Bodily Autonomy in Crisis: Peer and Community Narratives in Washington State After Roe's Overturn

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By Miranda Swanson: Master's in Policy Studies

The University of Washington Bothell

Academic Advisor: Dr. Camille Walsh

Second Reader: Dr. Keith Nitta

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Abstract

This capstone examines the social, ethical, and policy consequences of the U.S. Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade* and eliminated federal constitutional protections for abortion. The study combines policy analysis with original qualitative data gathered through an anonymous online survey of Washington State residents. The study also investigates how individuals emotionally and politically respond to the post-*Dobbs* legal landscape.

Key findings reveal that respondents overwhelmingly value reproductive autonomy as a fundamental right, yet express widespread fear, anger, and mistrust in government institutions. Many participants shared personal experiences with abortion care, legal uncertainty, and activism, underscoring the lived impacts of state-level restrictions even in a sanctuary state like Washington. The paper identifies four major themes: bodily autonomy as safety, the emotional toll of policy change, disparate impacts on marginalized communities, and a persistent drive toward civic resistance. In doing so, the project contributes to ongoing scholarly and policy discussions about reproductive justice, public health equity, and democratic accountability in a fragmented legal system.

This research highlights the urgent need for responsive and inclusive reproductive policy at both the state and national levels, emphasizing that legal frameworks must be informed by the lived realities of those most affected. By elevating community narratives alongside legal analysis, the study reaffirms that reproductive rights are not merely constitutional questions, but core issues of identity, dignity, and human freedom.

Chapter 1: Capstone Introduction

1.0. Introduction

1.1. Research Context

In June 2022, the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* overturned nearly 50 years of federal constitutional protection for abortion, dismantling the precedent set by *Roe v. Wade* (1973) and fundamentally reshaping the legal landscape of reproductive rights in the United States. While *Dobbs* marked a seismic shift in American reproductive policy, the groundwork for this transformation had been laid years earlier in decades of federal and state legislative and advocacy group policy proposals, from mandatory waiting periods and parental consent laws in the 1980s and 1990s to fetal heartbeat bills throughout the 2010s to Texas Senate Bill 8 in 2021; This surge of contemporary legislation is not without precedent. Abortion regulation in the United States has long been shaped by a complex interplay of professional, racial, and gender-based power struggles. As historian Leslie Reagan notes, abortion was widely practiced in the 18th and early 19th centuries, particularly before "quickening"- the point at which fetal movement could be felt - was seen as a natural, often private decision. Early statutes were not moral condemnations but poison control measures aimed at reducing deaths from unsafe remedies like pennyroyal and ergot. It wasn't until the mid-19th century that the American Medical Association began a concerted effort to criminalize abortion at all stages, driven more by physicians' desire to marginalize midwives and assert professional dominance than by concern for fetal life. This professionalization campaign was further fueled by anxieties about race, class, and gender roles, particularly fears over middle-class white women asserting reproductive control. These historical patterns mirror the logic of bills like SB 8, which not only restricts access but also outsources enforcement to private

citizens, creating a modern-day surveillance regime that echoes the gendered control strategies of the past. In both eras, the law has served not just to regulate health, but to assert dominance over whose bodies are trusted - and whose choices are criminalized. This capstone project examines some of the historical development, national diffusion, and public health implications of civil enforcement of abortion bans in the U.S., particularly in the wake of *Dobbs*. It situates those enforcements within a broader policy trajectory that illustrates how states have incrementally eroded abortion access through legal experimentation and strategic regulatory fragmentation.

The central argument of this capstone is that the post-*Roe* legal landscape has enabled a fragmented reproductive governance regime in which state laws diverge dramatically and enforcement is increasingly privatized. These changes compromise national health equity, legal accountability, and democratic oversight by creating contradictory standards, regional disparities, and constitutional ambiguity.

This project also incorporates original qualitative data from an anonymous online survey I conducted titled "Bodily Autonomy in Crisis: Peer and Community Narratives After Roe's Overturn." The goal is to situate contemporary community voices in a safer state like Washington within the broader national policy trajectory and to examine how lived experiences interact with the abstract legal and institutional narratives that shape reproductive policy.

1.2. Problem Statement and Objectives

As of 2023, more than half of U.S. states have enacted total or near-total abortion bans, many of which were triggered by *Dobbs* or were preemptively passed in anticipation of Roe's fall, and

some of which I mentioned prior. Others have implemented stringent gestational limits, mandatory ultrasounds, waiting periods, or complex procedural requirements designed to restrict access. At the same time, states like California, Illinois, and New Mexico have passed laws codifying abortion protections and safeguarding providers and patients.

This patchwork of state laws has produced a fragmented and unstable reproductive rights landscape, creating profound differences in access depending on where a person lives. In restrictive states, abortion bans have intensified legal vulnerability for providers and forced them to navigate ethically fraught situations where patient well-being, institutional policy, and fear of prosecution collide. Even in states like Washington, where abortion remains legal, the ripple effects are felt: patients operate within a national climate of uncertainty, misinformation, and heightened political scrutiny. For many, what was once standard reproductive care has become a decision shadowed by legal risk and institutional caution.

