

Intervals - Episode 17

Season 1: Intervals of Public Health
Lecture Title: "'Butchery' in Tijuana: Tijuana
Abortions and Abortion Decriminalization in
California"

Q+A Taping Date: March 5, 2021

Upload Date: July 28, 2021

Guest Lecturer: Alicia Gutierrez-Romine

Host: Christopher Brick

Preferred Citation Format

Alicia Gutierrez-Romine, "'Butchery' in Tijuana: Tijuana Abortions and Abortion Decriminalization in California," and Q+A interview with Christopher Brick, *Intervals*, podcast audio, June 9, 2021, <https://www.oah.org/programs/listen-to-history/>.

Initial Verbatim Transcript - May Contain Typos

Introduction

CHRISTOPHER BRICK: Hello everyone and welcome back to the Intervals pod. The Intervals series is a public humanities initiative of the Organization of American Historians, and I'm your host, Christopher Brick, here on behalf of the organization's Committee on Marketing and Communications.

And today it's also a real joy for OAH and myself to be welcoming Dr. Alicia Gutierrez-Romine to the show to deliver our seventeenth guest lecture of the series.

Alicia's currently an assistant professor of history at La Sierra University in Riverside, California, and her talk, "'Butchery' in Tijuana:

Abortions and Abortion Decriminalization in California," draws from some of the research she used to develop her recent book on this subject.

Entitled *From Back Alley to the Border: Criminal Abortion in California, 1920-1969* explores the history of illegal abortion in California focusing on abortion providers, and the women who visited them, and following them from the notorious back alley to the US-Mexico border.

The border has an important role to play in this story, bifurcating that part of north America into different states, yes, but also into distinct regimes of abortion access that shaped the region's politics, law, and culture as much as the health security of its women.

With abortion options severely limited in California, Alicia discloses, the proliferation of an abortion industry on the Baja California side of the U.S.-Mexico border produced a panic as its existence became more well-known in the U.S. State and federal law enforcement agencies devoted resources to the investigation of a so-called "international abortion ring" operating on Mexico's side of the border, and they put their considerable influence behind the establishment of new laws to "combat the problem."

The designation of Tijuana as a city synonymous with the "butchery" of American women energized California's abortion liberalization movement alongside and in league with racist tropes about Mexico that hardened American willingness to impose strict border controls. It's thoughtful, perceptive work that got me thinking about the history of public health in a whole new way, and here she is:

Dr. Alicia Gutierrez-Romine on Tijuana Abortions and the history of abortion decriminalization in California.

Lecture

ALICIA GUTIERREZ-ROMINE: "Abortion is health care." This is a slogan you might have heard lately. Since the U.S. Supreme Court decision in *Roe vs. Wade* in 1973, abortion rights and access have come under fire. While abortion is still technically legal, in many states it's becoming increasingly inaccessible. A greater understanding of the history of abortion decriminalization in the U.S. can help us see the public health origins of abortion legislation. If we forget what precipitated abortion decriminalization, we risk making this procedure dangerous again. I am Alicia Gutierrez-Romine, and welcome to this episode of *Intervals*.

Over the course of the 19th century, abortion became illegal in every state. These early abortion restrictions align with physicians' efforts to consolidate professional medical authority, concerns about race suicide and immigrant women's fecundity, and attempts to protect women from quacks. By the middle of the 20th century, abortion laws were well-entrenched, and criminal abortions were becoming easier to prosecute as legal abortions were almost exclusively taking place in hospitals. Legal abortions required quite a bit of red tape, and they weren't sure things. For most women, their desire to have an abortion was not enough to permit a legal one. So, for women who wanted to take matters into their own hands and

have control over their own destinies, illegal abortions were likely the best bet.

Illegal abortions run along a spectrum. They could be clean, hygienic, and safe, or they could be bloody spectacles of incompetence. They could be performed so safely that women could get them done during their lunch break and go back to work, or they could be performed by an untrained, unskilled butcher who accidentally perforated a uterus, or who failed to adequately clean their medical instruments. It's impossible to generalize illegal abortions and providers of illegal abortions who, too, ran along a spectrum--from legitimately trained professionals who provided abortions for illegitimate reasons, to uneducated profiteers seeking to earn a quick buck.

That being said, there are some things we can say in general. One: black markets are wealth-sensitive; that means those who can afford it often get the best treatment and they can often afford better quality. Black markets aren't accountable to anyone, and since the procedures are illegal there are only so many demands that women can make. In essence, take it or leave it. If you don't like what this illicit provider provides, then go somewhere else. This desperation can compel some to accept conditions that otherwise be unacceptable. Illegal abortions took place in the 19th century as these abortion laws were being drafted, and they continued to take place into the 20th century as legal abortions moved into the hospital. The only things that changed were how these abortions took place, how much experience illegal abortion providers had, and the treatment options that were available if or when these illegal abortions went badly.

As abortions became harder to get in the United States, they became easier to get in Mexico. According to Steven W. Bender, quote, "U.S. demands for abortions produced a surreptitious market, particularly in the 1960s. Tijuana and nearby Ensenada served as an abortion emporium for U.S. women who faced the alternative in the United States of back-alley abortions, or safer but cost-prohibitive abortions by U.S. doctors acting illegally. Tijuana was a cheaper option." Unquote. By the 1950s and 60s, the border had become more visible to Americans through increased regulation. Along this border with Mexico, concerns about illegal immigration added to this idea that the U.S.-Mexico border was a lawless place. Additionally, sensational newspaper coverage helped to quote "explicitly link the illegal Mexican aliens" unquote, with criminal activity and other vices.

In public opinion, border cities were vice-ridden and full of crime, and these concerns about borders emerged when an unprecedented number of Americans were traveling across them for pleasure and leisure. As Mexican border towns became sights of American decadence, abortions made their way into this space as well.

Now, American women had been traveling to other countries for abortions for years, but in the 1950s and 60s, they started seeking abortions right across the border. And this was in light a therapeutic abortion committee's more judicious interpretations of what constituted a legal abortion, and the increasing ease with which white American people could cross the border.

Additionally, concerns about the legality of border abortions may have been allayed after a California court decided in the case *People v. Buffum* in 1953. This case accelerated the abortion tourism industry at the border. In the Buffum case, Reginald Rankin and Dr. Roy L. Buffum were indicted for violating California's abortion law. According to the Buffum indictment, Buffum and Rankin operated in office in Long Beach, California, where they made arrangements with women seeking abortions. The arrangements would include taking women's phone numbers, calling them and arranging a designated meeting spot.

