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MUSING

Care and the Limits of a Pro-Choice Discourse

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Abstract

The global pandemic exposed many flaws in the gendered political economy. It also illuminated how essential care is to our economy and to our flourishing. Yet, when care is dependent on a capitalist system that relies on competition, there will always be people who receive care and those that will not. In such a system, care is wrongly perceived to be a "choice" one can opt into or out of. This short essay grapples with the discourse of care as a choice, particularly around reproductive decisions. Choices offered within a neoliberal market logic fail to understand the political relationalities of such choices. Drawing on my personal experience of an abortion and other examples from the first year of COVID-19, this essay demonstrates how little choice there is in matters of care; care connects and disconnects one another regardless of personal choices. If matters of care persist in the realm of the market reliant on rational economic autonomous actors, then the many interrelationalities of care that the pandemic exposed will not have any impact on attaining a more caring society. This is particularly important given the nature of abortion politics in the United States. I argue that abortion is health care, and is often the most caring decision a pregnant person can make for the world they are trying to maintain, continue, and repair (per Tronto 1993). Care is not a choice; it is fundamental to human society.

Reluctantly, I was forced to accept the disturbing reality of my second pregnancy: my baby's lungs were being crowded by his other organs and there was little chance that he would be able to breathe once outside my body. He developed a congenital diaphragmatic hernia, which was detected in my 11-week ultrasound when the sonographer noticed the baby's heart pointing to the right side of his body. After a few anxious weeks of waiting for the baby to grow and give the specialists better images to review, it became clear that his prognosis was bleak.

I was living in Aotearoa New Zealand at the time, where I had access to a team of state-subsidized compassionate and research-informed medical experts who communicated a long list of all the ways the baby would suffer once outside my body. Crucially, if the doctors had any chance of saving him, he would have required an unknown amount of time on a ventilator and an ECMO machine.

In what felt like an eternity of sleepless nights and disturbing days in medical clinics, waiting for results, consulting with specialists, coffees with my obstetrician, and

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somehow (barely) holding myself together as I continued to lecture at my university, my partner and I made the difficult decision to terminate the pregnancy, just shy of 18 weeks. If I hadn't made this heartrending decision, he would have been born in January 2020 as global awareness of COVID-19 was beginning to emerge and when all personal, local, and federal resources were increasingly needed to take care of those who are already on this earth.

In January 2020, I was residing in Washington state while on sabbatical from Auckland and where I *would* have given birth. Newspaper reports during those early weeks and months of the pandemic made it clear that delivering a newborn needing critical care during the pandemic would have been complicated (to say the least), when non-complicated births posed their own challenges (Guo 2020). For example, if the baby would have survived the birth, the small county hospital would not have had the means to take care of him and he would have spent an indefinite amount of time at Seattle Children's Hospital, the city where the virus first surfaced in the USA. I might have had to compete for a hotel room in Seattle with quarantined patients or healthcare workers (Fadal 2020), simultaneously juggling the caring needs of our 5-year-old daughter while my partner worked in an "essential" job two hours away. At some point, I might have had to leave the baby alone in the hospital because visitors were forbidden (UW Medicine 2020). Doctors might have had to decide if his ventilator and/or ECMO would be better utilized for someone who had a higher chance of survival (Hamblin 2020). Depending on how long he would have lived, given the fragile state of his lungs, he might have been vulnerable to acquiring COVID-19 and ultimately dying alone without an embrace of his parents. Meanwhile, I shudder thinking about what my insurance might (not) have covered (Chang 2019).

This hypothetical list of the caring challenges I would have had to face with a baby that I could have safely terminated reflects how abortion needs to be understood within a web of complicated relations rather than an individual choice; the most caring decision for the baby, for my family, and for the communities where we would have been competing for resources, was to not bring him into the world. In this short essay, I focus on the politics of care that were fundamental to my reproductive decisions and that underscored experiences of the global pandemic.

In referring to a *politics* of care, I am not engaging in an evaluative discussion of whether or not my actions were motived by caring dispositions or emotions. Certainly, I believe that my decision to terminate a pregnancy that had a very little chance to survive was, indeed, the most caring decision I could have made. I hope to make this clear to the reader through reflecting on my experience throughout the essay. But such an individualistic argument, in my opinion, ignores a more critical reading of care's political potential. Rather, the *politics of care* focus on a relational autonomy, or the interdependencies beyond the individual or dyadic care-giving relationship. Shifting attention to how care fundamentally challenges assumptions of autonomy, and therefore "choice," enables a more comprehensive analysis of the power relations and inequalities in which care is located, distributed, and accessed: "[s]ince care is a fundamental feature of collective human life, there is no way to remove power and interest from affecting how care practices are organized" (Tronto 2013, 10).

