who uses hormonal birth control, and any person who identifies as a woman regardless of their sex identified at birth.

³ Black, Indigenous, and People of Color

women, especially differences between racialized and classed groups. This chapter helps outline how autonomy is not uniform in past nor present contexts of birth control. It also addresses how feminist relational theories of autonomy can help reconcile those differences and improve the role that birth control can play in the lives of racialized and classed women. In Chapter 3: *Obstacles to Autonomy: The Issue with Informed Consent*, I argue that informed consent poses the greatest barrier to actual choice and control for all women because its conceptualization is based in mainstream masculine definitions of autonomy. I outline the factors that illustrate this conclusion by using an intersectional and relational approach and show why only changing the framework of informed consent is not enough to improve patient choice. Finally, in Chapter 4: *Improving Relational Autonomy for Birth Control Users*, I reiterate the role informed consent has within institutional frameworks of medical care. The deeply engrained use of informed consent as a proxy to autonomy within medical systems is harmful because of its masculine roots. I conclude that in order for autonomy for birth control users to improve, medical institutions must recenter their systems using a feminist relational autonomy approach.

CHAPTER ONE: DEFINING WOMEN'S AUTONOMY**INTRODUCTION**

For feminists, autonomy-based arguments are particularly important because they necessitate positions wherein autonomy is maintained even within systems of sex-based oppression, racism, agency, and subjugation (Mackenzie & Stoljar, 2000). This point is particularly salient for feminist bioethicists, because reproduction, birth control, and pregnancy and surrogacy are often central within conversations of autonomy, ethics, and morality, and impact female-sexed individuals differently than male-sexed ones. Although autonomy is vital to feminist analysis, relational feminists have found that traditional definitions of autonomy emphasize the ability to make choices without interference but say little about whether or not those choices are useful and meaningful. Relational autonomy is better for women because it focuses on acknowledging and repairing the systems of oppression, racism, homophobia, and patriarchy that deny valuable and meaningful choice (Mackenzie & Stoljar, 2000).

In this chapter, I seek to answer what women's autonomy ought to look like without centering masculine definitions. I first analyze several definitions of autonomy, including Kantian, procedural, and substantive definitions. Then, I offer feminist rebuttals to these definitions and explain why these definitions exclude women, especially those who are not privileged.⁴ Finally, I provide the feminist reconceptualization of autonomy, known as relational autonomy, which I will use throughout this paper.

⁴ In reference to privileged by race, class, immigrant status, ability, age, education level, and sexuality.

DEFINITIONS OF AUTONOMY

Traditional Definitions of Autonomy: Kantian

The word autonomy comes from the Greek words “autos” meaning self and “nomos” meaning rule or governance (Beauchamp & Childress, 2001, p.57). One of the oldest definitions of autonomy comes from German philosopher Immanuel Kant. His conception of autonomy relies heavily on universal principles such as justice, dignity, and normative competency (the ability to know right from wrong), which he argues are principles that prevail throughout individual or societal evolution (Internet Encyclopedia of Philosophy, n.d.). Kant describes non-intellectual factors, such as feelings, desires, emotions, and habits, as impediments to a state of true autonomy. Autonomous people are able to remove influences, desires, and personal interest that come from external forces (i.e., friends, family, government) when making decisions. In this conceptualization, being autonomous is entirely self-sufficient, where social relationships are abstracted (Stoljar, 2018). This definition centers independence, self-sufficiency, and self-reliance.

Traditional Definitions of Autonomy: Procedural

Procedural, or “content-neutral” definitions of autonomy rely less on Kantian universal principles and instead emphasize a unique individualized process of critical reflection regarding the motivation and/or action behind a decision (Internet Encyclopedia of Philosophy, n.d.). The content of the decision does not matter as much as in Kantian conceptions, but rather the ability to understand yourself, your values, and your reason for making a choice. This definition is more flexible and helps clarify autonomy in situations where there is no singular “correct” moral decision, whereas Kant would argue there would always be one “correct” moral decision. One well-known example of this is “The Trolley Problem,” in which a person must decide between

two “bad” options, like running over five children or five adults with a trolley. As long as a person is able to explain why they made their decision, and their decision is free from coercion or paternalism, they are autonomous. If a person is unable to explain their decision, or the decision they made does not align with their values, then procedural accounts of autonomy assert that the person is not autonomous (Internet Encyclopedia of Philosophy, n.d.).

Traditional Definitions of Autonomy: Substantive

Substantive theories of autonomy are centrally focused on normative competency, or the ability to identify right from wrong. Unlike procedural definitions, substantive definitions emphasize the relevance of the contents of the decision. In substantive definitions, autonomy relies heavily on the decision-makers’ ability to discern true norms from false norms – the ability to criticize a norm in an effective and unbiased way. If a person is unable to properly recognize true norms from false norms and/or is unable to identify right from wrong, the person is thought to have diminished autonomy.

Traditional Definitions of Autonomy within Bioethics

One of the most influential works on autonomy within bioethics was written by Tom Beauchamp and James Childress. In the 1970’s-1980’s, public attitudes towards health and medicine began to change from that of a paternalistic one, where doctors knew best, to a consumerist and shared decision-making one. Beauchamp and Childress responded to this change by organizing the four foundational principles of bioethics: Autonomy, Nonmaleficence, Beneficence, and Justice (Beauchamp and Childress, 2001). These principles were designed to reduce paternalism and coercion, as well as keep the patient’s best interest and best health in mind. Beauchamp and Childress define autonomy within a bioethics classification as “self-rule that is free from controlling interference by others and from limitations, such as inadequate understanding, that

prevent meaningful choice” (Beauchamp & Childress, 2001, p.58). This definition combines the original Greek definition of autonomy with substantive accounts of autonomy by acknowledging that the value of information, along with the content of the decision, is central to autonomy. This definition also led to the normative concept of informed consent, which a doctor must provide in order for patient autonomy to be realized. Informed consent and its connection to autonomy will be discussed in more detail in Chapter 3.

The other three principles are defined as such:

1. Nonmaleficence is the healthcare provider’s “obligation not to inflict harm on others,” but is different from helping others (Beauchamp & Childress, 2001, p.113).
2. Beneficence expands from nonmaleficence, which explicitly outlines the obligation to help others and provide benefit, in addition to preventing harm (Beauchamp & Childress, 2001, p.165).
3. Justice acknowledges inequalities in healthcare, especially unequal access (Beauchamp & Childress, 2001, p.225).

FEMINIST CRITIQUES TO TRADITIONAL DEFINITIONS OF AUTONOMY

Feminist Rebuttals to Kantian Autonomy

The biggest issue relational feminists see with Kantian definitions is the inherent masculinist ideals that serve as the foundation to autonomy. Kant’s definition ignores that humans are “socially and historically embedded,” and are not isolated in decision-making processes (Stoljar, 2018). Women are especially socially and historically embedded as a group of people who have been pushed under the thumb of racism, sexism, homophobia, and patriarchy. Relational feminists argue that if being autonomous is synonymous with making decisions within a social

vacuum, then being autonomous is, in Kant's definition, being denied to women. Moreover, relational feminists argue that Kant's definition is masculinist because women have often been denied access to resources that would allow them to be "self-made, and self-sufficient" such as academia, ownership rights, land titles, and instead often have to rely on the family and social relationships, such as marriage, for stability and comfort (Stoljar, 2018).