As they met at this meeting point, Buffum or Rankin would then transport the women to an office in Tijuana where another man would perform the procedure. After the procedure, Buffum or Rankin would drive the women home, and once they returned to Long Beach, they went their separate ways. In the abortions that brought about Buffum and Rankin's arrests, four women had been transported to Tijuana, and three had required hospitalizations. While they were hospitalized, it became clear that these women had illegal abortions, and this discovery led to an investigation, and Buffum and Rankin's arrest. However, the two men eventually won their appeal on what might, on the surface, appear to be a technicality.

Specifically, the initial Buffum decision was reversed because the actual abortions took place in Mexico. Although there was ample evidence, the fact that the crime had been performed out of the state muddied the waters.

Specifically, the court stated that although the statutes, quote "made no reference to the place or the performance of the abortion, it must be assumed that the legislature did not intend to regulate conduct taking place outside the borders of the state", unquote.

Thus, the judgement was reversed, the court recognizing the limits of its power. The Buffum decision opened the floodgates of American abortion tourism in nearby border cities and contributed to the development of California's 1950s and 1960s Tijuana abortion phenomenon. Despite countless undercover assignments and surveillance in Tijuana by law enforcement to professional medical societies, authorities were unable to stop the surge of American women procuring abortions along the border.

One report in 1967 estimated that there were about 75 abortionists operating regularly in Tijuana. But, border abortions weren't just limited to Tijuana, and this estimate didn't include other places like Mexicali, Juarez, or Ensenada, which all had their own abortion businesses as well.

As the abortion industry on the border grew, unskilled abortionists had greater opportunities to offer their services. Desperate women, many of whom simply crossed the border and asked around, they rarely looked for the most qualified abortionists, and they simply accepted the services of the first person they found. These unskilled abortionists didn't necessarily kill their patients; rather, women who went to these unskilled abortionists didn't get hygienic treatment, pain relievers, or sometimes even complete abortions. When these incomplete abortions became septic, these women

were treated for infections or had dilation and curettements in American emergency rooms.

Women's inability to access legal abortions didn't just result in an increase in border abortions. Self-induced abortions became more visible too. In 1966, Los Angeles County general hospital experienced a brief surge in tetanus infections from women attempting to self-induce miscarriage. According to hospital officials, these cases were pretty typical of, quote, "an alarming upswing in the number of women who were returning to old-wife remedies and self-induced abortions," unquote. Activist Pat McGinnis realized that some women's only option was to do it themselves.

She helped orchestrate workshops instructing women how to perform abortions and explaining when a trip to the emergency room was absolutely necessary. DIY abortion methods utilized knitting needles, coat hangers, Lysol, bleach, turpentine, kerosene, rubber catheters, and even, for the most desperate, raw spaghetti. And while you might cringe at the thought, these were methods that were available to poorer women. The goal of these abortions was to simply induce the abortion to a point where a hospital had to finish the job.

Between border abortions and DIY abortions, officials of Los Angeles County General claimed that the hospital saw about 100 patients per month with complications from these procedures. One staff physician claimed that the hospital had quote, "more experience treating women who had become infected due to an abortion than any other hospital in the state and perhaps, in the country," unquote.

The staff physician at Los Angeles County General believed the hospital had such a workload because of its proximity to Tijuana. Pat McGinnis also recognized the potential dangers that existed when women would cross the border for abortions. She often passed out leaflets with the names of reputable and safe providers in Mexico. However, the occasional crackdown from American or Mexican law enforcement complicated efforts to keep this list up to date. These lists also often included tips to help identify whether the abortionist they selected was reputable. For example, McGinnis encouraged women to ask taxi drivers to find regular gynecologists and cautioned that if an abortion was less than \$300, you might want to see some credentials first.

As California state legislatures debated abortion law in 1962, medical experts in the US believed that the number of abortions performed in the country ranged between 375,000 and 2 million per year, with 1 million being a pretty conservative figure. Although it's difficult to get a precise figure for black-market commodities and services, the medical experts estimated about 5,000 deaths per year as a result of poorly performed abortions. Though the percentage of abortion deaths represented in the Los Angeles county coroner's office had steadily declined since the 1920s and 30s, representing on average 0.09% of the total number of coroner cases, abortion was becoming more visible in public discourse.

With continued coverage of illegal abortions, illegal operations in daily newspaper, it became clear that this problem was not going away. According to Kristin Luker, efforts to standardize abortion law generated greater publicity and

brought abortion into the public purview. As abortion became increasingly legislated and it moved from the home to the hospital, or from the doctor's office to the hospital, with more people becoming involved, there were just more opportunities for conflict to arise.

So let's put a pin in what we know about illegal abortions in Mexico, and let's switch gears to talk a little bit about what's going on in the U.S. in the 50s and 60s.

After World War II, with the Baby Boom, abortion and maternal mortality became important figures in representing America's status as a modern nation. Babies that were born in the post-War period experienced a new social, cultural and medical world that was very different from that of their parents' and really from most other people before them.

Post-war parents of means spent more on their babies, they bought them more clothes and toys, they purchased pre-made baby food at the grocery store, and they even took them to the doctor more often. In short, post-War babies were precious, and suburban families and motherhood were exalted. Additionally, because of advances in medicine, there weren't as many illnesses or diseases that could prevent a woman from carrying a pregnancy to term.

In this modern, pro-natalist world, women who wanted abortions were anomalies--that is, of course, unless their desire for an abortion fell within very specific parameters, like there is a problem with her, there is a problem with the baby, or with this pregnancy as a whole. And the

Thalidomide tragedy and Rubella outbreak, which resulted in the births of infants with severe defects, opened the door for discussions about abortion to take place.

Thalidomide was a pharmaceutical drug that many women took for its off-label uses, like fighting nausea or morning sickness. In 1962 its effects became known world-wide. Most commonly, thalidomide affected embryonic limb development and growth, which resulted in phocomelia, which is a rare disorder where the limbs are not fully formed or not fully developed in utero. Now, the United States did not see many of these cases, and there was no outbreak on the scale as it was in Europe, but knowledge of this outbreak was enough to produce quote, "an anxiety about pregnancy," unquote.

Now, the Rubella, or the German measles epidemic of the 1960s was significant in changing public perceptions about abortion laws in the U.S. While Rubella caused only a minor rash and fever in adults, if a woman was pregnant it could result in miscarriage, infant death, intellectual disability, blindness, deafness, or even heart malformations. According to the Centers for Disease Control and Prevention, about 20,000 babies were born with congenital rubella syndrome during this epidemic.

There was no cure for Rubella, and though the vaccine was first licensed in 1963, mass vaccination didn't begin until the late 1960s. Now, Rubella did not pose an imminent threat to the mother, but it was up to doctors and therapeutic abortion committees to determine whether the possibility of fetal abnormalities was enough to justify a therapeutic abortion, but physicians

disagreed whether it did. As a result, hospitals and therapeutic abortion committees were uneven in their application when it came to Rubella patients.