The very nature of COVID-19 illuminated how deeply interconnected and interdependent we all are, but not everyone received or gave care the same. The virus travelled swiftly and transnationally, requiring governments around the world to take action to prevent the loss of life. Yet, rather than a "leveller," the virus exposed the unequal caring relations and pervasive structural inequalities that underpin capitalist societies. Feminist

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scholars have argued for decades that caring relations are woven through power relations and therefore distributed and felt differently across gender, class and race stratifications (e.g., Tronto 1993, 2013; Robinson 2011; Naryan 1995; Raghuram et al. 2009). Abortion and other gendered politics during the pandemic provide examples of how important it is to expose these relationalities in order to build a more caring society. The examples I discuss in this essay demonstrate that care is *not* a matter of personal choice, but a matter of politics.

As a dual citizen of the USA and NZ, I am viscerally aware of the different policies and approaches toward laws governing women's reproductive bodies. Less than a week after my termination, the Aotearoa New Zealand Labour-led coalition government introduced new legislation serving to decriminalize abortion and repeal outdated laws; the Abortion Legislation Act 2020, which was voted into law in March 2020, allowed the rulebook to come up to date with the reality of how abortions have been carried out in the country for decades (Little 2020). Notwithstanding significant obstacles some people face in Aotearoa New Zealand regarding abortion access for religious, social, or geographical reasons (Le Grice 2014; Silva and McNeill 2008), the new legislation was accepted around the world as a win for "women's rights," and gave Aotearoa New Zealand a media spotlight before their Prime Minister, Jacinda Ardern, took center stage shortly thereafter for her leadership during the pandemic (U. Friedman 2020). Importantly, the new legislation unequivocally defines abortion services within the remit of state-subsidized maternity health care options.

The politics of abortion, and healthcare more generally in the USA, are historically more ideologically polarized and convoluted than in Aotearoa New Zealand. These differences were brought to stark contrast when the same month that Aotearoa New Zealand passed their progressive legislation, some states in the USA attempted to restrict "elective surgeries," including safe and timely abortions, until the threat of COVID-19 was "under control" (Bazelon 2020). Coincidentally, I was not living in one of those states, and even though Washington state has been a consistent champion for women's reproductive bodies over time, the unprecedented nature of the pandemic made it clear to all of us around the world that *nothing* was to be taken for granted. Within the USA, the unpredictable behavior of the virus, the dearth of scientific data on the virus, the void of political leadership, the proliferation of misinformation, and general panic across the country resulted in a breeding ground for the erosion of civil liberties and quick and dirty policy changes (L. Friedman 2020; Milano 2020). Reproductive freedoms, precariously legislated at best, were not immune.

The United States Supreme Court's decision to overturn *Roe v. Wade* (1973) has been a disaster waiting to happen (Rebouché and Ziegler 2022). While women gained the right to an abortion in *Roe*, American legislation governing women's reproductive bodies remained woefully insecure due to the intersections of political ideology with the structure of American democracy, as *Dobbs v. Jackson Women's Health Organization* (2022) made very clear. This essay does not attempt to discuss the history, politics, or ramifications of *Dobbs*, but acknowledges that this disastrous ruling is the first time in US history where the Supreme Court *removed* a fundamental right, which importantly was a *gendered* right. Rather, this essay discusses that women's right to abortion has always been under threat, not only during the pandemic, due in part to the failures and short-sightedness of the "pro-choice" discourse abortion advocates espouse, while simultaneously failing to grasp the extent of the caring relations where such "choices" are situated.

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The limits of choice-based governance have been a primary concern for BIPOC (Black, Indigenous, and People of Color) leaders in the reproductive justice movement for decades. In tracing the history of the reproductive justice movement, Ross and Solinger (2017, 102) state that white feminists in the 1970s adopted the rhetoric of "'choice' … over the harder-edged political term 'rights'. … 'Choice' was palatable in part because it directly associated sexual women with an approved female activity, consumerism…" Slavery, forced sterilization, economic opportunities, and structural conditions demonstrate that not all women have equal choices in the marketplace or writ large. Consumerism is hardly a rallying cry when Black women have not had full control over most aspects of their lives, especially their reproductive freedoms, including access to contraception, motherhood, and, of course, abortion. Ross and Solinger argue that access to structural and personal resources "fundamentally shapes the meaning of choice" (2017, 102).