Feminist Rebuttals to Procedural Autonomy

The key issue relational feminists have identified within procedural autonomy is that it fails to address problems of "inadequate or inappropriate socialization" which impact an individual's ability to properly understand their true "self," their true values, or to even critically reflect on their own decision-making process in an unbiased way. While a person may think they understand why they made a decision and may be able outline the values that led them to a particular choice, relational feminists argue that oppressive socialization can undermine both the formation of the "self" and the process of critical reflection altogether. Moreover, procedural autonomy fails to acknowledge women's position as mothers and caretakers, who are not only socialized in specific and gendered ways, but who are also socialized to make decisions in the interest of the collective group or family rather than for themselves. As secondary or even tertiary citizens to men, women have been forced to cede their preferences to men because of strict gendered social norms. These decisions may go against their values in some way, yet relational feminists argue this does not necessarily mean the decision-maker was acting without autonomy, but rather within the confines of their environment. They may have chosen, just like The Trolley Problem, the lesser of two evils. Procedural autonomy fails to acknowledge how, if at all, autonomy can exist in that scenario (Mackenzie & Stoljar, 2000, p.19).

Feminist Rebuttals to Substantive Autonomy

Relational feminists extend the “inadequate or inappropriate socialization” critique to substantive accounts of autonomy. An individual’s capability of normative competence can be undermined by oppressive norms and/or unjust values and can make it harder for an individual to separate themselves from internalized beliefs and true beliefs (Benson, 1991, p.403). If an individual has internalized racism, sexism, patriarchal norms, or colorism, then these factors negatively impact an individual’s normative competence and therefore their ability to be truly autonomous.

Moreover, there is little acknowledgement of how normative competency is measured. Just like in the Trolley Problem, sometimes the right decision in one situation would be the wrong one in another, or neither option is ideal. Kant argues that ideas of right and wrong universal, but relational feminists argue that conceptions of right and wrong are culturally and socially embedded and thus argue for a more anthropologic approach where these differences can coexist with autonomy. For example, one woman may perceive the practice of veiling as oppressive, while another may perceive this practice as empowering. Employing a more intersectional and relational approach to autonomy helps account for these discrepancies in a way where autonomy can be recognized in multiple and diverse contexts.

Feminist Rebuttals to Traditional Definitions of Autonomy within Bioethics

Beauchamp and Childress’ conception of autonomy within bioethics has been criticized by relational feminists as once again being individualistic and masculinist. Relational feminists argue the definition of autonomy within bioethics assumes the decision maker’s choice is entirely atomistic and separate from social relationships and larger systems (Dodds, 2000, p.216). This assumption often proves false for women. Women’s social position under patriarchy has socialized women to make decisions with other people in mind, where non-uniform

racialized and classed ideals of femininity, family, and reproductive capability also plays a role (Benson, 1991, p.403).

Beauchamp and Childress' definition of autonomy within bioethics has also served as the foundation to the standards of informed consent, which focus on how doctors can increase patient autonomy by providing standardized framework for information-sharing. Feminist relational bioethicists have rejected standards of informed consent. This argument will be discussed in greater detail in Chapter 3.

FEMINIST RECONCEPTUALIZATIONS OF AUTONOMY: RELATIONAL AUTONOMY

The main relational feminist critique of all mainstream definitions of autonomy is they are inherently masculine and fall apart when analyzed within structures of oppression, which impacts women especially. Relational feminists assert that autonomous individuals can be rational, emotional, creative, and social at the same time, without any of the factors contradicting each other. These factors can add to the individuals' autonomous state in meaningful and positive ways (Mackenzie & Stoljar, 2000, p.21). Relational autonomy feminists have thus developed the definition of relational autonomy as one response to the deficiencies found in mainstream definitions of autonomy.

Mainstream masculine definitions of autonomy assert that autonomy either exists or it does not. An autonomous person must have all of the factors of autonomy, and if they lack even one, they have no autonomy at all. Relational autonomy shifts this paradigm by asserting that autonomy can increase or decrease, that it exists on a spectrum. This idea is more comprehensive than consumer autonomy, the ability to choose one product over another. This idea pertains to how someone may lose autonomy because of larger systems. For example, most men do not need

to think about the logistics of walking alone at night. Women are more likely to be victims of street harassment than men (Stop Street Harassment, n.d). Therefore, women's autonomy is inhibited by larger systems of violence, sexism, and patriarchy because women have to consider these external factors. Moreover, certain types of women, such as Black transgender women, are more likely to be targets of street harassment and violence, once again showing how autonomy exists on a spectrum both between and within groups of women (Stop Street Harassment, n.d.)

Relational autonomy also revisits the construction of the "autos," or the "self" by exploring how oppressive environments negatively impact a person's conception of themselves. Mainstream definitions of autonomy suggest that the construction of the self is independent of these factors, but relational autonomy recognizes that the factors that construct the "self", i.e. people's beliefs and attitudes towards social norms, are impacted by oppressive structures. Therefore, theories of relational autonomy reconcile how autonomy can still exist when the "self" is constructed within these oppressive structures. Further, relational autonomy analyzes how oppression and other restrictive factors limit the range of significant options available to the individual.

Relational Autonomy in Bioethics

Relational autonomy is especially crucial in the contexts of medicine and bioethics. Using a relational lens can help us understand how racist and sexist medical research histories, and sometimes current practices, influence how people interact with medicine today. Bioethics is a hub for medical-ethical conundrums, such as voluntary euthanasia, but also for gendered topics including surrogacy, in-Virto fertilization (IVF), and abortion. Moreover, the specialized nature of science and medicine often requires a relationship of reliance of the patient to the doctor. Mainstream definitions of autonomy, especially Kantian, would reject this sort of relationship

and suggest the patient's autonomy is being inhibited because of the doctor's influence.

Relational autonomy analyzes how this sort of doctor/patient relationship impacts autonomy, in both positive and negative ways, and how it can be improved.

Using a relational autonomy approach in bioethics is also helpful to individuals who are disabled and rely on a caretaker or legal guardian to make healthcare decisions. Disabled people are often incorrectly perceived as lacking the capacities needed to be autonomous, such as self-reflection, normative competency, and/or morals (Charlton, 1998). This view reifies the idea that choices are made *for* disabled people, rather than *with* them. Relational autonomy reassesses the way disabled people interact with medical communities to ensure greater access to resources that enable disabled people to maintain meaningful control over their own bodies and lives.

NEGATIVE REACTIONS TO RELATIONAL AUTONOMY

Some may say that relational autonomy is an oxymoron in the same way “jumbo shrimp” is an oxymoron. Relational autonomy muddles the very definition of autonomy by making it an idea that centers connection to others. After all, autonomy is about the self. What feminist reconstructions of autonomy aim to assert is that the creation and conception of the self has always been incorrectly defined as an individualistic and atomistic process. Rather, all individuals require connections to others in order to understand who they are. What actually enables people to be autonomous is “not isolation, but relationships – with parents, teachers, friends, and loved ones, among others with whom we have relationships” (Nedelsky, 2011, p.3). It is the nature of these relationships – positive or negative, oppressive or equal – that creates or inhibits a state of autonomy.

Another issue taken with relational autonomy is that its approach is overly complex – how can autonomy exist when so many systems and identities are taken into consideration? While the main focus of relational autonomy works to acknowledge these complications and still prove that autonomy can exist, relational autonomy also serves as a critique to the larger systems that act on autonomy. Relational autonomy posits that the systems that restrict autonomy can be reimagined to increase autonomy for the diverse population they serve.

CONCLUSION

As definitions of autonomy evolved over time, they consistently failed to recognize the social status of women. Feminist contributions to the definition of autonomy include an intersectional approach that is both inclusive to women and cognizant of larger interconnected systems that impact them. When relational feminists consider autonomy in contexts of medical systems and gendered topics of bioethics, relational autonomy is the most dynamic and useful definition because it allows for better analysis of intersectionality, larger systems of oppression, and improvement of choice and control over one's body.