One investigation of several hospitals in San Francisco Bay area from August 1964 to 1965 found that three hospitals had performed therapeutic abortions following Rubella diagnoses in the first trimester of pregnancy. Another three had performed abortions following Rubella diagnoses for psychiatric reasons, specifically concerns about suicide. And another would allow therapeutic abortions for Rubella within the first fourteen weeks of pregnancy; however, this was only if a woman had consulted with a physician at the time that she was infected.

Most hospital representatives acknowledged the inconsistencies in their rules, but since the victims of German measles were predominantly white, middle-class women with normative sexual practices, the outbreak opened the door for discussion about abortion as a public health measure and helped make abortion more acceptable. These weren't careless, unwed women--together with their husbands, they were respectable parents whose concerns about their children's livelihoods fit within certain parameters of the post-War period's pro-natalist focus. Together, these families were utilizing this new vocabulary of family planning and genetics to argue for legal abortion when a woman's life is not at risk.

This is the context when Doctor Leon Belous referred a woman to an abortionist. Though neither she nor the fetus had an illness or disease, he referred her to an abortionist because he feared her life would be at risk if he didn't.

Dr. Belous was a Russian born obstetrician and gynecologist and for all intents and purposes he was a respected member of the medical community in Los Angeles, and he had become a leading crusader against California's existing anti-abortion laws.

In 1966 he referred Cheryl Bryant to an unlicensed physician for an illegal abortion. Eventually he was found guilty, and in 1969 he appealed his conviction, defending his actions. He believed the young woman and her fiancé were determined to terminate the pregnancy one way or another, and even though the couple planned to marry, they had other goals they wanted to pursue first. Dr. Belous refused to perform the procedure himself, but ultimately referred Cheryl Bryant to a trusted colleague for the illegal procedure, because he worried that the couple's desperation would push them too far, and he worried that this desperation would push them to butchery in Tijuana or to self-mutilation. Having witnessed the results of several Tijuana abortions, he knew of their danger, and he went so far as to tell this couple that when they went to Tijuana for abortions, they were quote, "taking their lives in their hands," unquote.

On May 10th, 1966, Dr. Karl Lairtus performed an abortion on Cheryl Bryant in a Chula Vista apartment office. The police had been tipped off and they raided the building as she was recovering from her procedure. Notebooks in the office suggested that Dr. Belous had referred 13 other women to Dr. Lairtus before. Dr. Belus was arrested, indicted, and ultimately found guilty of abortion and conspiring to commit abortion. The court of appeals affirmed the lower courts' decision, so Dr. Belus took his case to the

California Supreme Court, where he challenged the constitutionality of California's abortion statute.

When *People of the State of California v. Belus* made its way to the California Supreme Court, the case drew national attention. The press immediately recognized its potential as a landmark case for abortion legislation. The professional medical community overwhelmingly supporter Dr. Belus. They overwhelmingly respected him.

The public even felt sympathy for Cheryl Bryant. In a letter to the *Los Angeles Times*, a woman from Sherman Oaks, California asked what was better: for a doctor to perform the procedure safely, or to send women off to abortion clinics in Tijuana. She argued that countless young girls would be saved by not having to resort to leeches who profited from botched abortions.

Dr. Belus believed that the potential butchery, whether imagined or imminent, was sufficient for him to state that Cheryl Bryant's life was in danger. His fears weren't simply based on some kind of idea about racial, ethnic or nationalistic superiority. In fact, just weeks after Cheryl Bryant's abortion, a 24-year-old woman from Woodland Hills, California was found dead in Tijuana after an illegal abortion. When Belus appeared before the California Supreme Court, he and his attorneys argued that California's abortion statute was vague and unconstitutional.

Specifically, Belus's argument challenged the validity of the, quote, "necessary to preserve life" clause in the abortion statute. According to their argument, the requisite phrase had no clear meaning; was potential danger an acceptable

justification for a legal abortion, or did the danger need to be imminent?

The courts had already rejected the interpretation that the statute required certainty or immediacy of death in *People v. Abarbanel* and *People v. Ballard* because the requirement would abridge a woman's constitutional rights. Furthermore, the U.S.

Supreme Court decision in *Griswald v. Connecticut* had already held that couples had a right to marital privacy that protected their use of contraceptives. And since about 90% of abortions were performed on married women, it might appear that abortions fell within *Griswald's* purview.

As the arguments unfolded, it became clear that abortion laws didn't stop abortions--they simply reduced the number of safe abortions. According to contemporary evidence, hygienic abortions performed early in pregnancy resulted in minimal risks to women, while illegal abortions were one of the greatest causes of maternal deaths in California. While not all illegal abortions resulted in death, the rate of infection from criminal abortions was significantly greater than that of legal abortions. And in an amicus brief submitted to the court, 178 deans of medical schools from California and rest of the country stated that the unfortunate reality was that the statute, designed in 1850, which was designed to protect women, had quote "in modern times become a scourge," unquote.

The California Supreme Court ruled in Belus's favor; the basis for his challenge had been in an assumption about what border abortions meant for American women. Specifically, Belus feared that Cheryl Bryant would quote "seek an illegal abortion

in Tijuana under substandard medical conditions” unquote. That the judges took on Belus’s case and California’s antiquated law, suggested that California Supreme Court accepted this fear of border abortions as a reasonable premise.

While Mexico had offered real relief for countless women, the problem with Mexican abortions was the American law that drove women to them. While advances in medicine had all but eradicated justifiable reasons for therapeutic abortions, physicians questioned whether they were expected to turn away women whose desperation would drive them, quite literally, to the abortionists of Mexico. Citing fears of potential butchery, doctors claimed that not being able to provide these women safe abortions was the danger.

California’s Supreme Court found its abortion statute void for vagueness, and by 1970 a number of states had pushed for repeals of their existing abortion laws, while several others legalized abortion on demand. Nevertheless, the issue had not yet been decided at the federal level and it would not be until *Roe v. Wade* in 1973.

As the pendulum began to swing towards abortion liberalization, anti-abortion groups mobilized and became increasingly organized. The passage of the Hyde Amendment in 1976 prohibited federal dollars from being used for abortion. This ruling specifically affected Medicaid users and prohibited poorer women and predominantly women of color from acquiring legal abortions affordably.

Though abortions were legal in 1977 when Rosie Jimenez needed an abortion, the \$400 fee was cost prohibitive. She was a student, a single mother,

and she relied on welfare. Her desire to seek a cheaper abortion put her in the path of an unlicensed abortionist, and this decision cost her her life.

The U.S. Supreme Court decision in *Harris v. McRae* upheld the constitutionality of the Hyde Amendment, essentially saying that a woman's inability to afford an abortion was her own problem, and not one of the state's creation. And with the anti-abortion, anti-feminist, and anti-welfare administrations of Reagan and Bush Sr., abortion restrictions started becoming part of the fabric of American life.