The market logic of choice, dependent on personal responsibility and autonomous rational actors (Budgeon 2015; Ludlow 2012) is not only a key component of the white liberal feminist movement, but also a key component of the United States' neoliberalized healthcare system. While Aotearoa New Zealand removed the market (and stigma) from the distribution of health *care options* for pregnant people, polarizing and divisive healthcare politics in the USA are principled on market logics. Perpetuating abortion politics as a politics of choice fails to grasp the full spectrum of emotions, relations, policies, structural and personal failures, and responsibilities pregnant people weigh before reaching a decision to end a pregnancy (Gilligan 2003; Laguens 2013; Piepmeier 2013; Price 2010; Ross and Solinger 2017; West 2008).

To the woman who chooses to terminate a pregnancy, the complicated webs of relationality matter on the deepest most intimate scale. As reproductive justice scholars and activists have done important work in reframing choices as multi-scalar and multidimensional, immersed in structures of racism, misogyny, misogynoir, and patriarchy, scholarship on the politics of care could offer further insights in which to better understand how reproductive decisions are immersed in intricate *caring* relationalities (Tronto 2013; Robinson 2011). In fact, caring reproductive decisions can be made with few, or no, viable choices (A. Smith 2005).

Tronto argues that when "human life is viewed as the sum of individual 'choices,' for which he or she will be responsible … [care] becomes an entirely personal and private matter" (Tronto 2013, 40). One is assumed and expected to make choices about how to take care of oneself and others, but these choices are not equal, they lead to further injustices, and fail at the promise of "freedom" (Tronto 2013, 40). In fact, the choices of how to best care for oneself or another are often tangled in a web of conflictual and even detrimental relations, not (only) choices.

In my particular case, while I had access to healthcare choices in Aotearoa New Zealand, my "choice" was still implicated in knotty social and professional caring relations. Moreover, because reproduction decisions hold emotional and professional weight for women in the workplace, I felt powerless, despite my freedom (e.g., Porschitz and Siler 2017).

When I was pregnant with my first child (in Aotearoa New Zealand) a few years before my second pregnancy, colleagues in my department seemed to ignore my growing belly. I believed this to be progressive and felt honored that my decision to become a mom wasn't being focused on in a negative way in the work environment. As my belly grew, I marched on towards my due date while maintaining my caring duties in the home and at work. My (deliberately planned) maternity leave coincided with a semester

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I was not scheduled to have any teaching load. In other words, I am a well-trained neoliberal subject: my five months away from campus shouldn't have put any extra labor burden on my colleagues. I approached family planning as relational—relational to my professional responsibilities and the caring relations that sustain it. While family planning doesn't always work out, I was lucky that mine did.

My neoliberal subjectivity influenced the timing of my second pregnancy as well (also in Aotearoa New Zealand), which was to coincide with my scheduled sabbatical, thereby not adding additional burdens onto my colleagues. Again, I was lucky that my family plan worked out, but only part of the plan.

Like so many working pregnant people, I tried to keep my second pregnancy hidden in the first trimester, less because I feared discrimination and more because I feared my baby might not make it. As I moved (what I hoped was inconspicuously) into my second trimester and every day was a day closer to deciding my baby's fate, I suffered with existential angst, fear, shame, and extreme anxiety. I was unable to provide myself with the care I needed to maintain, continue, or repair my world (per Tronto's much cited definition of care) and because the workplace is often a site where caring relations are fraught, including mine, I had no way to share the emotional load that overwhelmed me. Rather, I continued to care for others: my unborn baby, my nuclear family, my job, my students, and my colleagues, which is a heavy emotional load to carry during an uncomplicated pregnancy, but my second one was not. I was dealing with life or death, which made all other day-to-day logistics seem inconsequential. I needed care, but if care is not distributed, then it cannot be received; care giving and receiving are rarely choices made solely at the individual level. They are entangled in knotty political, contentious, personal, *and* structural relations.

Those uncomfortable caring and uncaring relations were metamorphosed and amplified just a few months after I terminated the pregnancy and the pandemic wrought havoc. If the baby had survived, the many challenges I would have faced with a sick child needing critical care during the pandemic demonstrate that my own caring decisions would have led to relations of conflict over resources, time, and space with my partner, daughter, healthcare providers, and countless others. At the most fundamental level, if people are unable to make their own caring decisions around how to or if to deliver a baby, undoubtedly, conflict is inevitable. Unfortunately, COVID-19 provided many other vivid illustrations of entanglements between care, conflict, and inequalities; most of these entanglements had very little to do with choice but invariably had inequitable consequences (Lewis 2020c).