CHAPTER 2: HISTORY OF BIRTH CONTROL

INTRODUCTION

History is often told from one viewpoint – usually the dominant White, male, Christian version. This dominant viewpoint of history has also been extended to the evolution of birth control. Many people are taught to think of birth control as the impetus to the sexual revolution, and a wonderful medical addition that helped women everywhere achieve greater control over their lives. However, not all women were impacted positively by birth control. The history of birth control within the United States is fraught with racism and sexism that constricted women’s control over their bodies and lives and has lasting implications for women’s autonomy today. Capturing a brief historical snapshot of the relationship between birth control and autonomy helps better illuminate how and why the relationship between birth control and autonomy continues to struggle, and why it is important that a relational autonomy approach is used as a means to improve that relationship and therefore increase women’s ability to control their own bodies and lives.

In Chapter 1, I explained why the feminist relational definition of autonomy helps best understand a person’s level of choice and control within larger systems. In this chapter, I explain how women’s current use of birth control is negatively impacted by U.S. history, and why this relationship poses challenges to efforts that aim to increase women’s autonomy in birth control contexts. While birth control has improved autonomy for some women, namely White upper-class women, it has not had the same effect for other women, namely BIPOC and lower-class women. While the scope of my paper focuses mainly on modern methods of hormonal birth control, the analysis in this chapter includes non-hormonal methods to illustrate how current attitudes have been shaped by history.

BIRTH CONTROL: WHITE MOTHERHOOD AND LIBERATION

For many middle and upper-class White women, their experience with birth control has played a central role in increasing their autonomy, where the quality of their lives and their health increased (Roberts, 1997). In this section, I analyze the role of birth control on autonomy for White middle and upper-class heterosexual women through the lens of motherhood and family planning, and social liberation under patriarchy.

Motherhood and Family Planning

In the late 1800's, family structures started to resemble modern nuclear-style families, where each family was a private unit independent of other family units (Gordon, 2002, p.9). Since White women were seen as second-class citizens to men with few opportunities for social advancement besides marriage, marriage and childbearing became their primary social role. Under this structure, White women had little autonomy over their lives. In an effort to gain an elevated social status, White women participated in the voluntary motherhood movement (Gordon, 2002, p.55). Although women were still tightly bound by expectations of marriage, this markedly pro-motherhood movement fought to expand autonomous choice within marriage by giving women a "right to refusal" (Gordon, 2002, p.61). This movement helped White women gain more control within their marriages, where they were expected to fulfill the sexual needs of the husband. White women were also able to delay pregnancy not only in consideration to their personal desires, but also in consideration of other factors, such as their age, health, financial situation, other children, and desire to reduce their risk of death during childbirth (Gordon, 2002, p.63). While other birth control methods besides abstinence did exist (such as the male or the external condom) abstinence was emphasized because of the perception that women did not and should not have sexual desires.

In the 1920's, Margaret Sanger coined the term "birth control" and championed the movement for increased access to birth control for all women. As a nurse, Sanger recognized the personal and social need for birth control. Her efforts sought to "liberate women's sexual pleasure from the confines of maternity, marriage, and Victorian morality" (Roberts, 1997, p.57). Over time, the concept of widespread legal use of birth control grew until it was legally recognized during the 1960's, when the Supreme Court Case *Griswold v. Connecticut* overturned the ban on hormonal contraceptives for married couples (*Griswold v. Connecticut*, 381 U.S. 479 (1965)). In 1972, the Supreme Court Case *Eisenstadt v. Baird*, legalized contraception for unmarried women (*Eisenstadt v. Baird*, 405 U.S. 438 (1972)). These legal efforts helped shift the idea of birth control from one of morality to one of medical and social necessity.

Liberation

Shortly after hormonal birth control became more widely available on the market, White feminist groups used its availability to push other feminist agendas, such as liberation from patriarchy and from social roles of motherhood. To many liberal White feminists, motherhood still represented domestic confinement and economic dependence on men in the same ways it did in the 1800's (Poltanick, 1996). Hormonal birth control provided women with the tools necessary to gain "freedom over the 'tyranny' of childbearing" (Poltanick, 1996). Feminists also saw how hormonal birth control allowed for more autonomy over sexual pleasure and sexuality, which was still considered taboo and even immoral for women.

At the same time, however, other feminists questioned the validity of the Pill under patriarchy. Some feminists viewed hormonal birth control as another way for men to control women's reproductive systems (PBS, n.d.). Barbara Seaman's 1969 book "The Doctor's Case Against the Pill," revealed medical dangers about hormonal contraceptive methods, including an

exposé on how the Pill was originally tested on minority women without informed consent (Liao & Dollin, 2012). This uncertainty about health risks played a large role in the negative perception of the Pill. Moreover, many women also questioned why the male-dominated medical fields and pharmaceutical industries were marketing the Pill to women instead of men. For many women, the availability of the Pill roused questions about women's social responsibility, women's role in childbearing, and autonomy.

Modern Attitudes

White women's attitude towards birth control remains mostly positive. According to CDC data, 93.2% of sexually active heterosexual White women who wanted to prevent pregnancy used any method of contraception at all. Additionally, 61.2% were more likely than Black and Latina women to use "highly effective methods," which were categorized as female or male sterilization, IUD, or implant (Grady et al., 2015). This data has not been updated to reflect the uptick (21%) in demand for long-acting reversible contraceptives (LARCs) following the 2016 election of former President Donald Trump, which suggests that post-2016 election reports of birth control use in the United States are likely higher than the latest national reports (Pace et al., 2019).⁵ The majority of White women also share positive attitudes towards government-subsidies for birth control programs (Rocca & Harper, 2012).

BIRTH CONTROL: SLAVERY, EUGENICS AND POPULATION CONTROL,

MOTHERHOOD

For BIPOC women, birth control has not always yielded the same benefits as it has for White women and has in fact played a coercive and damaging role. The autonomy and reproductive

⁵ This data compiled reports of any person who sought LARCs nationwide. It does not include data divided by race, sexuality, or class.

capabilities of BIPOC women has been and continues to be under attack by White institutions, namely the US government (Roberts, 1997). In this section, I analyze the role of birth control on autonomy for Black women through the lens of slavery, eugenics and population control, and motherhood. I also analyze similarities between Black, Hispanic, and Indigenous populations and their experiences with forced sterilization.

Slavery

During the period of slavery, Black women had little to no control over pregnancy. Black women's bodies were exploited for reproductive labor, where her children could be sold for profit. For Black women, infanticide and abortifacients were used as a form of resistance and rebellion. Not only did Black women use these birth control methods to protect their children from lives of slavery and servitude, but also to resist the perpetuation of slavery (Roberts, 1997, p.55). Black women would use tactics such as "medicine," "violent exercise," and "internal and external manipulation" to kill the fetus in early stages of gestation (Roberts, 1997, p.47).

Moreover, slaveholders would use tactics of violence and rape to subjugate Black women and to deny them power over their own bodies (Roberts, 1997, p.55). Once again, Black women would use infanticide and abortifacients to prevent the birth of a child conceived through rape. Black women's experience of motherhood and pregnancy in slavery was a brutal denial of reproductive autonomy (Threadcraft, 2016, p.22)

Enslaved women were also used as the foundation to many gynecological tools and procedures used today. Dr. Marion Sims, known as the "Father of Modern Gynecology," repeatedly experimented on the bodies of enslaved women without their consent or use of anesthesia (Vedantam, 2017). Betsey, Lucy, and Anarcha were just three of the names recorded out of unknown numbers of enslaved women upon whom Dr. Sims experimented. Anarcha, who

was brought to Dr. Sims at age 17, was experimented on over thirty times without anesthesia during a period of four years. Many have reframed the phrase “Father of Modern Gynecology” to center the role of the enslaved women. Betsey, Lucy, Anarcha, and the other unknown women are now referred to as the “Mothers of Modern Gynecology” (Vedantam, 2017).