For patients, particularly those from historically marginalized communities, the path to care is shaped by geography, privilege, and resilience, as they contend with mounting logistical, financial, and emotional barriers. In this environment, legality alone does not guarantee access or equity.

This study responds to that reality by asking:

- ➔ How do Washington residents perceive the impact of abortion bans in other states on their access to reproductive healthcare?
- ➔ In what ways have recent laws and court decisions, including the Dobbs ruling, changed how individuals think about their reproductive rights?

- ➔ How do participants believe post-Dobbs policies are affecting equity in healthcare access and outcomes, particularly for historically marginalized groups?

Through an original, anonymous survey of Washington residents, this research centers the voices and perspectives of those directly navigating the post-Dobbs landscape, pairing lived experience with broader policy analysis to better understand the intersection of law, healthcare, and human rights.

These questions aim to connect macro-level policy shifts with their micro-level consequences on patients, institutions, and communities. Rooted in the voices of young people, this capstone positions reproductive governance as a lived experience that intersects with race, gender, class, and identity. It challenges the notion that law alone defines rights and asks instead how communities survive, resist, and reimagine autonomy under threat.

1.3. Insights from Prior Studies

Legal scholars have long chronicled how Roe v. Wade (1973) and *Planned Parenthood v. Casey* (1992) shaped abortion jurisprudence in the U.S., grounding access in the right to privacy and the “undue burden” framework. However, these decisions left room for state-level restrictions, and from 2010 to 2020, more than 400 abortion-related laws were passed, many strategically designed to test legal limits and slowly erode Roe’s protections.

Public health research documents how abortion restrictions worsen health outcomes, particularly for poor people, people of color, and those in rural areas (Foster et al., 2023). Studies also reveal

that abortion bans increase maternal morbidity and infant mortality, while compounding stress and reducing healthcare-seeking behavior among vulnerable populations.

From a clinical perspective, research by Chervenak, Grünebaum, and others illustrates how legal uncertainty has disrupted medical practice. Physicians now report delaying miscarriage care or denying treatment entirely to avoid criminal or civil liability. Training programs have reduced or eliminated abortion-related instruction, threatening future workforce development and patient safety.

Philosophers such as Toscano (2023) and Chen (2022) critique the ideological underpinnings of anti-abortion laws, particularly the "Responsibility Objection," which asserts that individuals who consent to sex must carry any resulting pregnancy to term. These scholars challenge the gendered moral logic of this argument and its selective application, emphasizing how it reinforces patriarchal norms and undermines bodily autonomy.

Taken together, these interdisciplinary studies underscore the consequences of Dobbs-era governance: growing inequity, institutional instability, and the entrenchment of competing legal regimes.

1.4. Methodology and Contribution

This capstone uses a mixed-method approach in which the primary research method is an original, qualitative survey of Washington State residents, conducted in 2025. The survey was designed to capture lived experiences, perceptions, and policy opinions in the wake of the Dobbs v. Jackson decision. It included both quantitative and open-ended questions, inviting participants

to share how they believe abortion bans in other states, particularly those using civil enforcement mechanisms, affect their access to reproductive healthcare, their understanding of reproductive rights, and their views on systemic equity.

The survey was administered anonymously and yielded 28 usable responses out of 31 (some were removed due to not meeting the living requirements of Washington State). Open-ended answers were coded thematically to identify recurring patterns, unique insights, and points of divergence across demographic groups. Respondents frequently expressed fear, mistrust, anger, and determination to act, underscoring how reproductive governance is experienced as both a deeply personal and political issue.

To situate these findings within a broader legal and historical context, the study also incorporates a targeted policy analysis. This secondary research draws from legislative texts, judicial rulings, medical association statements, and scholarly literature to trace the evolution and diffusion of civil enforcement abortion bans, examine the legal strategies used to circumvent judicial review, and assess how these measures contribute to interstate legal conflict and fragmented access nationwide.

By combining firsthand community narratives with structural legal analysis, this dual approach creates a layered understanding of policy change, linking high-level legal trends with ground-level lived experience, and offers a necessary bridge between theory and practice in an increasingly uncertain reproductive policy landscape.

1.5. Significance

As the United States continues to navigate the fallout of *Dobbs*, this project offers a timely and multidimensional account of how reproductive governance is being reshaped, not only in the courts but in hospitals, legislatures, and homes. It highlights the role of legal innovation (such as civil enforcement), the erosion of federal protections, and the risks of a fragmented regulatory system in which constitutional rights depend on geography.

The inclusion of community narratives ensures that this policy history remains grounded in lived experience. It affirms that the consequences of abortion bans are not merely abstract legal outcomes but affect people's health, identities, and futures.

By documenting this critical moment in U.S. history, this capstone contributes to scholarly, institutional, and policy conversations about reproductive justice, democratic accountability, and health equity in the post-Roe era.