For example, as governments around the world paused economic activity and required people to stay at home, it became clear that taking care of each other was the only way to beat the pandemic. Taking care of each other was also premised on taking care of one's self. Proper handwashing, keeping social distance, and wearing a mask was proven to be the most effective way to take care of one another during the pandemic: keeping yourself healthy would also help keep those around you healthy. Yet, from very early on in the pandemic, the media were reporting evidence of people purchasing and hoarding basic hygiene products, food, face masks, and other essential commodities (Lewis 2020b). While those products were necessary to take care of oneself and proximate others, hoarding by some left many others without the same caring devices. Inarguably, the market *enables* people to choose to consume more than they need, even when others suffer as a result. When care is dependent on a capitalist system that relies on competition, there will always be people who receive care and those that will not. Care scholars have documented examples of unequal relations of giving

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and receiving care at various scales, particularly within neoliberalized economies (S. Smith 2005; Datta et al. 2010; England 2010); COVID-19 illuminated the inequalities of care on a deeply personal scale for many people around the world. Ultimately, COVID-19 demonstrated how the market fails to take care of people, and it will continue to fail if care remains the personal responsibility of each one of us.

Beyond the failures of the market to provide equitable distribution of basic items necessary for care, COVID-19 also made it clear that not all people have the same freedoms to make the most caring choices for themselves or their families. For example, stay-at-home orders around the world provided little choice for those who resided in abusive households. Domestic abuse skyrocketed and was disproportionally experienced across genders (Neuman 2020). No doubt those who were killed by their abusers during the pandemic will not be counted in the COVID-19 death-toll, a clear sign that "stay-at-home" orders were severely uncaring for some citizens who did not have the freedom to choose otherwise (Grierson 2020). Stay-at-home orders also raised incredible challenges for parents required to "work at home" while simultaneously caring for children in the home. Media reports indicated that increased childcare duties and homeschooling responsibilities in heterosexual households fell predominantly on the shoulders of women (Lewis 2020a), exposing the privileged irresponsibility some people enjoy in a system that devalues care and care work (Tronto 2013, 58). These women's increased caring responsibilities will undoubtedly impact their productivity while working from home and their CVs will reflect this setback; quarantined time at home for others without the care-giving penalty allowed them to increase their productivity (Kitchener 2020). Reports suggested that this unequal dynamic of care will further exacerbate gender bias in promotions and advancement post-pandemic (Minello 2020).

In other words, the freedoms women had to "lean in" to the workplace prior to the pandemic were exposed as a farce; incorporating caring relations complicates a simple solution to women's professional achievements. And parents who were deemed "essential workers" were faced with even less freedom to choose throughout the pandemic. These parents were required to juggle childcare duties while working in underfunded and undervalued service industries with often inadequate personal protection from the virus (Robertson and Gebeloff 2020). These (often) low-waged, gendered, and BIPOC employees risked their own lives so that they could provide services, such as healthcare, but also commodities, such as food, to other families required to stay at home (Kagen 2020). The pandemic exposed countless other examples of how convoluted assumptions are around choice and freedom, but they all reveal the same basic premise: care is *not* a choice. A system that sees care as a matter of choice will perpetually fail to understand that care is a fundamental premise to human society and connects us all, regardless of the choices we make.

In conclusion, the global pandemic certainly exposed many flaws in the gendered political economy. The pandemic also highlighted how essential care is to our economy and to our flourishing, and that care is, importantly, unequal and immersed in power relations. When care is presented as something we can elect into or out of, our social, economic, and political systems fail. Care is not a choice, rather, care is nonnegotiable. Those of us who acquired the virus, or who lost a loved one to it, will viscerally know this. And those of us whose health or household was less impacted by the virus, will undoubtedly recall the myriad ways that their caring responsibilities, and caring needs, increased in subtle and overt ways over the span of the pandemic.

Care is also political. While I grieve the loss of a fetus I had hoped to welcome into the world as a baby, I am grateful that I was not further burdened with the conflicts of care that would have arisen if he was born. I do not feel any greater sense of freedom for

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having the choice to make this decision. Rather, what my decision and other examples in this essay demonstrate is how little choice there is in matters of care. If matters of care persist in the realm of the market reliant on rational economic autonomous actors, then the many interrelationalities of care that the pandemic exposed will not have any impact on attaining a more caring society. Moving forward, feminists have the opportunity to better understand the ways care connects us, but also provide more analysis of how unequal caring relations also disconnect us.[1] Bringing these power relations more to the fore has the potential to increase a more genuine and equitable caring society.

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Note

1 There are crossovers with the arguments I make in this essay with Odozor's recent essay (2022) calling for a *love ethic* to address the politics of care, particularly for Black feminism: "A love ethic then, is a conscientious affirmation of Black lives and ontologies. We must choose to love. It is not passive. It is not intrinsic. To love, we must care, we must listen, we must speak honestly, there must be trust, and we must seek out intention and recognize that intention sometimes fails to manifest in right action (hooks 2001: 94). That is not to say that we must accept wrong, but that we must recognize humanity as being subject to error" (245).

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