Motherhood in Slavery – the “Mammy”

Being mothers to their own children was consistently denied to enslaved women. Those who did become mothers often saw their children sold to other slave holders, where future communication was nearly impossible, and many children lost track of their true names and true ancestors. Instead of resembling White Victorian nuclear-style families, Black family structures resembled a kinship-network, which operated as an adaptive survival strategy for Black families (Roberts, 1997, p.54). Many Black women could depend on other Black women to take care of their child as if it were their own.

At the same time that motherhood over their own children was being denied, enslaved women were often forced to be the caretakers of White children. The identity of a dutiful, caring, and obedient Mammy was thrust upon Black women, who were only seen in this light as long as the children they cared for were White (Roberts, 1997, p.14). Many White people believed Black mothers with Black babies were careless, selfish, and poor providers (Roberts, 1997, p.15). Moreover, White people considered the conditions of slavery to be the antithesis to Black motherhood, because enslaved women were perceived to be unmarried and criticized for performing “dirty” backbreaking work in the plantations of the slave holders.⁶

⁶ Many enslaved people were married, but their marriages were not recognized by White people who excluded Black people from White systems of marriage (through the Church). Black people were instead married using their own customs.

Eugenics and Population Control

While Margaret Sanger was seen a champion of birth control for White women, she also influenced the use of birth control in spheres of eugenics and population control. The eugenics movement, which grew in America and inspired later practices during the Nazi period in Germany, focused on the genetic superiority of certain groups to regulate reproduction between the “fit” and the “unfit” citizens (Roberts, 1997, p.59). Eugenicists also believed that personality traits were both race-related and inheritable, thus making race, class, and ability central in discerning the fit from the unfit. Black women were often categorized as unfit, not only because of their race but because of their low-class status. What Sanger once advocated for as a right for all women soon transformed into a controlling reproductive policy used to regulate unwanted and unfit citizens.

The impact of the eugenics movement on the use of birth control for Black women was profound. In 1927, the Virginia Supreme Court decision in *Buck v. Bell* legalized forced sterilizations for “the [promotion of] the health of the patient and the welfare of society” (*Buck v. Bell*, 274 U.S. 200 (1927)). Although the plaintiff of the case, Carrie Buck, was White, she was famously categorized as “feeble-minded” and poor, and thus was deemed unfit to reproduce by the state (*Buck v. Bell*, 274 U.S. 200 (1927)). This Court ruling effectively legalized compulsory sterilization for the benefit of society (read: without consent of the patient). Feeble-mindedness was loosely defined, which resulted in the admittance of thousands of young girls and women into mental institutions for the sole purpose of being sterilized. Promiscuity, truancy, poverty, and insolence fell into the category of feeble-mindedness and could land a woman in an institution to be sterilized. Many women, especially Black women, were viewed as sexually promiscuous and were intentionally targeted to be sterilized. By 1980, over 70,000 Black women

across America had been sterilized without consent, and the total number of Black women who experienced sterilization without consent remains unknown (Roberts, 1997, p.90). *Buck v. Bell* was overturned in 1974.

In addition to sterilization, the medical community is guilty of using certain marketing tactics, incentives, and even State bills that pressured poor women of any race, but mostly BIPOC women, into using Norplant, a 5-year hormonal birth control surgically inserted into the arm (Roberts, 1997, p.105). Women who received Medicaid, public assistance, and even women ineligible for Medicaid were offered free or heavily subsidized opportunities to receive Norplant (Roberts, 1997, p.108). Norplant was relatively new to the market in the 1990's, and its efficacy rate was higher than all other birth control methods available at 99% efficacy (Roberts, 1997, p.108). The United States Government intentionally over-marketed and over-subsidized Norplant to target poor Black mothers who were seen as “undesirable” and “unfit for reproduction” as a means of population and race control. Those who resisted the implant were threatened with loss of welfare benefits, and those who accepted the implant were rewarded with a \$500 incentive and a \$50 bonus each year the device remained in place – approximately \$1,030 and an additional \$103 per year in US dollars today (Inflation Tool, n.d). Within four years of Norplant's availability on the market, the United States spent \$34 million on Norplant-related benefits (Roberts, 1997, p.108). While the recipients of Norplant were not directly coerced into using Norplant, it is clear that these marketing tactics and government subsidies played a large role in the ability for BIPOC women to consider, and even afford, other options.

Compulsory sterilization laws also disproportionately impacted immigrants of Puerto Rican or Chicana origin. Many Hispanic women were sterilized coercively during labor and childbirth or other hospital stays. Doctors would capitalize on women's fear and pain during

childbirth to coerce their signature on a document saying they “consented” to a C-section birth and sterilization (Novak et al., 2018). Most often, the signer could not read the document for three reasons: (1) the pain from labor was too intense to properly understand the contents of the document, (2) language barriers because the document was written in English rather than Spanish, or (3) language barriers because the document used words too complex to understand. Most Hispanic women who were sterilized lived in California, which had its own compulsory sterilization law. The California compulsory sterilization law was revised in 1963, but sterilizations continued for California state prisoners, which disproportionately held higher numbers of BIPOC people, through 2014 (California Legislative Information, 2018).

Indigenous women were also uniquely targeted by U.S. sterilization programs. The bloody genocide committed by European immigrants against Indigenous populations not only reduced Indigenous population sizes (a total Indigenous population size of 800,000 was recorded in 1976, compared to a pre-colonization population as high as 112 million and as low as 8 million) but forced Indigenous people to live on reservations closely monitored by the U.S. government (Torpy, 2000, p.11; Deneven, 1992). Health institutions on reservations were subsidized and controlled by the U.S. government, which made it easy for the Indian Health Service (IHS) to take advantage of their connection to Indigenous women. During the 70’s, the IHS sterilized thousands of women, with total numbers unknown (Torpy, 2000, p.7). Similar to Hispanic women, interpretation services for consent forms were absent, and similar to Black women, doctors threatened to deny access to welfare benefits if women refused sterilization (Torpy, 2000, p.9).

Modern Attitudes

The effects of slavery have a lasting impact on the way researchers understand the intersection between race, reproduction, motherhood, and medicine. The attitudes Black women hold towards birth control today are both varied and deeply rooted in history. For example, both Black and Hispanic women are less likely to use highly effective methods (male or female sterilization, IUD, or implant) of birth control (Grady et al., 2016). Black women reported 55% using highly effective methods, and Hispanic women reported 54.7% using highly effective methods (Grady et al., 2016). The data in this study also finds that even after socio-economic status, healthcare access, healthcare utilization, and even education was adjusted for, Black and Hispanic women were still less likely than White women to use highly effective methods. It is not that these women do not *want* highly effective methods, but is a reflection of the historical treatment Black and Hispanic women have faced from the medical field (Grady et al., 2016).

Slavery has also impacted Black women's attitudes towards family, motherhood, and birth control. Studies have found that many Black women view birth control as a means of controlling Black reproduction, constricting Black family structures, and limiting Black motherhood (Poltanick, 1996; Bambara, 1970). In fact, some Black women who feel strongly about Black women's role as modern mothers, no longer controlled by slavery, denounce abortion as a legalized form of racial genocide controlled by the predominantly White medical institution (Roberts, 1997, p.56). Thus, Black women are less likely to share the same view of "tyrannical and oppressive" motherhood as White women, instead seeing motherhood as a benefit to their lives. (Polatnick, 1996, p.697). Black motherhood may also represent social mobility because post-slavery kinship networks remain within Black family structures, and

capture new connections Black women make with others outside of the home (Polatnick, 1996, p.697).