1.6. Background on *Roe v. Wade*

The Supreme Court's 1973 decision in *Roe v. Wade* transformed the legal landscape of reproductive rights in the United States by recognizing abortion as a constitutional right. The case was brought by "Jane Roe" (Norma McCorvey), who challenged Texas laws that criminalized abortion except to save the life of the pregnant person. The Court, in a 7-2 ruling, concluded that these laws violated the Due Process Clause of the Fourteenth Amendment by infringing on the "right to privacy," a concept the Court had previously recognized in cases involving marriage and contraception (*Griswold v. Connecticut*, 1965; *Eisenstadt v. Baird*, 1972).

Justice Harry Blackmun's majority opinion outlined a now-famous trimester framework, which sought to balance individual liberty with the state's interests in maternal health and potential life.

In the first trimester, abortion decisions were left entirely to the pregnant person and their physician. In the second trimester, states were permitted to regulate abortion procedures in ways that were reasonably related to maternal health. After fetal viability (typically around 24–28 weeks), the state could restrict or ban abortion, provided there were exceptions for the life or health of the pregnant person (*Roe v. Wade*, 1973).

The legal reasoning in *Roe* was groundbreaking but also controversial. By framing abortion within the broader right to privacy rather than as a fundamental question of gender equality or bodily autonomy, the Court avoided directly engaging with feminist arguments about reproductive freedom. Critics, including the dissenting justices, accused the Court of engaging in judicial overreach by "creating" a constitutional right not explicitly found in the text of the Constitution. Justice Byron White's dissent called the decision an example of "raw judicial power," arguing that abortion policy should remain with state legislatures.

The social response to *Roe* was immediate and polarizing. Many feminists and reproductive rights advocates hailed the ruling as a monumental step toward gender equality and personal freedom, framing abortion access as essential to women's autonomy and economic participation. At the same time, the decision galvanized anti-abortion activists, who criticized the trimester framework as arbitrary and morally flawed. Religious organizations, particularly the Catholic Church and evangelical groups, mobilized to challenge *Roe* in courts, legislatures, and public opinion. Over the decades, *Roe* became a central flashpoint in the culture wars, shaping political platforms, judicial appointments, and federal-state tensions.

Despite its landmark status, *Roe*'s legal foundations were gradually narrowed by subsequent cases such as *Planned Parenthood v. Casey* (1992), which replaced the trimester framework with

an “undue burden” standard. Nonetheless, *Roe* stood as the controlling precedent for nearly five decades, fundamentally influencing public discourse and reproductive healthcare access until it was overturned by *Dobbs v. Jackson Women’s Health Organization* (*Roe v. Wade*, 1973).

1.7. Connecting *Roe* to *Dobbs* and Survey

While *Roe* had provided a nationwide baseline for access, *Dobbs* fragmented the legal landscape, resulting in stark disparities across state lines. This legal reversal has left many healthcare providers uncertain about what care they can lawfully offer, and many patients unsure of what rights, if any, still apply. In states where abortion is banned or severely restricted, the consequences are particularly acute for people of color, low-income individuals, and those in rural areas, populations already underserved by the healthcare system.

This capstone study was developed in response to the rapidly changing post-*Dobbs* climate. Recognizing the gap between legal theory and lived experience, the survey at the heart of this research sought to document personal reflections, ethical concerns, and policy opinions from individuals navigating the fallout. The responses collected reveal that the spirit and logic of *Roe*, particularly its emphasis on privacy, autonomy, and protection from state interference, remain deeply meaningful to many, even in the absence of legal enforcement.

One respondent wrote, “People will still get abortions. They will just get them in worse conditions, or risk jail for helping someone,” echoing the concerns about unsafe, criminalized care that *Roe* originally sought to prevent. Another shared, “Roe v. Wade was about privacy, about trusting people to make their own decisions. Losing that is terrifying.” Several participants explicitly connected the loss of federal protections to broader fears about regression: “We’re not

just losing abortion rights. This opens the door to controlling other aspects of people's lives, like access to birth control, or even LGBTQ+ rights."

These quotes demonstrate that *Roe*'s core principles, bodily autonomy, privacy, and freedom from governmental overreach, still resonate. In contrast to the abstract legal frameworks debated in courtrooms, the emotional and ethical stakes are deeply personal. As one participant put it: "This is about being able to live your life with dignity, without having to ask permission."

By grounding this study in both legal history and contemporary voices, the research underscores that *Roe v. Wade* continues to shape how people understand reproductive rights, not just as a legal issue, but as a matter of identity, health, and humanity.

Chapter 2: Review of Literature

2.0. Effects of the Dobbs v. Jackson Decision on Abortion Access and Healthcare

2.1. Introduction

The Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* marked a seismic shift in American constitutional law and reproductive health policy. By overturning *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992), the Court eliminated the federal constitutional protection for abortion, thereby returning regulatory authority to individual states. Justice Alito, writing for the majority, argued that *Roe* was "egregiously wrong from the start" and lacked a basis in the Constitution's text, history, or tradition (*Dobbs v. Jackson Women's Health Organization*, 2022). This ruling rejected the longstanding interpretation that the right to abortion was implicit in the concept of "liberty" under the Fourteenth Amendment, a legal principle that had shaped reproductive jurisprudence for nearly half a century.