When Pennsylvania decided to stop allocating Medicaid funds for abortion in 1985, one women's center volunteer noted that the center began to receive phone calls from desperate women asking whether a fall down the stairs would be enough to induce a miscarriage.

In 1989, Pennsylvania governor Bob Casey signed the Abortion Control Act. This ruling was one of the first attempts by an individual state to restrict abortions after *Roe*. The act had several provisions that were designed to limit abortions, like informed consent, spousal notification, parental notification, and a 24-hour waiting period. And when Casey signed the act it was immediately challenged by a number of abortion providers, counselors, doctors, and it ultimately turned into a class action lawsuit--*Planned Parenthood of Southeastern Pennsylvania v. Casey*.

It was 1992 when Casey made its way to the U.S. Supreme Court. The attorneys for the appellants argued that Pennsylvania's Abortion Control Act

effectively overturned *Roe* since it imposed so many regulations on the women seeking abortions and on the doctors providing them. On the other hand, the attorneys for the defendants argued that they weren't overturning *Roe*--they were just regulating abortion. In prior challenges to *Roe*, the U.S. Supreme Court had already cited two things: the existence of a fundamental right, like abortion, and the enjoyment of a fundamental right were mutually exclusive. And since the state had an interest in potential life it could favor or encourage pregnancy and childbirth, so long as it didn't prevent women from getting abortions.

The court also moved away from *Roe*'s trimester system towards an undue burden standard, which reflected the state's potential interest in life. In their biding dissent to *Casey*, the minority wrote the following: the undue burden standard has quote, "no basis in constitutional law, and will not result in the sort of simple limitation, easily applied.

To evaluate abortion regulations under that standard, judges will have to make the subjective, unguided determination whether the regulations place substantial obstacles in the path of a woman seeking an abortion, undoubtedly engendering a variety of conflicting views. The standard presents nothing more workable than the trimester framework the joint opinion discards, and will allow the Court, under the guise of the Constitution, to continue to impart its own preference on the States in the form of a complex abortion code," unquote. Now, some would argue, that an American woman's access to abortion is more defined by *Casey* than it is by *Roe v. Wade*.

In an episode of *Last Night Tonight with John Oliver*, the pundit discussed recent anti-abortion measures. In Oliver's recorded interview with Andrea Ferrigno, the corporate vice president of Whole Women's Health, Ferrigno explained that she had women who were unable to come to her clinic for their legal abortions and instead asked, quote, "what if I tell you what I have in my kitchen cabinet, and you tell me what I can do?" unquote. Oliver noted that the surge of these new restrictions was forcing women to partake in quote, "the most depressing, quick fire challenge in top chef history."

According to the Guttmacher Institute, most women of reproductive age in the United States live in areas that are considered hostile to abortion. The recent barrage of anti-abortion measures overwhelmingly call for mandatory waiting times, parental notification, ultrasounds, and the prevention of the dispensation of the abortion drugs mifepristone and misoprostol in clinics without operating rooms.

Some states have even proposed eliminating legal access to abortions at six to eight weeks gestation, measures Iowa and Ohio passed among the 308 other abortion restrictions that were introduced in 37 states in the first quarter of 2018. In 2019, more than a dozen states introduced legislation to ban abortion as early as six weeks into a pregnancy--so soon after a missed period that some women may not have the time for mandatory waiting periods or to get the funds and travel to one of their states' few abortion clinics.

While such proposed laws have been subject to legal challenges, they represent part of an aggressive

pattern to shorten the window of time a woman has to access a safe and legal abortion. Many, if not all of these regulations disproportionately affect young women, women of color, low-income women, and women who live in rural areas.

Some have argued that these bills are inconsequential, that they are about preventing fetal pain and protecting women's health and safety. Critics of these restrictions argue that their efforts to shame and demean women out of getting the procedure or to impose so many regulations that it's unfeasible for them to get the procedure at all. Against a mountain of evidence that shows that abortion restrictions cause more harm than good, some just want to make abortion difficult to access.

The *Roe* decision declared that all women had the right to safe, legal abortions in their first trimester. However, depending on where a woman lives, the reality of that decision does not extend to her. As reproductive justice advocates and scholars have noted extensively, there is no choice where there is no access.

At this point it might appear that overturning *Roe* is more symbolic than anything. *Roe* has been weakened to a point that overturning it is simply opening the door for states that are hostile to abortions to recriminalize the procedure. This is a step that is just a continuation of a process and pattern that has been ongoing since the 1970s. Yet, in the face of such anti-abortion fervor, the rates of abortion in the U.S. have actually steadily declined. Though fewer people are having abortions, abortions haven't lost their significance.

Abortion restrictions prevent women from exercising the opportunity to make decisions of their own. And, historically laws that restrict abortions have done little more than make the procedure more dangerous for the women seeking them. Abortion laws do not discourage desperate women from submitting themselves to unknown practitioners. Rather, abortion restrictions do nothing but advance the notion that women cannot be trusted with their own bodies.

Q+A

[segue from lecture]

CHRISTOPHER BRICK: What sorts of connections were there between "butchery" in Tijuana and the United States Supreme Court decision in Roe versus Wade, which follows very quickly upon - just a few years in fact - the point in time when Alicia concludes this talk. I was curious to ask that and a lot more. Enjoy.

[beginning of group conversation]

CHRISTOPHER BRICK: Alicia Gutierrez-Romine. Welcome to the podcast.

ALICIA GUTIERREZ-ROMINE: Hello, thank you for having me!

CHRISTOPHER BRICK: Well, it's a great honor to this series to have you here and --

You start talking about how abortion became illegal throughout the states in the 19th century-- throughout much of the 19th century-- and you list three pretexts, or reasons, or factors, that bear upon that process in a meaningful way historically.

So, you talk about the consolidation of professionalized medical authority in the 19th century, you talk about race suicide, and immigrant woman fecundity, and then you talk about— also, you mentioned harm reduction. That's another pretext that's out there for the criminalization of abortion services.

What should we know about each of those concepts and how they inform our understanding of this moment in the 19th century story?

ALICIA GUTIERREZ-ROMINE: Well, so I think it's important to consider that, you know, prior to this we don't really have the same kind of public discourse about abortion, that it's not really an issue that people are up in arms about, and I think that's maybe difficult for us to grasp now since abortion is such a polarizing issue. But before this, you know, it wasn't really something that people debated or discussed about in public; it was something that it was understood that women did.