Some Black families continue to rely on kinship networks because of the likelihood for Black mothers to be arrested at higher rates than White mothers for similar crimes. Drug abuse among pregnant patients was found to be evenly distributed among Black and White patients, but almost all of the drug abuse *reports* were for the Black patients (Roberts, 1997, p.172). Black women are also more closely associated with welfare programs, which makes them vulnerable to state monitoring in their jobs, schools, doctor's visits, and every other aspect of their lives (Roberts, 1997, p.173). This close monitoring results in disproportionate numbers of Black women being punished and put in jail. Relying on kinship networks for the duration of a stay in jail or prison helps Black families to continue resisting White efforts of population control even today.

CONCLUSION

Birth control does not have an equal history for all women. While birth control was liberating for upper- and middle-class White women, lower class BIPOC and White women were targeted during the height of eugenics and forcibly sterilized. The way these racist histories continue to impact the autonomy of BIPOC women today is real and measurable, because BIPOC women are less likely to choose highly effective methods that involve surgery and/or LARCs. Knowing the history of birth control can help contextualize why birth control continues to circumstantially prevent women's ability to have control over their bodies. Using a relational approach to autonomy will be better for women, especially BIPOC and poor women, because it leaves room for consideration of the impact of these histories on current attitudes towards birth control.

CHAPTER 3: OBSTACLES TO AUTONOMY: THE ISSUE WITH INFORMED CONSENT

INTRODUCTION

Relational feminists allow for relationships between doctors⁷ and patients to be beneficial to the patient, whereas other conceptions of autonomy would label this relationship as a negative one. Informed consent helps ensure that doctor-patient relationships are beneficial and not coerced or paternalistic, especially since the majority of healthcare decisions are dependent on information and services that only a doctor can provide. Understanding informed consent and doctor-patient relationships as assets to autonomy is central in both bioethics and feminist relational theories of autonomy. In this chapter however, I argue that using the standard of informed consent as a measure for autonomy is weak because it currently relies on mainstream and masculinized definitions of autonomy rather than feminist relational ones. Moreover, even though informed consent is meant to prevent coercion and paternalism, coercion and paternalism still occurs, especially towards BIPOC women. I argue that one of the biggest obstacles to relational autonomy are the current normative standards for informed consent, which are based on mainstream definitions of autonomy. In order for patient autonomy to be properly maintained, the requirements of informed consent need to be reconstructed within relational theories.

In Chapter 1, I defined relational autonomy. In Chapter 2, I summarized the history of autonomy in contexts of birth control, including how informed consent was used coercively or not used at all. In this chapter, I outline what the normative standards of informed consent are. Then, I challenge this standard by showing how informed consent fails to acknowledge a

⁷ In this thesis, I use the word doctor to encompass all health care providers

relational autonomy theory in medicine. Finally, I make a suggestion for how the standards of informed consent can be improved by including relational theories of autonomy.

DOCTORS, PATIENTS, AND INFORMED CONSENT

In the past, birth control was mainly used to prevent pregnancy. Nowadays, however, the nature of birth control has changed. Besides pregnancy prevention, hormonal birth control has developed into a first-line defense against many other reproductive illnesses. Moreover, the non-localized mechanism of action, numerous hormonal formulations, and various delivery formats require monitoring for possible side effects. Using birth control under the care of a physician is paramount because of these challenges. However, physicians have more of an involved role than just monitoring and responding to side effects – they also are the prescribers. Whenever a doctor prescribes a medicine for a patient, they are legally and ethically obligated to ensure the patient has provided informed consent – a specific type of consent that acknowledges the patient understands and agrees to the healthcare plan. The concept of informed consent is strongly connected to Beauchamp and Childress' definition of autonomy in bioethics, which emphasizes adequate understanding, or lack thereof, as a measure for whether or not the patient is making an autonomous decision. Informed consent consists of five main aspects, which each connect to mainstream definitions of autonomy by attempting to make sure the patient has enough information to be making a truly autonomous, not coerced or paternalistic, choice in their healthcare plan. In the following sections, I outline the five aspects of informed consent. Later, I offer objections to these five aspects and explain why relational feminists object to normative definitions of informed consent.

Aspect 1: The Nature of the Intervention/Decision

A patient may seek the care of a healthcare professional for two main types of care: preventative and diagnostic. Preventative care focuses on evaluating the status of a patient's current health status and is often referred to as a routine check-up or annual wellness visit. Diagnostic care, on the other hand, involves assessing and/or treating a health issue (Kaiser Permanente, n.d.).

Acquiring a prescription for birth control is diagnostic care, even if there is no health issue *per se*, because hormonal birth control can be used to “treat” or prevent an unwanted pregnancy.

Regardless of whether or not the prescription is for contraceptive use or for reproductive health, the bare minimum required for this first aspect of informed consent is ensuring the patient knows about the “what” and the “why” of the intervention. What is the intervention, and why is this intervention being suggested? The doctor is required to make a recommendation for the patient's healthcare plan and explain why they think their recommendation will suit the needs of the patient (De Bord, n.d.).

Aspect 2: Alternatives

After the doctor has made their official recommendation, they may recommend alternative options, including forgoing treatment. In regard to birth control, this may mean explaining why they recommend a specific hormonal formulation or why they recommend the format of delivery. For example, if a patient struggles to swallow medicine in capsule format, the doctor may recommend birth control that can be surgically inserted into the arm, inserted into the uterus, or transdermal patches. Suggesting alternatives helps the patient become familiar with other methods they may not have known about. Having this alternative information to the doctor's original recommendation is meant to strengthen the patient's ability to make a choice.

Aspect 3: Risks and Benefits

After the doctor makes their recommendation and suggests possible alternatives, they are obligated to explain the relevant risks and benefits of the proposed intervention (De Bord, n.d.). Disclosing risks and benefits are up to the discretion of the doctor. In prescriptive scenarios, since the patient is not involved in a medical study, the doctor is not obligated to list every possible risk and every possible benefit. Thus, disclosing risks and benefits often fall under the “average person” measurement, which suggests disclosing the risks and benefits that an average person would need to know about the prescription. Additionally, doctors may use the doctrine of therapeutic privilege, which allows them to withhold certain information if they feel disclosing it would have a “significant probability of creating confusion or anxiety in a patient” (Beauchamp & Faden, 1980, p.332). For example, patients who smoke tobacco are at a higher risk for blood clotting and possible death if they smoke while using hormonal birth control (Planned Parenthood, 2010). If a patient is a non-smoker, telling the patient about the dangers of smoking while using birth control may be unnecessary and unduly overwhelming. However, since it may be difficult for a doctor to know what information may be relevant to their patient depending on the nature of their relationship, it is the responsibility of the doctor to ensure the patient knows they are part of a decision-making process (De Bord, n.d.). The doctor may do so by using verbal clues i.e. “It’s up to you,” “It’s your decision,” or “Do you have any questions?” These cues are meant to help the patient feel more involved in their healthcare plans.

Aspect 4: Assessment of Patient Understanding

After the doctor has provided their recommendation, suggested alternatives, reviewed relevant risks and benefits, and has helped make the patient feel they have a choice, the doctor must use discretion in assessing whether or not the patient has understood their options. Informed consent

is considered valid if the patient is “competent and participation is voluntary” (De Bord, n.d.). The state mandates how much information is considered “adequate” for patient understanding using three possible measurement systems. The first measurement is the “reasonable physician standard,” which measures if adequate information has been given based on what a typical physician might say. The second measurement is the “reasonable patient approach” which focuses on what a reasonable patient would need to know to be an informed decision maker. The third measurement is the subjective standard, which asks what any *specific* patient would need to know and understand in order to make an informed decision based on their specific health concerns and health status. The majority of U.S. healthcare systems use the reasonable patient approach for informed consent purposes.