The Court's decision opened the door to a fragmented policy landscape in which abortion access now depends almost entirely on where a person resides. Within days of the ruling, trigger laws and previously dormant statutes went into effect in several conservative states, banning or severely restricting abortion with few or no exceptions. As Chervenak et al. (2023) note, by mid-2023, eleven states had banned abortion without exceptions for rape or incest, and only seven allowed abortion without strict gestational limits. Meanwhile, states like Washington moved to codify protections, expand funding for reproductive healthcare, and prepare for increased demand from out-of-state patients. This bifurcation of rights has created a dangerous legal and medical environment, particularly for marginalized communities.

Importantly, the implications of *Dobbs* extend far beyond the courtroom. The loss of federal protection has real consequences for patients, providers, and public health infrastructure. From delayed care and increased maternal mortality risk to the criminalization of providers and widespread confusion about legal obligations, the impacts of this decision are both immediate and long-term. Moreover, these consequences are not distributed equally. Adolescents, low-income individuals, and communities of color face heightened barriers due to pre-existing disparities in access to healthcare, transportation, and financial resources. Healthcare providers now operate in an environment of fear, constrained by unclear or hostile legal regimes that can contradict medical ethics and clinical best practices.

This literature review explores the multifaceted consequences of *Dobbs* for abortion access and healthcare delivery in the United States. Drawing on peer-reviewed literature, federal health data, legal scholarship, and a synthesis of journalistic reporting, the review analyzes five key areas: clinical ethics and medical practice, socioeconomic barriers to access, healthcare workforce impacts, philosophical and legal-ethical debates, and Washington State's specific policy response. In doing so, it provides an integrated understanding of how this ruling is shaping real-life reproductive decision-making and healthcare delivery in both restrictive and protective states. This review also centers on personal experiences gathered through an original survey, highlighting how legal shifts reverberate emotionally, socially, and politically among individuals navigating reproductive decisions in this post-*Roe* era.

2.2. Socioeconomic Consequences and Barriers to Access

Abortion restrictions do not operate in a vacuum; they compound and intensify existing

socioeconomic and racial disparities in the U.S. healthcare system. Foster and Kimport (2013) found that abortions at or after 20 weeks are rarely elective. Instead, they result from barriers such as difficulty affording care, traveling long distances, securing time off work, or simply identifying one's pregnancy late, barriers more frequently encountered by low-income people, youth, and people of color. These structural delays are not just logistical obstacles; they represent institutional failures that deny timely and dignified care.

This theme is strongly echoed in recent surveillance data. According to the CDC (2024), women aged 20-29 had the highest abortion rates in 2022, underscoring how access is especially critical during early adulthood, a time often marked by economic instability. Black women experienced an abortion rate more than four times that of White women (24.4 vs. 5.7 per 1,000), a stark disparity not rooted in race itself, but in poverty, underinsurance, and decades of unequal access to contraception and comprehensive sex education. These data dismantle common myths that frame abortion as a purely individual or moral issue; they show that structural conditions shape reproductive outcomes.

Adolescents, especially those under 15, had the highest abortion ratios and were more likely to obtain abortions after 13 weeks, indicating that minors face additional hurdles such as fear, lack of parental support, and fewer legal rights. These delays in care for minors speak to systemic neglect and the criminalization of youth sexuality rather than protection.

Biggs, Karasek, and Foster (2012) further highlight the role of misinformation and limited contraceptive access in fueling unintended pregnancies. Misinformation disproportionately affects marginalized communities, where culturally competent health education is lacking or politicized. Even though most abortions (78.6%) occur early in pregnancy (at or before 9 weeks),

people of color and youth are overrepresented in later-term procedures, not because of indecision, but because of systemic delays, misinformation, and inequitable access.

These intersecting barriers underscore a central theme: reproductive autonomy is a function of privilege. Geography, race, income, and immigration status determine not just whether abortion is legal, but whether it is realistically available. As several survey respondents in this capstone noted, legality without access is a hollow promise; one participant wrote, “It’s not a choice if you can’t afford it, or if the clinic is five hours away.” Another stated, “If you don’t have a car, or insurance, or time off work, you’re just out of luck.” These voices illustrate how reproductive freedom is deeply conditional and how Dobbs widened the gap between rights on paper and rights in practice.

2.3. Clinical Ethics and Medical Practice

Healthcare providers are among the groups most directly affected by the aftermath of the *Dobbs* decision. In states where abortion is now banned or heavily restricted, physicians, nurses, and midwives are forced to reconcile their ethical duties to patients with rapidly shifting legal obligations. This dynamic introduces unprecedented levels of uncertainty into clinical environments, particularly in emergency care, obstetrics, and family medicine. Providers who were previously trained under guidelines that prioritized patient autonomy and safety must now operate within frameworks that may criminalize standard-of-care procedures.