And so, when we're looking at the professionalization of medicine there's, you know, some of the works from like Kristin Luker and Leslie Reagan. They show us that this was, for physicians, something to kind of rally behind. It was understood that the people who provided these services, like abortions, were typically midwives and oftentimes physicians of color. And so, as the mainline kind of medical field is organizing around, you know, the East Coast and professional white men. Then this becomes this kind of gulf that that it makes it easy for these professional men to kind of say "We don't do those types of services" that we are educated enough. People like Horatio Storer to say that "We know that fetuses are

humans, that they are our life and so we are focusing on preserving and protecting life and the people who perform these services are less educated, less informed."

CHRISTOPHER BRICK: So, there's a class stratification, or like a respectability stratification, that's going on here?

ALICIA GUTIERREZ-ROMINE: Absolutely, and so it becomes this really kind of simple organizing issue, I guess we could say, because it seems to be the one service that can define what is respectable medicine or not, whether you're performing this procedure— if you are performing this procedure then you are not respectable, then you are uneducated and you don't know that fetuses are humans. And you're not protecting women from, you, know, moral ruin. And if you are not, you know, performing these procedures then that means you actually respect life and you respect, you know, appropriate gender roles for women.

CHRISTOPHER BRICK: You know it's so interesting because -- The Roe decision, to me, I mean, when I read it now, it reads more like a decision about *doctors* than about women.

ALICIA GUTIERREZ-ROMINE: And it was the exact same way in the Bellis decision. I don't remember if I said that a lot in this talk, but in the Bellis decision there was a considerable amount of time devoted to physicians' rights because physicians were denied due process if they give an abortion and then someone later says, "Oh, that wasn't a justified reason." And so, you would imagine that you know cases about abortion would be about women's health. You think they would be about

rights to you, know, constitutional rights to privacy, but instead, it seemed like a lot of the reasoning and justification fell on giving physicians the leeway— giving them the rights to practice— over a women's right to control her body.

CHRISTOPHER BRICK: I feel like this is more true of Roe [than] of the text in the Casey decision, which comes later and you talk about that as well -- but it does seem like the liberty interest at stake is really the freedom of doctors to perform medicine or to provide medicine without fear of retaliation or recursion by the state.

There was no law against what he was doing -- kind of arranging to bring women across to Tijuana, into Mexico, to facilitate abortion service on the other side of the border. There was nothing particularly illegal about that, right? So, in effect, it kind of creates this market for this service back and forth across the border, this whole commerce, if you will, this trade. Is that an accurate characterization of sort of the background of the case? And what do we know about him?

ALICIA GUTIERREZ-ROMINE: So, Buffum, he, you know, his family was from the Midwest and he and his brothers ended up making their way to California. He is related, through marriage, to the Chandler family of Los Angeles, so really wealthy, well-to-do family.

He has some run-ins with the California Board of Medical Examiners beginning around the 30s, narcotics peddling, things like that— I have so much more information that I actually had to cut out about him. He was almost lured into an abortion ring in the mid 30s, but he says he said no. And he

kind of disappears from the picture a little bit, and then he gets involved in this case with Reginald Rankin and Reginald Rankin was the person who tried to get him involved in the abortion ring in the 30s. And so, Rankin is also a really interesting character— he ends up making a few different appearances in my book, I follow him through abortion rings in the Thirties, 40s and 50s in California, Nevada, and then this kind of border one.

So, the context for this is that, you know, Reginald Rankin had just gotten out of prison *again*. And, you know, he gets involved in all of these different abortion rings— perhaps because he thinks it's an interesting or fast way to make money and for whatever reason Buffin does agree this time to be part of this syndicate that they are starting to form. And so they have a front in Long Beach, which is basically just an office where they make negotiations, and they transport women across the border for the procedures.

So, when this goes to trial, the court recognizes the limits of its power. There is a California law against abortion, there is a Mexican law against abortion, but a California law can't— or a California court— cannot penalize them for an abortion that took place outside of its bounds, and they can't convict them or accuse them of violating Mexican law because they don't have that power either. So, it really puts the California court in this kind of awkward position because there is really nothing that they can actually get them for. They didn't violate California law, because it didn't take place in California and the California court can't penalize them for violating a Mexican law.

But Mexico is not, you know, attempting to do it, California is trying to get them for something, but there isn't really anything that California can get them for. So, the state of California does try to basically create laws after this to kind of fill this legal loophole that was eventually created.

So, beginning in some areas around the 1930s, it's harder for women to get *legal* abortions come through their hospital therapeutic abortion committees, through physicians who are maybe feeling backlash of, you know, some people having kind of willy-nilly justifications for therapeutic abortions. And so, there are these different ways that people are trying to basically restrict the number of abortions that are taking place in in the state.

So as individual hospitals are kind of cracking down, they're saying "You know only legal abortions should be taking place in hospitals. They should be approved by these committees, physicians shouldn't really have the power or the authority to do these on their own in their offices or anything like that." So legal abortions are moving into hospitals, and they're coming under the oversight of these therapeutic abortion committees who are trying to kind of be invisible. They don't want their hospital to be the one that approves every single abortion and that has high abortion numbers, they're kind of imposing their own regulation and their own quotas, which then results in women having less access.

CHRISTOPHER BRICK: If I could pick up here too. I did not know what these were before your talk;

therapeutic abortion committees. These were like, the abortion deciders in in this moment?

ALICIA GUTIERREZ-ROMINE: In short, yes. So basically, if a woman wanted an abortion, she would tell her physician and then her physician would appeal for her in front of this committee, you know, where at the hospital at where this physician has— I miss... the word is escaping me— visiting privileges?

CHRISTOPHER BRICK: Privileges?

ALICIA GUTIERREZ-ROMINE: Yes, so at the hospital where this physician has privileges, they appeal before the abortion committee there. Usually there's like a physician, a surgeon, and then like some other maybe like psychology psychologist or something clinician whatever. There's usually three to five people on these committees, the physician for the patient, would basically say "I have this patient, and these are the reasons that she wants an abortion. These are the reasons that I, as a physician, believe they're necessary for her life or health." And then the committee debates and they either approve or disapprove. They don't look at the woman, they don't treat the woman, they're taking the word of this physician to determine whether this woman can have the procedure or not.

CHRISTOPHER BRICK: Who was on these committees?

ALICIA GUTIERREZ-ROMINE: So, usually another physician, a surgeon, and then at least one other person. So usually all from that hospital.

CHRISTOPHER BRICK: All medical people.

ALICIA GUTIERREZ-ROMINE: Yeah, so it there might be like a psychologist, especially if one of the justifications is she's suicidal, then there might be like a psychologist on the panel as well, but they're all people who practice or work at that physician, and they are all medical professionals in some capacity.