Aspect 5: Acceptance of the Intervention by the Patient

Once the doctor has ensured they have provided all relevant information and believes the patient agrees to the healthcare plan competently and voluntarily, the doctor and patient work together to implement that plan. The doctor and patient continue to work together to monitor any side effects and make potential changes to the healthcare plan and will repeat this process with any new medications.

Exceptions to Informed Consent

There are several scenarios in which there are exceptions to informed consent, such as emergency situations where the patient is unconscious, in situations where the patient has been diagnosed with a mental disability that would prevent them from making a meaningful decision, or for children under the age of seventeen (Shah et al., 2020). These scenarios fall outside the scope of this thesis, so I will not analyze the role of autonomy here.

LIMITATIONS TO INFORMED CONSENT FOR RELATIONAL AUTONOMY

In bioethics, informed consent is often seen as a proxy for patient autonomy. However, the foundation of informed consent uses a mainstream definition of autonomy rather than a feminist relational one. This immediately poses a challenge to autonomy for women, especially those who are BIPOC and/or poor. Additionally, there are several situations in which informed consent does not provide a clear picture of what a truly informed and autonomous decision really looks like. In this section, I challenge current approaches to informed consent and consider scenarios where external factors – namely race, gender, and the history of birth control – may negatively impact a patient’s ability to make an informed decision and have autonomy.

“Average and Reasonable”

The first limitation of informed consent as a proxy for patient autonomy is using the term “average person” to decide what risks and benefits to disclose. The issue with this wording is that there is not really an “average” patient when it comes to reproductive healthcare or medicine in general. Patient experiences are variable based on their age, race, gender, ethnicity, ability, religion, education level, and even insurance status. Moreover, reproductive healthcare can often involve partners or family members, and thus could change what that patient needs to know about the proposed intervention. Even worse, using the word “average patient” makes it all too easy for the healthcare provider to fall into the trap of stereotypes, biases, and misjudgment based on their idea of “average.” Although it is in good medical practice not to judge, racism and sexism is still prominent in medicine. Doctors may assume a patient’s knowledge based on their identity, and this can be dangerous for all parties.

Another limitation of informed consent as a measure for patient autonomy is how the state measures patient understanding. In the same way that the phrase “average patient” is

exclusionary to those who are not “average,” “reasonable patient approach” has the same effect. What is a reasonable patient? Since the definition of reasonable in this context is up to a doctor’s perspective, there is no way to ensure all patients are getting the right amount of information they need based on who they are and what their health background is. This phrasing could marginalize groups of people who do not have an Americanized understanding of health and healthcare, such as Indigenous groups, immigrants, Eastern cultures, and racial minorities. Moreover, the majority of physicians in the United States are White (AAMC, 2019). The way a White doctor may define “reasonable patient” may be very different than the way a Hispanic or Black doctor may define “reasonable patient.” For example, one Black doctor shares that his ability to code switch⁸ for his Black patient helped him understand his diagnosis, “all because I [the doctor] could recognize what everyone else seemed to miss, from a cultural perspective” (Kenney, 2018). Additionally, all women under patriarchy are stereotyped as being unreasonable, hysterical, and irrational decision makers. This stereotype is often exacerbated in spheres of medicine, where women’s medical decisions sit at the intersection of personal, social, and gendered significance, and historical influence. Doctors, especially male, are often dismissive of these influencing factors and believe female patients to be unreasonable because men are not influenced by these factors as much as women (Tsugawa et al., 2017).

Using the “average/reasonable” measurement for disclosure and measuring patient understanding is the standard for informed consent. Within this standard, there is no distinction between disclosure of information and patient *understanding* of information. Some researchers argue that in order for consent to be valid, the information not only must be disclosed to the patient, but it also requires that information is understood (Millium & Bromwich, 2021). If the

⁸ Code-switching is the ability to alternate between languages or varieties within one language in a conversation. African-American Vernacular English (AAVE) is a distinct language from American English.

information is not properly understood, the consent is invalid, and the patient's autonomy has been constricted.

Coercion, Paternalism, and "Informed Consent" in the BIPOC communities

In Chapter 2, I provided a brief overview of the history of birth control in the United States. I want to use this space to remind the reader again of how informed consent was used as a coercive tactic for Black, Hispanic, and Indigenous women who were denied proper interpreters, forced to sign under coercive conditions, and/or told their benefits would be taken away if they refused the sterilization procedure or birth control. Other famous cases of poor use (or lack thereof) of informed consent in the Black community is the Tuskegee Syphilis Experiment, where Black men were infected with Syphilis without their or their family's consent or proper knowledge, and Henrietta Lacks, whose cells were collected without her consent and without compensation. (CDC, n.d.; Henrietta Lacks Foundation, n.d.). Her cells, known as HeLa cells, continue to be used for research in the medical community today. These failures of informed consent have influenced modern unreliability of informed consent for BIPOC and poor women.

ADDITIONAL OBSTACLES TO INFORMED CONSENT

The effectiveness of informed consent for patient autonomy also fails when it is situated within poorly organized and inaccessible healthcare systems. In order for informed consent to be effective, it not only needs to be measured differently (i.e., without the "average and reasonable" patient approach) but it also needs to consider the complex needs of patients and the numerous interventions that may suit them. This is in part so difficult to achieve because of the inaccessibility of healthcare. When it comes to reproductive healthcare, there are many forms of interventions that require specialized training beyond what a general physician may know.

OBGYN's, endocrinologists, and even specialists *within* those practices go through years of extensive training to be able to understand and treat issues related to reproductive organs. Thus, general physicians may not always know enough about these alternatives to mention them to a patient, may think these alternatives are not necessary, or might assume what procedures the patient could afford. Most of the time when an "average patient" seeks treatment related to reproductive organs, birth control is both the first line of action and the solution that generally suits the needs of the patient.⁹ Although another option may actually suit a patient better, that patient may go years without knowing about these alternatives because they were unable to access the specialists who could have offered them a different healthcare option. Endometriosis is a very common example of this situation. Most of the time, the symptoms of endometriosis can be held at bay with hormonal birth control therapy. However, birth control does not cure the endometriosis, it only reduces symptoms. In fact, endometriosis can still grow and cause worsening damage even if the patient can no longer feel the symptoms. Most general physicians do not know this (Farland & Horne, 2019). The only way to truly stop further growth of endometriosis is to see a specialist and have the damaged and scarred tissue surgically excised (removed) through a laparoscopic procedure. On average, it takes women eight years to get a proper endometriosis diagnosis because doctors do not know enough about the disease or how to properly treat it. What's worse, Black women are consistently underdiagnosed with endometriosis, and may never receive a proper diagnosis (Farland & Horne, 2019).

Another challenge to informed consent is White-coat syndrome, which describes the phenomenon in which patients have elevated blood pressure in clinical settings but normal blood pressure outside of clinical settings (Siegel et al., 1990). This sweaty-palmed, weak-kneed, heart-

⁹ Use of "average patient" here refers to measure of "average" based on the third and fourth aspects of informed consent – which often centers White upper- to middle-class cisgender women

racing reaction is a part of the sympathetic nervous system, a.k.a. “fight or flight,” which helps the body respond to dangerous or stressful situations (Kwiek, 2018). This system, in short, helps us “outrun the mountain lion.” When the body is experiencing a sympathetic nervous system response, neurons in the brain behave differently than if someone was in a parasympathetic (rest and relax) nervous system response. Not only does the physical body experience changes, like elevated blood pressure, increased heart rate, and temporary loss of fine motor movements, the brain also experiences changes. Memory storage is impeded, and the brain may struggle to make careful considerations because it is instead primed to make snap decisions (Kwiek, 2018).