Chervenak et al. (2024) describe this tension as a result of “rights-based reductionism,” in which legal interpretations reduce complex ethical decisions to binary choices: either absolute fetal

rights or absolute maternal rights. This framework leaves little room for professional discretion, moral nuance, or situational ethics, especially in cases involving fetal anomalies or life-threatening conditions. In response, Chervenak and colleagues propose a “professional responsibility model” that re-centers the physician’s role in navigating care decisions with accountability to the patient, fetus, and broader society. While ethically compelling, this model becomes difficult to implement in regions where legal risk outweighs clinical judgment.

Real-world consequences are already visible. Arya et al. (2022) report that physicians in restrictive states are increasingly reluctant to discuss abortion as a treatment option, even in cases of fatal fetal anomalies or severe maternal complications. This fear stems not just from personal convictions but from the threat of legal repercussions, professional discipline, or loss of licensure. A growing number of clinicians report delaying necessary procedures until patients’ conditions deteriorate to the brink of life-threatening emergencies, a practice that would have previously constituted malpractice. This is tragically illustrated in the case of Josseli Barnica, a 28-year-old woman in Texas who was 17 weeks pregnant when she began miscarrying in 2021. Despite clear signs of an inevitable miscarriage and risk of sepsis, her medical team reportedly told her they could not act until there was no fetal heartbeat: “It would be a crime to give her an abortion” (Jaramillo & Surana, 2024). For 40 hours, Barnica lay in a hospital bed with an open cervix, exposed to infection. She ultimately died of sepsis, a death more than a dozen OB-GYNs described as preventable and "egregious" had standard miscarriage care been provided earlier. Her story exemplifies how vague legal definitions and prosecutorial threats can override clinical judgment and patient safety, with fatal consequences.

These legal constraints particularly endanger patients who cannot afford to travel to states with more permissive laws. In survey responses collected for this capstone, several participants

expressed distress at how quickly medical care had become politicized. One respondent wrote, "The idea that I could go into a hospital and be denied care because of a state law is terrifying. I don't want my doctor to hesitate in a crisis." Another added, "It's scary knowing that people will just suffer until it's bad enough. We shouldn't have to almost die to get help."

The case of Adriana Smith, a brain-dead woman whose body was kept on life support in the state of Georgia to sustain a then very early pregnancy against her family's wishes, underscores the ethical extremes of these laws. As detailed in *The New York Times*, her case was not an isolated medical anomaly but the result of a legal system that no longer considers bodily autonomy sacrosanct, even in death (Gay, 2024). It exemplifies how anti-abortion laws can intersect with and override medical ethics, patient dignity, and family decision-making.

In sum, the Dobbs ruling has created an ethical quagmire for medical professionals, whose training, codes of conduct, and moral compasses often conflict with legal mandates. As clinical discretion becomes subordinate to legal doctrine, the foundational principles of medical ethics, autonomy, beneficence, non-maleficence, and justice, are increasingly compromised. These shifts not only endanger individual patients but also undermine public trust in the healthcare system as a whole.

2.4. Philosophical and Legal-Ethical Dimensions

At the heart of the abortion debate lie deeper philosophical questions about bodily autonomy, moral agency, and the limits of state power. Scholars like Chen et al. (2024) draw from Judith Jarvis Thomson's "violinist" analogy to argue that even if we accept fetal personhood,

compelling someone to sustain another life with their body against their will violates foundational ethical principles. The analogy, a thought experiment where one is involuntarily connected to a dependent violinist, illustrates the difference between recognizing life and mandating life-sustaining bodily sacrifice.

Toscano (2023) critiques the “Responsibility Objection,” which claims that consenting to sex entails consenting to pregnancy. She challenges this by exposing the double standards embedded in such reasoning, imagining parallel obligations for men, such as state-mandated vasectomies, which would never be politically or socially acceptable. Her work demonstrates how abortion restrictions reflect and reinforce gendered power imbalances, cloaked in moral rhetoric.

These frameworks are not abstract; they directly shape the lived realities of patients and providers. Chervenak et al. (2024) and Arya et al. (2022) warn that legal mandates grounded in moral absolutism flatten the ethical complexity inherent in reproductive medicine. Medical decisions involve balancing risks, values, and context, and laws that override professional judgment violate the ethical duty to prioritize patient-centered care.

These philosophical debates surfaced in this study’s survey responses as well. One participant wrote: “It’s my body. If I don’t have the final say, then it’s not mine anymore.” Another noted, “Lawmakers don’t have to carry a dying fetus. I did. I almost died. But they don’t care.” Such statements reflect the deep emotional and moral stakes of reproductive decision-making and the harm of policies that reduce ethical complexity to binary legal outcomes.

2.5. Abortion Access and Policy in Washington State

Washington State has emerged as a reproductive sanctuary in the post-Dobbs era, actively expanding access through legislation, funding, and cross-state collaboration. Unlike many states that moved to ban or restrict abortion, Washington codified abortion rights into state law and created mechanisms to shield providers from prosecution. This proactive approach has drawn attention from reproductive rights advocates and healthcare professionals alike.