CHRISTOPHER BRICK: It was easier if you're a person of means to successfully navigate that therapeutic abortion committee process to obtain the outcome that you want, right, to terminate a pregnancy? And so, as that becomes more difficult for that sort of elite group of women, who are able to successfully navigate that process, as it becomes harder for them to do so they're turning to people like Buffam to facilitate a work-around? Is that that's-

ALICIA GUTIERREZ-ROMINE: Essentially yes, and so you know if a physician is unable to kind of clear it away for a legal abortion for their patient, then their patient might turn to, you know, female networks. They might see if their friends know somebody who knows somebody, they might ask their physician if they know somebody who can kind of make this happen. And so, it's through these different networks. And you know, maybe they talk to a pharmacist who might direct them because people like Rankin and Buffum might offer pharmacist kickbacks if they can refer people. So, they would maybe find *some* connection through one of these other places and then they find someone like Buffum or Rinken and Rinken or Buffam would just take their information, they would select a meeting place and then arrange transport, negotiates cost, everything like that and then the procedure in this case took place in Tijuana, Mexico and then they came back.

CHRISTOPHER BRICK: One of the main takeaways from your talk that I think is that it's sort of impossible to restrict access to that degree and *not* create a public health catastrophe.

ALICIA GUTIERREZ-ROMINE: Absolutely. I think, you know, the more barriers you create to a medical procedure— this medical procedure, especially— it's just going to create opportunities for people to... for this black market to thrive and the lack of regulation in that is going to hurt some women in irreparable ways.

CHRISTOPHER BRICK: One of the effects of this is a lot self-harm occurring in connection with self-induced abortion -- attempts to create enough of a wound or an injury to implicate that hospital's legal powers to decide who can have access to this service or not.

At this moment, kind of one of the choices they're left with is well; "How much am I going to harm myself to get the medical attention or care that I require?"

ALICIA GUTIERREZ-ROMINE: And I mean, I think it shows the desperation that they have. That, you know, that they're willing to undergo this type of harm in hopes that they'll be able to get one of these hospitals to do what they need to do. I mean, I... You know, just I think the fear that, you know, some women feel when they're missing their period when they're expecting it, and you know just how everything just starts clicking in your mind of you know "What am I going to do? What am I going to do? OK, I can't get it from here. Where do I go from here? OK, what if I just fall down the stairs?"

What if I, you know, use Lysol? What if I find a hanger..." and I think it just shows that there's kind of this domino effect in in their thinking, and the lack of options that they that they really have for that to seem like "OK, this is what I'm going to do."

CHRISTOPHER BRICK: How do you bring these women and what they're encountering and what they're enduring and dealing with? What allows us to get inside their feelings?

ALICIA GUTIERREZ-ROMINE: So that was hard, and I feel like that might be the one area in in the book where I took more liberties, I suppose, in trying to, you know, think "What did this woman feel like? What were her options? What would I have felt like in that situation?"

I mean, I have coroners records, I have records and investigation files from the medical examiners. They talked to friends, they talked to family members, they interview sisters, partners. I have those I have newspaper articles sometimes where they also interview other friends or family members and it's, kind of, I have these little different pieces of information and then my interpretation is basically what the gaps are.

And so I actually opened my book with a story about a woman who was a waitress and mother of four, and she found out she was pregnant again and she was married, and she decided to, you know, go get an abortion in Tijuana and she died. And so, thinking about; OK, this is a woman who's in a relationship that's— I don't know the stability of her relationship— I know she already has children. I know she's working. I know she already has a job.

Is it financial? Is it emotional? Is it a relationship thing?

And, you know, you can only think of so many different options and so part of it is, you know, me assuming or guessing or trying to make a decision or an understanding based on all of these different factors that we can gather from, you know, coroner's records and, you know, interviews with friends and family members.

CHRISTOPHER BRICK: I can really relate to what you're talking about having to kind of encounter and reconstruct the experiences of these women who surface in your story, in your book, irrespective of however, or, you know, much kind of that needs to rest on the balance of probabilities in some cases.

ALICIA GUTIERREZ-ROMINE: Yeah, and I think a lot of that has to do with just the nature of the sources as well. I mean, I'm in the confidential records at, you know, the California State Archives and, you know coroners' records where they're using the body as evidence and so, it's not the woman's testimony. It's not... You know she is deceased, and she is on a table, and you know the details from the coroner's records might say her age and you know if she's married or if she had any other kind of medical conditions.

In some instances, there was one report I recall, and, you know, the coroner did the autopsy everything, and then he just provided additional notes or comments and he said, you know "Four other children, state relief." So, this woman had other children and she was on welfare, and this was, I think, a case during the Depression era. And so,

you know, recognizing those other contributing factors...

And abortion is stigmatized. And so, people don't speak about it. They don't speak about abortions they have that are successful, because then there's, you know, criticism about the procedure itself, justifications for it. And so, the abortions we hear about, are the cases where women die. It perpetuates this idea that abortions are inherently unsafe because no one is talking about safe abortions that were performed, that they survived. And so because, you know, fatal abortions are the ones that I have sources for, you know, I... There's only so much that I can actually get from the subject themselves.

CHRISTOPHER BRICK: Yeah, that's it. On the one hand these sources have such powerful material that, you know, you bring into the work that you need to use them, right? I mean, but they do come with these challenges that all of us have to... Wow, yeah, I hadn't thought about that, amazing.

ALICIA GUTIERREZ-ROMINE: And you know, the narrative is coming from law enforcement, medical men, medical men.

CHRISTOPHER BRICK: What about their motivations? I mean, is it— it seems like Buffum, was he... was it altruism? Was it medical altruism, or was it financial incentive at work? Because it seems like he's working with more kind of like an elite class of women, and Bellis too, I suppose.

ALICIA GUTIERREZ-ROMINE: I you know I have a hard time putting my finger on Rinken and because he... During the Depression era he did some kind of shady tax things and so, he seems like a person who's

interested in making money. And I think that might be his primary thing. However, I won't disparage him, because when he— and again, he's one of those people who makes a few appearances in my book— in the 1930s, he provided a really large and safe abortion syndicate for women all along the West Coast. They were making the modern-day equivalent of millions of dollars a month just providing these procedures and so that's he goes to San Quentin for it for a little bit, and then he kind of, goes to Vegas, tries to, or Nevada and tries to do this other abortion rinks.

CHRISTOPHER BRICK: So, this isn't just business, but it's big business.

ALICIA GUTIERREZ-ROMINE: It's big business and when he had that really large syndicate on the West Coast in the 30s, he was providing safe abortions for women. I did not find, in my records, any fatalities that occurred under his watch. And so, if, you know, he was in this— and I do believe he was in this in the interest of making money— however, he did it in a way that he was providing safe procedures for these women and so I... That's one of the things that makes me kind of conflicted about him.