Alternatively, some patients who do not experience White-coat syndrome still make medical decisions in a state of confusion, pain, information overload, etc. that can impact the patient’s autonomy. Relational feminists ask how White-coat syndrome can be mitigated with improved doctor-patient relationships.

THE MOST PROMISING IMPROVEMENT, AND ITS LIMITATIONS

The Subjective Standard of Informed Consent

Relational feminists agree that the subjective standard of informed consent is the best for relational autonomy because its approach is tailored and specific to the individual. This helps ensure that patients have a deeper understanding of the proposed medical intervention and are more involved in the decision-making process because a doctor would take into consideration the social implications of the patient’s age, race, gender, ethnicity, ability, education level, religion, and insurance status, but also, and more meaningfully, their healthcare and lifestyle values, past experiences with health care, concerns for current and future health status, and possible social or structural barriers that influence medical decision-making.

The subjective patient measurement for patient understanding is an improvement for relational autonomy, but it lacks practicality. While information like age, sex, gender, etc., can be filled out on a checklist, I argue that information such as values and future concerns is not only more relevant to relational autonomy and a patient's ability to have control over their body, but also unlikely to be disclosed unless the doctor is able to spend a lot of time with the patient at their appointment, and/or has a close relationship with the patient over several years. The longer a patient is able to have a relationship with their doctor, both within appointments and over long periods of time, the more likely the patient is to disclose information that shapes healthcare decisions (Dugdale, 1999). Longer appointment times resulted in higher patient satisfaction and better health outcomes (Dugdale, 1999). This would improve women's ability to control their bodies. Unfortunately, the American healthcare system is not set up for a subjective patient approach. 33% of doctors spend only 17-24 minutes with their patients, but the majority of that time is spent looking over the patient's chart rather than getting to know the patient or addressing their concerns (Franklin, 2019). The subjective standard approach is preferred by most relational feminists, but unless the larger systems in which informed consent operates is restructured to allow for this type of relational autonomy, this standard is unlikely to be effective within healthcare systems.

CONCLUSION

Limitations to informed consent pose a challenge to a patient's ability to make meaningful choices regarding their bodies and lives. The relationship between a doctor and patient can increase the patient's autonomy, but at the same time a negative relationship, even inadvertently, may inhibit patient autonomy. Under current medical systems, it is a challenge for doctors to

know what information is necessary to tell a patient, or how to measure if a patient truly understands the information provided. While there are some ways to improve informed consent, such as the subjective patient approach, other systematic barriers prevent the kind of relationship between doctor and patient that would allow for improved patient autonomy. In the next chapter, I suggest how feminist relational autonomy approaches can remedy some of these systemic barriers, and how doing so would increase patient autonomy.

CHAPTER 4: IMPROVING RELATIONAL AUTONOMY FOR BIRTH CONTROL USERS

INTRODUCTION

As mentioned in Chapter 3, informed consent is the main pathway to ensuring a patient has autonomy in their healthcare decisions, but its basis in mainstream theories of autonomy and its use of standardized measurement systems make it problematic and hard to implement in pragmatic and inclusive ways. Even though informed consent has limitations, removing it would be even worse. Informed consent could be amended to favor the subjective standard but doing so would be ineffective unless followed by structural changes to healthcare systems that would support a subjective patient approach.

Relational feminists have recognized that even if informed consent was left as-is, reframed, or changed entirely, it still operates within larger healthcare systems that can be oppressive and inaccessible. Relational feminist bioethicists have instead turned from focusing on informed consent alone towards broader ideas of how healthcare can either exacerbate or ameliorate oppression, and constrict or broaden autonomy (Dodds, 2000). Relational feminists ask how institutional frameworks of medical resources and medical education can change the extent to which medical care no longer perpetuates oppression or constricts autonomy. In this section, I analyze universal healthcare, college affordability, and education programs as systems where issues with informed consent can manifest. I argue that using a relational autonomy approach when reconstructing these three systems is vital to the amelioration of oppression and expansion of BIPOC and poor women's control over their bodies and lives.

SYSTEMS: UNIVERSAL HEALTHCARE

One aspect of U.S. healthcare that currently exacerbates oppression and constricts autonomy is the lack of a functional universal healthcare policy. Universal healthcare has been an incredibly hot political topic especially among recent 2016 and 2020 political cycles. With the novel coronavirus SARS-CoV2 global pandemic revealing inequalities and blind spots within medical systems, healthcare has taken even more of a center stage in political discussions than ever before. Currently, 28.9 million non-elderly Americans are uninsured, and this number has not been adjusted to account for insurance coverage lost due to unemployment rates during the COVID-19 pandemic (Tolbert et al., 2020). More than 70% of the uninsured cite high insurance costs as the reason for being uninsured, and lack of insurance is the main barrier to healthcare access (Tolbert et al., 2020). When people do not have insurance, they are more likely to go without health care, and are more likely to spend more money when they do seek care. Moreover, those without health care are more likely to utilize healthcare services that are easy to access and relatively cheap, such as retail clinics and pharmacies (Dalen, 2016).

In contrast, countries with universal health insurance pay less in health care costs overall. For example, Canadian health care costs spends approximately 7% less than the U.S. on healthcare because preventable care is more accessible (Luthra, 2017). While 7% may not seem like a lot, it adds up when counting the trillions spent on health care each year (Kurani et al., 2020). Moreover, the United States ranks last in healthcare access and quality among comparably wealthy countries, which demonstrates that the U.S. has higher rates of amenable mortality (Kurani et al., 2020). A familiar Americanized image that has come to symbolize the epitome of U.S. healthcare is of American citizen's GoFundMe accounts, a website where people can receive donations from anyone online for unaffordable medical treatments. The GoFundMe

website even has a webpage dedicated to medical and health insurance fundraisers to make it easier to find accounts seeking support for medical care (GoFundMe, n.d.).

Continuity of Care

One of the central benefits to a universal health care policy is improved continuity of care. Currently, continuity of care is very low because people are not typically able to see the same doctor. Since many doctors see patients for the first time, 67% of physicians interrupt their patients at a median of 11 seconds before interruption for clarification about the patient's medical history (Canan, 2020). Allowing a patient to speak uninterrupted for even just 3-4 minutes yields 90% disclosure of healthcare history, current concerns, and symptoms (Canan, 2020). This is not only beneficial to the patient to build trust with their doctor, but it is also beneficial for the doctor who is more likely to provide an accurate diagnosis using the patient's healthcare history. Being able to spend more time with the patient can help the doctor understand specific needs of the patient more clearly and can help resolve problems that may arise when using "average patient" approaches with informed consent. Additionally, spending longer amounts of time with doctors has resulted in decreased severity and likelihood of White-coat syndrome (Cobos et al., 2015).

Those who have stable and unchanging health insurance – either privately purchased, supplied to them by an employer, or offered to them by the government – are more likely to visit the same doctor during their lifetime as opposed to those who are uninsured or have unpredictable health insurance (Sudhakar-Krishnan et. al, 2007). Patients who were able to see the same doctor felt they valued their relationship more, felt they had more control over their health, and had increased patient satisfaction (Sudhakar-Krishnan et al., 2007). Continuous care with the same healthcare provider halves emergency room admissions, positively effects clinical

outcomes, and results in higher patient education about options and treatment plans (Sudhakar-Krishnan et al., 2007). These measurable outcomes help strengthen feminist relational autonomy arguments, which posit that relationships between people strengthen their ability to be more autonomous than without said relationships. Continuity of care can function as a central pillar to medical autonomy, but it is dependent on the revisions of current U.S. healthcare systems.