Thompson et al. (2023) found that most Washington residents live within reasonable proximity to abortion services, a sharp contrast to states where clinic deserts are expanding. However, this accessibility comes with new challenges. As Rader et al. (2023) observe, cross-border patient traffic from Idaho and Montana has surged, especially in eastern Washington. Clinics in Spokane and surrounding areas are now serving dual roles, caring for local patients while absorbing out-of-state demand.

Washington's policy leadership extends to telemedicine as well. Allsworth (2022) notes that the state has robust infrastructure supporting medication abortion through telehealth, making it a model for digital reproductive care. Yet legal scholars warn that future federal action, such as regulatory rollback or Supreme Court intervention, could undermine state-level protections, even in progressive states like Washington.

Equity remains a concern. Foster et al. (2023) highlight persistent barriers for undocumented individuals, non-English speakers, and those lacking transportation or childcare. Legal access alone does not guarantee timely care. Survey participants echoed this: "I live in Washington and it's still hard. I couldn't afford to take time off work," one respondent wrote. Another said, "I

helped a friend from Idaho. She had to drive 7 hours, stay overnight, and miss two days of work. That's not accessible, it's exhausting."

Washington's case illustrates both the promise and the limits of state-level policy. Its proactive legislation offers a roadmap for protecting reproductive rights, but it also reveals the gaps that remain even in the most supportive environments. Real equity requires not only rights but resources, outreach, and structural change.

2.6. Post-Dobbs Enforcement and Human Impact

The fall of *Roe v. Wade* through *Dobbs v. Jackson Women's Health Organization* did more than shift legal precedent; it inaugurated a climate of fear, surveillance, and punishment. In the months since the ruling, enforcement mechanisms have become increasingly aggressive and invasive, creating a carceral environment where not only patients, but also providers, family members, and even bystanders may face criminal consequences for facilitating abortion access. This shift reflects what many scholars have referred to as the expansion of the "reproductive surveillance state," wherein bodies capable of pregnancy are subject to increasing scrutiny under the guise of legal and moral oversight.

The legal actions against healthcare workers are illustrative. A midwife in Texas was criminally charged for assisting with a medication abortion, despite not performing a surgical procedure (NYT, 2024), and a physician in New York was indicted for mailing abortion pills to patients in Louisiana (Stack, 2024). These cases highlight how post-Dobbs enforcement targets not just the procedure itself, but the broader ecosystem of care and support. Missouri's temporary judicial

block on abortion access further underscores the legal chaos, in which providers may be held in legal limbo, unsure of the legality of care from day to day (Williams, 2024).

The rollback of federal protections has intensified this precarity. The Trump administration's decision to rescind the Biden-era rule requiring hospitals to provide abortions in life-threatening emergencies (Weiland, 2024) has created an ethical and legal vacuum. Emergency room physicians are now forced to weigh professional obligations against the possibility of criminal liability. The Supreme Court's narrow ruling allowing the Idaho ban to remain in place (Savage, 2024) signals a broader trend: the federal government is retreating from reproductive healthcare oversight, leaving states to implement increasingly divergent, and often contradictory, regulations.

Perhaps the most chilling example of post-Dobbs enforcement is the case mentioned on page 21 with Adriana Smith, a brain-dead woman in Georgia who was kept on life support against her family's wishes to gestate a fetus (Gay, 2024). Smith was not merely denied autonomy in life; her autonomy was stripped in death. This tragic example illustrates how abortion bans do not stop at restricting access; they extend into a fundamental erasure of personhood for pregnant individuals.

2.7. Conclusion

The Dobbs decision has reshaped the landscape of reproductive healthcare, not just legally but materially, ethically, and socially. The evidence synthesized throughout this review demonstrates that abortion bans do not simply restrict procedures; they reconfigure systems of care, challenge professional ethics, and deepen the marginalization of vulnerable populations. The result is a

patchwork of legality that breeds confusion, punishes autonomy, and pushes reproductive care further out of reach for those already on the margins.

From a clinical perspective, Dobbs has forced physicians to practice under fear, balancing their Hippocratic oath against vague and shifting legal standards. As Arya et al. and Chervenak et al. underscore, this undermines the ethical foundation of medicine. The criminalization of care disrupts not only patient-provider trust but also the entire infrastructure of professional training, workforce stability, and safe service delivery.

Socioeconomic consequences compound these clinical dilemmas. Marginalized communities, including adolescents, BIPOC individuals, and those living in rural areas, face the greatest barriers to access and are most frequently punished by the system's gaps. As one participant in this capstone wrote, *"If you're not rich and white, you're in danger."* This sentiment is not hyperbolic; it is backed by federal health data and decades of reproductive justice scholarship.

At the philosophical core lies the unresolved tension between autonomy and state control. Legal theories that assume consent to sex equals consent to pregnancy ignore the complexity of lived experiences, trauma, and systemic inequality. The work of Chen et al. and Toscano helps frame this contradiction: that moral clarity requires nuance, not absolutism. Ethics is not an optional layer in this conversation; it is the foundation.