But he also, in this 1930s, venture he made it accessible. If a woman couldn't pay, he allowed them to finance it. He allowed them to, you know, put up things for collateral for a loan, for the proceeds, and so— still making money. And, of course, you know, he made them pay interest on it, but it was still kind of more accessible, and these women were getting safe treatment from medical professionals. So, I think that is that is one of

the main reasons that I don't know if I could speak ill of him. [Laughing]

CHRISTOPHER BRICK: The women themselves, you talk about getting into this moment in the 1950s and '60s that's very pro-natalist. This is something I bring up whenever I talk about this period, because students are interested in it and it does call attention to this complicated admixture of like cost and benefit, right? So how does that inform, that pronatalist ideology that you talk about— and I don't want to mischaracterize it so if I have mischaracterized it, please do correct me.

ALICIA GUTIERREZ-ROMINE: Yeah, and I don't think you're mischaracterizing it at all. If you have this kind of pronatalist baby boom era, right, the idea that families are kind of the center of American life in this, you know, Cold War era. You have the nuclear family as like the basic unit for American life at this time and you have economic opportunity with the rise of the suburbs, the GI Bill, like it's— I and I think in my own classes when I teach this, I called this like the golden era of capitalism, you know? That this is a moment or an opportunity where the middle class is doing pretty well and so if that is kind of the national sentiment, right? If we're taking a temperature of what the nation is like, it's pro-family, it's pro-suburbs, it's pro all of these things, and so for a woman who kind of doesn't fit with that— or if a woman wants an abortion, it doesn't quite fit or align with that national sentiment.

This is also this era where we have sometimes referred to as the baby scoop era, right where you have young women who are maybe having a child out

of wedlock, and they're essentially forced to give up that child for adoption because there are families who want children and can't have them. There are people who are buying into this, you know, nuclear family American life with you know the 3.5 kids or 4 you know 4.5 kids— whatever it is in the baby boom— but who maybe can't. And so, you have this moment where babies are desirable. They're wanted. You have this moment before birth control is accessible and this kind of pronatalist society. So, for a woman who doesn't want a child, for a woman who wants an abortion, it doesn't quite align well.

There are other options, it seems in this moment, which are to essentially force her to give this child up for adoption, kind of repent, that's one way to kind of get over for this, you know, perceived moral failure. And then for that young woman to be able to go on, get married, have a respectable future and then for that child that she has now given up to have a good life in some nuclear home in the suburbs somewhere.

CHRISTOPHER BRICK: Right wow, so it yeah this is a powerful constraint and influence on—

ALICIA GUTIERREZ-ROMINE: At least ideologically. You know it's possibly playing into the minds of these physicians on the Therapeutic Abortion Committee, who are saying, "Well, you know, you're healthy. You don't have any medical issues. You don't need an abortion, you just accidentally, you know, hooked up with this kid who went off to college now and now you're left with this child. But there are these families that want that. So have the child give it up for adoption. You don't need an abortion; your life is not in danger.

Your life is not at risk, and someone will take the baby and then you will get over it and be fine.”

CHRISTOPHER BRICK: I'm assuming that all— the vast majority of time that the people making these decisions on the therapeutic abortion committees are all male.

ALICIA GUTIERREZ-ROMINE: Yeah, for the most part. I mean, I don't recall any specific instance where there was a woman on one of these boards and I definitely did not study every single therapeutic abortion committee in this state or anything like that. But of the records that I did encounter about listed physicians on these, they were all male. But there aren't, you know, sometimes women social workers who are encouraging, you know, young women to give up children for adoption. They're in these other capacities, but they're still kind of operating under the same umbrella of like what is good for you.

ALICIA GUTIERREZ-ROMINE: It's infantilizing.

CHRISTOPHER BRICK: Yeah! It would seem to have just enormous mental health consequences downstream from that, right?

ALICIA GUTIERREZ-ROMINE: Yeah, I think you know the baby scoop era was something that I you know came across in tangent and if you have, you know, these 16 to 20 year old women— young women— and, you know, this might have been their first sweetheart or real relationship, or the first time they were intimate with someone, and then they have to bear, I think, not just the physical cost of having to give the child up for adoption, but the mental cost as well.

And so, I think for a lot of those women who had no say in giving up their child for adoption, there were a lot of mental wounds. Now in terms of, you know, studies that have been done on like mental health and abortion. I think recently there was one that came out that said about 95 or 96% of women who had abortions were still happy five years later that they had their procedure and so the vast majority. But you know, a lot of these young women who were forced to give up their child for adoption, right, that was the only option that they had, and I think many of them had wounds from that that they were unable to heal from.

CHRISTOPHER BRICK: I want to ask about how you came to this work and what drew you to it and how did you get to be this historian that I'm talking to right now?

ALICIA GUTIERREZ-ROMINE: I was always interested in medical history and so from undergraduate through Graduate School, I knew I was interested in something with medical history. I thought it was actually going to be the eugenics movement and then, as I kind of went through my graduate coursework, I came across different physicians of color in Southern California.

And you know, in the 30s and 40s, and I wanted to kind of write my dissertation about them in some way so, talking about medicine and race in Southern California from like the 30s to the 50s. And so, I got funding to go to the California State Archives, I wanted to look at physician license revocation files. I thought that's where I would find more physicians of color was in people getting their licenses revoked.

And I made a mistake. I didn't contact the archivist in advance to get records from the '50s, because they were still too recent, and so I was unable to access the records that I wanted. And I had funding to be there for a whole week and I was really upset at myself, and I just told them to let me access the records that were old enough that I could look at.

CHRISTOPHER BRICK: Right.

ALICIA GUTIERREZ-ROMINE: And I think I spent the whole first part of the day, you know, cursing at myself under my breath and going through these records and I kept coming across documents that said "illegal operation" as the reason that this physician got their license revoked and I didn't really understand what that meant. At this time, I was probably in my 4th year of Graduate School maybe 5th Year of Graduate School, I was really young and naive, and I didn't... you know, what makes a surgery illegal? What makes an operation illegal? I thought physicians determined when something necessary. And I just kept coming across that phrase, and then over the course of the day, I realized that it was a euphemism for abortion, and these physicians were getting their licenses revoked for performing them.

And so, then I started having questions. You know why are they doing that? If they're going to get their license revoked, what are the incentives for the position and then you know, thinking historically. Like, I'm a millennial, I've only lived in a post-Roe world, I've never even considered what it was like before abortion was legal, and the fact that we have a case that says, "OK, it's legal from here," suggests that it was

completely illegal before that and so I just started kind of asking questions.

And then over— I think it was like in the last hour of my first day was when I ran across my first records that were about the Pacific Coast Abortion Ring, which was the multimillion-dollar ring that Reginald Rankin had set up and it was headquartered in LA. And I just was like what is going on? They're making so much money this is insane! I did a really quick Google search and I found absolutely nothing.