SYSTEMS: DIVERSITY AND THE PROBLEM WITH COLLEGE AFFORDABILITY

Increasing healthcare access through universal healthcare programs does not necessarily mean relational autonomy will automatically improve for patients, especially if their doctors are not a diverse group of individuals. As mentioned earlier, doctors who share similar identities to their patients are more likely to know how to communicate effectively with their patients (code switching) or can more readily identify with the struggles the patient may be facing. Racism is still rampant in the medical community, where Black women's mortality during birth is four times higher than White women (Creanga et al., 2015). Black people are also less likely to be prescribed pain medication and are still believed to have "thicker skin" than White people (Hoffman et al., 2016). Racism, sexism, and phobic attitudes pose medical dangers to patients, and increasing the population of doctors who share similar backgrounds, identities, or even health journeys as their patients will likely ameliorate medical oppression and limitations to autonomy. Studies have found that patients treated by female doctors had lower 30-day mortality and lower 30-day readmissions (Tsugawa et al., 2017). These studies also found that not only were female doctors more likely to perform better on standardized examinations in medical school, but they were also more likely to use the subjective patient approach by using patient-centered communication and were more likely to provide psychosocial counseling than male

doctors (Tsugawa et al., 2017). These studies lack an intersectional analysis, so it is currently unknown how race or gender identity factors into doctor-patient care. However, this data supports that increasing the diversity of doctors is beneficial to the patient's health and may improve the relationship between doctors, patients, and trust.

The need for a more diverse group of doctors speaks volumes to the barriers within medical schooling systems. College tuition remains at the highest in history, and medical school tuition is even higher (National Center for Education Statistics, 2019). Medical schools are fairly exclusive and have historically tended to favor admissions of middle- and upper-class White cisgender men. OSU College of Medicine was founded in 1914, and between 1914 and 1934 only had 55 female graduates (Ohio State University Libraries, 2011). Harvard Medical School, one of the most prestigious medical schools in the U.S., only opened its doors to women in 1995 (The Joint Committee on the Status of Women, n.d.). Neither of these histories provided an analysis on admissions based on race or class. Only recently has there been a mass shift towards increasing diversity and scholarship opportunities for non-White and non-male doctors in medical fields. Medical schools must continue to encourage and make accessible their admissions for BIPOC and poor women.

SYSTEMS: EDUCATION PROGRAMS

Another system relational feminists include in discussions of reform is school education. In particular, feminists focus on sex education, which is abysmal in the U.S. and mostly abstinence based. Many young Americans know very little about birth control or how it works (Planned Parenthood, n.d.). Only 18 out of 50 states require educators to share information about birth control, but the information shared is not regulated by a larger governing body and can therefore

vary in depth or even accuracy (Planned Parenthood, n.d.). When patients visit a doctor, it is often the first and only time they receive any education about birth control. Poor sex-education programs also contribute to knowledge barriers about reproductive anatomy, and may not recognize medical terms versus layman's terms. For example, menstruate vs. period, or vulva vs. private parts or other slang, and even the use of the word "contraception" instead of "birth control" can pose barriers to women's ability to understand the intended therapy, why it is being suggested, and how it works. Patients may thus experience the ever-so-common "you don't know what you don't know" phenomenon in which they are unable to ask questions they need the answers to because they do not know it is something they should ask about.

In addition to improving education programs for future patients, improving education programs for future medical professionals is equally as pertinent of an issue. Medical schools should require diversity training programs for all students, including training programs that are culturally inclusive and LGBTQ+ aware. As stated earlier, the exclusivity of medical school often results in doctors who have some sort of privileged background, and this is only changing as of recently. Unless future medical professionals are required to spend time learning about healthcare inequity, identity, histories of racism and sexism, and alternative attitudes people hold towards health, the changes women need to see in order for their autonomy to increase will be truncated.

Education is an example of how relational autonomy can have both positive and negative effects on autonomy - sex education that lacks a comprehensive structure, or for that matter doesn't exist at all, has lasting negative effects on people's ability to understand their bodies and make carefully considered and educated decisions about their bodies and their health. On the other hand, however, comprehensive sex education, which includes lessons on anatomy, medical

terminology, age-adjusted content, LGBTQ+ and disability inclusion, and birth control has the power to increase people's ability to understand and control their bodies. The US currently lacks a single governing body that implements and monitors a sex ed program such as the one I have mentioned here. However, it is important not to lose sight of the importance of founding a program on relative autonomy theories, which centers intersectionality and accessibility, and would help establish these programs with cultural awareness about larger systems such as race, sexuality, gender, and patriarchy, and their impact on medical socialization.

CONCLUSION

While it is not my intent in this section to answer *how* universal healthcare, diversity and college affordability, and education programs should be reformed, it is important to recognize that *when* these systems are reformed they must center a feminist relational autonomy approach. Studies have shown that when aspects of relational approaches are included within medical spheres, like increasing time spent with patients, and increasing diversity of doctors in the medical field, health outcomes improve, and patients are more satisfied with their care. Reforming the medical systems that expand relational ideals will help women have more control over their bodies and lives. This chapter highlights what relational feminists seek to highlight – that social systems are interrelated and inform social attitudes in medical spaces. If one system shifts towards relational autonomy, then others must follow closely behind for any of these shifts to be meaningfully effective, especially for members of society who are the most marginalized.

CONCLUSION

In Chapter 1, I show why mainstream definitions of autonomy are pointedly masculine and prove exclusionary to all women, especially BIPOC and poor women. I explain why a feminist relational approach to autonomy is necessary to future measurements of women's ability to have control over their own bodies. Relational conceptions of autonomy are especially important within bioethics because medical decisions have also been assumed to be based in masculine/atomistic decision-making pathways. Feminist relational autonomy reminds us that under oppressive systems, most systems assumed to be gender-neutral are in fact masculine, racist, oppressive, and perpetuate inequality.

In Chapter 2, I demonstrate the larger relevance of relational autonomy using the history of birth control as an example for how unequal autonomy has been for birth control users in both the past and the present. Seeing how birth control has impacted so many different groups in vastly different ways can benefit the way doctors' approach autonomous decisions in contexts of birth control. This history can also help contextualize why informed consent does not always guarantee the same levels of autonomy.

In Chapter 3, I expand on issues with informed consent and argue that using informed consent as a proxy for autonomy is exclusionary and poorly fit for women, especially in contexts of birth control where autonomy can manifest differently for different groups of women. Informed consent lacks intersectionality, relationality, and practicality especially when situated under larger systems of oppression that threaten individual autonomy.

In Chapter 4, I expand on the ways informed consent is limiting by contextualizing informed consent within larger systems of universal healthcare, college affordability/diversity in the medical field, and education programs. If informed consent is to be reconstructed to fit into

feminist conceptions of relational autonomy, then the systems in which informed consent is used must also be reconstructed with a feminist conception of relational autonomy. If the systems remain as-is, they will continue to act oppressively on patient autonomy instead of acting in positive ways and increasing relational autonomy for patients.

Currently, informed consent is still an important part of the way medical decisions are made. Informed consent has acted positively in the transitional stage between paternalism and shared decision making between doctors and patients. However, feminist analysis of autonomy and informed consent has exposed weaknesses within these normative definitions and has offered a framework to reestablish and reconstruct ideas of autonomy and informed consent within medical systems and bioethics. Many of these policies, such as college tuition, improving education, and diversity in the medical field, are being discussed in political cycles today. This demonstrates that positive headway is both possible and within reach, but unless these reconstructions are made with feminist relational autonomy approaches in mind, any reconstruction without feminist relational approaches threaten to perpetuate oppression in ways that are harmful to women and other minorities.

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