State responses vary widely, with Washington State offering a robust example of how local policy can affirm reproductive freedom. Washington's efforts to expand telemedicine, safeguard providers, and welcome out-of-state patients mark it as a leader, but its role is also precarious. Rising demand, clinic backlogs, and logistical limitations show that no state can shoulder the

burden of national failure alone. As one Washington-based respondent put it, *“I’m proud of where I live, but even here I worry we’re running out of room.”*

The post-Dobbs era demands more than resistance; it demands reimagination. Legal protection is necessary, but insufficient. Real reproductive justice will require robust infrastructure, culturally competent care, and a healthcare system that centers people over ideology. This review, grounded in academic research, government data, journalism, and lived experience, calls for a future in which reproductive health is not a privilege of geography or income, but a fundamental human right.

Chapter 3: Methodology: The Who, What, When, Where of Data Collection

3.0 Methods

3.1. Research Design: Reflection and Development

The study centers on individuals' lived experiences and perspectives on reproductive freedom after the *Dobbs v. Jackson Women's Health Organization* decision. The survey is designed to capture both measurable trends and personal reflections through a combination of closed-ended (multiple choice) and open-ended questions.

This capstone project began with the intention of conducting a secondary data analysis of national-level reproductive health indicators and attitudes toward abortion policy. My early research focused on datasets like the KFF Health Tracking Poll and CDC abortion surveillance reports, with the goal of analyzing public opinion and access trends following the Dobbs v. Jackson decision. However, I quickly encountered a significant limitation: much of the available data had not yet fully captured the immediate effects of the Dobbs ruling, especially in terms of lived experiences and legal enforcement mechanisms. Academic studies often lag behind real-time events due to peer review timelines, and many large national datasets either predate the Dobbs decision or have not yet reflected its long-term impacts on individuals and providers.

Faced with this challenge, I decided to pivot toward a more exploratory, qualitative approach that would allow me to center the real-time experiences of people affected by the post-Dobbs policy landscape. I designed an original survey to collect anonymous, open-ended responses from individuals living in Washington State and beyond. The goal of the survey was to capture a snapshot of people's attitudes, fears, and experiences regarding reproductive healthcare access, bodily autonomy, and state policy after the fall of Roe.

This pivot allowed me to build a more grounded, community-informed project. Rather than relying solely on secondary datasets, I was able to incorporate voices that are often left out of formal policy discourse, particularly young people, BIPOC respondents, disabled individuals, and gender-diverse participants. The thematic coding and analysis of these narratives not only provided insight into the emotional and ethical dimensions of post-Dobbs abortion policy but also helped shape my policy recommendations in ways that are directly responsive to lived realities.

While the shift required a rethinking of my methodological strategy late in the process, it ultimately enriched the capstone's depth and relevance. This experience reinforced the importance of methodological flexibility, especially when addressing rapidly evolving policy landscapes. It also emphasized the value of qualitative inquiry and narrative methods in surfacing complex, intersectional dynamics that cannot be fully captured by statistical datasets alone.

3.2. Primary Data Collection

To better understand how people in my community are experiencing and interpreting reproductive rights post-*Dobbs*, I created and distributed an anonymous online survey using a secure digital platform. The survey includes 18 questions that I created and grouped into six sections:

1. **Demographic Information** – Age, gender identity, race/ethnicity, state of residence, and educational background (optional).

2. **Awareness and Knowledge** – Familiarity with the *Dobbs* decision and state-level abortion laws.

3. **Beliefs and Values** – Attitudes toward abortion, definitions of reproductive freedom, and opinions on who should make reproductive healthcare decisions.

4. **Personal Impact** – Questions about how the reversal of *Roe* has affected participants' sense of autonomy, access to healthcare, or lived experience.

5. **Emotional and Social Response** – Questions exploring emotional reactions, activism, and social engagement.

6. **Final Reflections** – Open-ended questions inviting participants to share anything else they want policymakers or others to understand.

Participants were recruited through peer and community networks via word of mouth, digital communication, and social media. The only inclusion criteria were being 18 years of age or older and currently (or previously) residing in Washington State, U.S.; I was able to gather 31 responses total, but had to exclude 3 responses due to them not meeting the living requirements. I did receive IRB approval through the University of Washington to execute this study.

My inspiration behind the questions I chose was to gain a better understanding of my peers' feelings towards this huge constitutional shift and total loss of autonomy. I've seen similar questions as these while learning about statistical data analysis, and thought they would be a

great gauge in understanding emotions, reactions, and life experiences that aren't easily sorted as qualitative data in its raw form.

This study builds on prior policy survey research conducted by the author, using the May 2023 KFF Health Tracking Poll (Roper #31120305) as a methodological reference point. That project employed univariate, bivariate, and multivariate analysis, as well as exploratory factor analysis (EFA), to examine public attitudes toward abortion policy. The findings demonstrated the usefulness of attitudinal surveys in reproductive policy research, particularly in capturing the intersection of belief systems, identity, and political ideology.