There was one footnote on Leslie Reagan's *When Abortion Was a Crime* and that was it. That was the only thing that I found that came up. So, I packed up my boxes because everything was, you know, it was time to go and as I was making my way back to my hotel room, I sent an email to my advisor, Bill Deverell, and who's like the King of LA history and I said, "Have you ever heard of the Pacific Coast abortion ring? They were headquartered in LA 1930s—" It wasn't complete sentences at all— "And, you know, they provided abortions," and he wrote me back— I think before I'd even made it back to my hotel— and he said, "I've never heard of it. You need to find out everything you can."

CHRISTOPHER BRICK: [Overlapping] OK, yeah.

ALICIA GUTIERREZ-ROMINE: And once I heard that from him and I was, you know, I wanted to do this other project about physicians and race and everything like that, but I also wanted to finish my dissertation in a reasonable amount of time. And when I realized that this was potentially that way to get that, I just completely switched gears and said, OK, like, my dissertation is somewhere right

here with abortion with the Pacific Coast abortion ring, I just need to figure it out.

CHRISTOPHER BRICK: We're going to be in a post-post-Roe moment probably within the next few years. So, what do you think this history has to teach us about looking forward to that? I listen to oral arguments in the Supreme Court, I don't think there's any mystery about what's likely to happen there in the next few years, so how can this history prepare us to encounter that moment, should it happen?

ALICIA GUTIERREZ-ROMINE: I think in the event that Roe is overturned, for states that already protect abortion we're not going to see much of a change. I think some individual states are beginning to lay a framework for a post-post-Roe world. I think it was recently— I forget if it was Tennessee, Mississippi or Alabama— one of them rewrote their constitution to say that abortion was not a bright in in just the last, probably, three to six months.

And so, the fact that some of these individual states are either taking the initiative to protect Roe, to enshrine Roe, in state constitutions or to set the framework for the elimination of legal abortion should Roe be overturned kind of tells us that states are basically on two divergent paths. In some places, like California— you know, where I live— abortion will probably still remain legal if just Roe were overturned, but in some of these other Southern states, I think they are setting up everything for the eventual elimination of legal access to the procedure.

However, I also think, to an extent, Roe is symbolic more than anything at this moment. I think

we see more and more that women's access to abortion is more defined by Casey, the Casey decision; how many hoops they have to go through in order to access an abortion, how many clinics remain open in their state has more to do with the Casey decision, and whether they're going to have to drive 500 miles or five miles to find their nearest clinic, whether they're going to need to visit that clinic twice.

We are essentially already living in a post-post-Roe world. We're living in a Casey world. Where access to abortion is already becoming restricted through this kind of undue burden standard. And so, I think the states where abortion is legal and protected, I think they will remain kind of bulwarks of this.

This will be the places where people in other states have to go to, but then that will also result in the fact that poor women are going to be most at risk. They're going to have the least resources, women of color, women in rural areas. These are the women who are not going to have the ability to take a weekend trip to California to go get a procedure and then come back home. These are the women who can't get a sitter to drive across the state for a day, have their 72 hour mandated waiting period, and then go back.

These are the people who are going to be most affected, and so in places where abortion, potentially, becomes illegal after Roe is overturned, I think we will begin to see more of a rise in self-induced abortions. We're going to see a return of a black market in some way.

CHRISTOPHER BRICK: Well, that would fall right into the pattern that you describe in this '50s, '60s, where a lot of the harm that's arising from these legal restrictions, the impediment to kind of legal access to these services, becomes a kind of reason to began tinkering with his laws and liberalizing them in some places because all that harm is becoming more visible, more evident.

ALICIA GUTIERREZ-ROMINE: And the fact that even some states were using COVID-19— using the pandemic— in order to push anti-abortion agendas to limit the administering of the abortion drugs, because people couldn't meet in person or see their physician in person. So, people in some states were actually using this pandemic we were in, using this current public health crisis, in order to essentially facilitate another one.

CHRISTOPHER BRICK: Well, it doesn't seem like all that many minds have been changed on the issue, you know?

ALICIA GUTIERREZ-ROMINE: So, I think this stems from a few different issues. So, I think if you look at statistics, I think it's about 80? About 70-80% of Americans agree with abortion *in some aspect*. That doesn't mean they're full pro-choice or anything like that, but at least you know in the event of a health issue for the life of the mother, so this whole spectrum, in at least some instances, abortion should be legal at minimum medical requirement at most pro-choice. Do what you want OK?

So, most Americans believe in an access to a medical procedure. And again, I want to reiterate

that like you know, you're never going to see an article about like, oh, you know, what is your opinion on, you know rhinoplasties, or, you know, breast augmentations? It's not that's not the same kind of thing. Those are medical procedures as well, but this is one that draws particular ire. And I think part of that is because there are some people who, regardless of anything, believed that a fetus is a person from the moment of conception. And those are people you cannot argue with, you cannot sway for whatever reason because of religious reasons, moral reasons, personal reasons. They believe that as soon as conception happens, it happens that as a person, and so that is a faction of the population that you will never get on board with Roe and they are vocal because they believe it is murder.

And so, part of this is, I think, that group of people there are also people who don't like Roe for other reasons; that it's seen as kind of like a feminist agenda, or that it's about women kind of separating reproduction from sexuality, and so you might have religious people who think it contributes to the decline of the family. And so, I think there are some people who will not be swayed on the public health or the personal aspects of Roe.

And I think there was something that was really interesting that came up, I think, during the Amy Coney Barrett confirmation when they were talking to her about stare decisis about, you know accepting precedent of previous cases. And you know, they— I think they did ask her about Brown and then they did ask her about Roe versus Wade. And so, you know, one of the questions was, you know, is Brown, you know, precedent? Or is it like

challenged by— I don't remember the exact words, so excuse me— but she was like “No. like, you know, to my knowledge no one is trying to overturn Brown, so it stands. It's firm. And the fact,” she later said, “that people are still trying to chip away at Roe suggests that it is not established precedent.”

CHRISTOPHER BRICK: Clearly this is still with us, they're things were going to have to continue to confront and encounter moving forward. And I know that you have enabled me to do that a little bit more wisely today. I know, also to all of everyone out there who's listening, so I want to thank you for a wonderful talk and for bearing with me for over an hour of my liking.

ALICIA GUTIERREZ-ROMINE: Oh no, this was enjoyable. Otherwise I have no humans to talk to today.

CHRISTOPHER BRICK: All right, well we thank you and we honor you. Alicia Gutierrez-Romine.

ALICIA GUTIERREZ-ROMINE: Thank you so much for having me. I've really enjoyed it.

Conclusion

CHRISTOPHER BRICK: And that's a wrap. Next time around the scene shifts up the West Coast to Alaska, and Tess Lanzarotta joins the pod to explain why Alaska's history of tuberculosis control during the early Cold War is something all of us should know about and acknowledge. Please join us.