Drawing inspiration from this approach, the present study uses a custom-designed, anonymous online survey to elicit nuanced, open-ended responses from Washington State residents. While the earlier KFF-based project emphasized national trends and statistical modeling, this capstone study prioritizes thematic depth and personal narrative. However, both projects share a conceptual foundation: they treat individual opinion as both a reflection of policy impact and a potential driver of future legislative and social change.

3.3. Data Analysis

Quantitative (multiple-choice) responses were reviewed for descriptive trends (e.g., common emotions, agreement levels), while open-ended responses were thematically coded to identify key themes and recurring ideas. This included categories such as:

- ➔ Distrust in government

- ➔ Fear of losing bodily autonomy
- ➔ Calls for justice or activism
- ➔ Emotional responses (e.g., helplessness, motivation to act)
- ➔ Reflections on gender, race, or economic barriers

These findings were then analyzed concerning existing literature on healthcare access, reproductive justice, and abortion law to offer a richer understanding of how national legal shifts are experienced on a personal level.

3.4. Limitations

This survey is based on voluntary participation and self-reporting, which may limit generalizability. Participants were primarily from my own peer and community circles, which may reflect a certain demographic or regional bias. However, the goal of this project is not to generalize to all populations, but to elevate specific, lived experiences and voices that are often left out of formal policy discourse.

This study contains several important limitations that impact the generalizability and depth of the findings:

1. **Sampling Bias / Non-Representative Sample**

   Participants were primarily recruited through personal networks and social media, resulting in a sample that may not reflect a broad cross-section of the population. Geographic, racial, political, and age diversity may be limited.

2. **Self-Selection Bias**

   Because participation was voluntary, individuals with strong opinions or personal stakes in reproductive justice were more likely to respond, possibly skewing the results toward more passionate or polarized viewpoints.

3. **Limited Demographic Depth**

   To protect participant anonymity, minimal demographic information was collected. While this ensures privacy, it restricts analysis of how some identity factors, like socioeconomic status (for example), influence perspectives.

4. **Limited Generalizability**

   Due to the small sample size and recruitment through informal methods, results are not generalizable to larger populations. Instead, the findings reflect an exploratory snapshot of attitudes within specific communities.

5. **Restricted Follow-Up or Clarification**

   The anonymous format prevented follow-up with respondents to clarify or expand on

their responses, limiting the depth of insight into open-ended answers.

6. **Use of Digital Consent and Tools**

   The online nature of the survey may have excluded those without stable internet access or familiarity with digital platforms, creating accessibility limitations.

7. **Potential Social Desirability Bias**

   Despite the anonymity, participants may have shaped their responses to align with what they perceived as socially acceptable, especially on sensitive topics like abortion.

8. **Automated Translation Limitations**

   If any translations were conducted using automated tools, there may have been a loss of nuance or cultural meaning, affecting comprehension and interpretation.

Chapter 4: Results and Discussion

4.0. Results

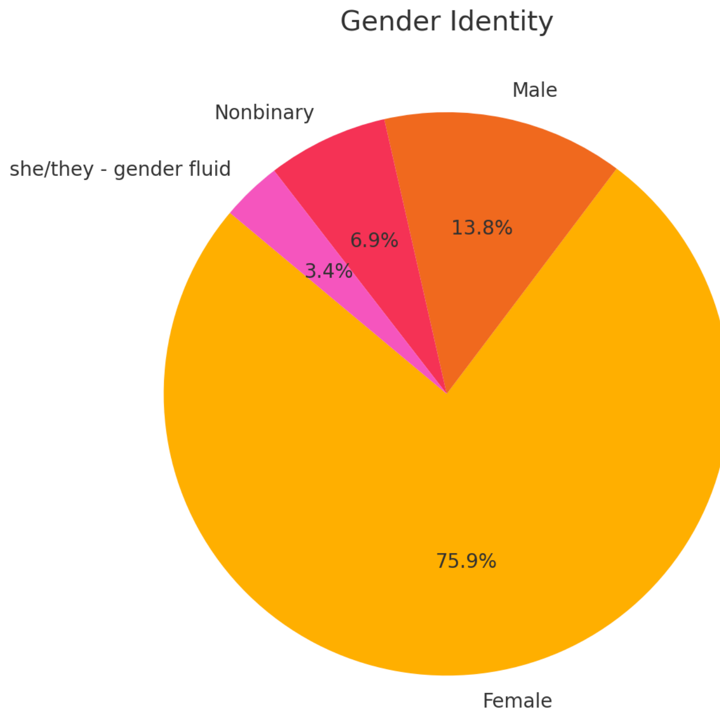
4.1. Overview

The following section presents the raw data results from the online survey, which gathered 31 anonymous responses from individuals, primarily residing (or previously residing) in Washington State (28 usable datasets). The survey was designed to explore participants' understanding of reproductive freedom, emotional and personal responses to the overturning of *Roe v. Wade*, and perceptions of policy and healthcare systems post-*Dobbs*. The results are organized thematically by survey question and response trends.

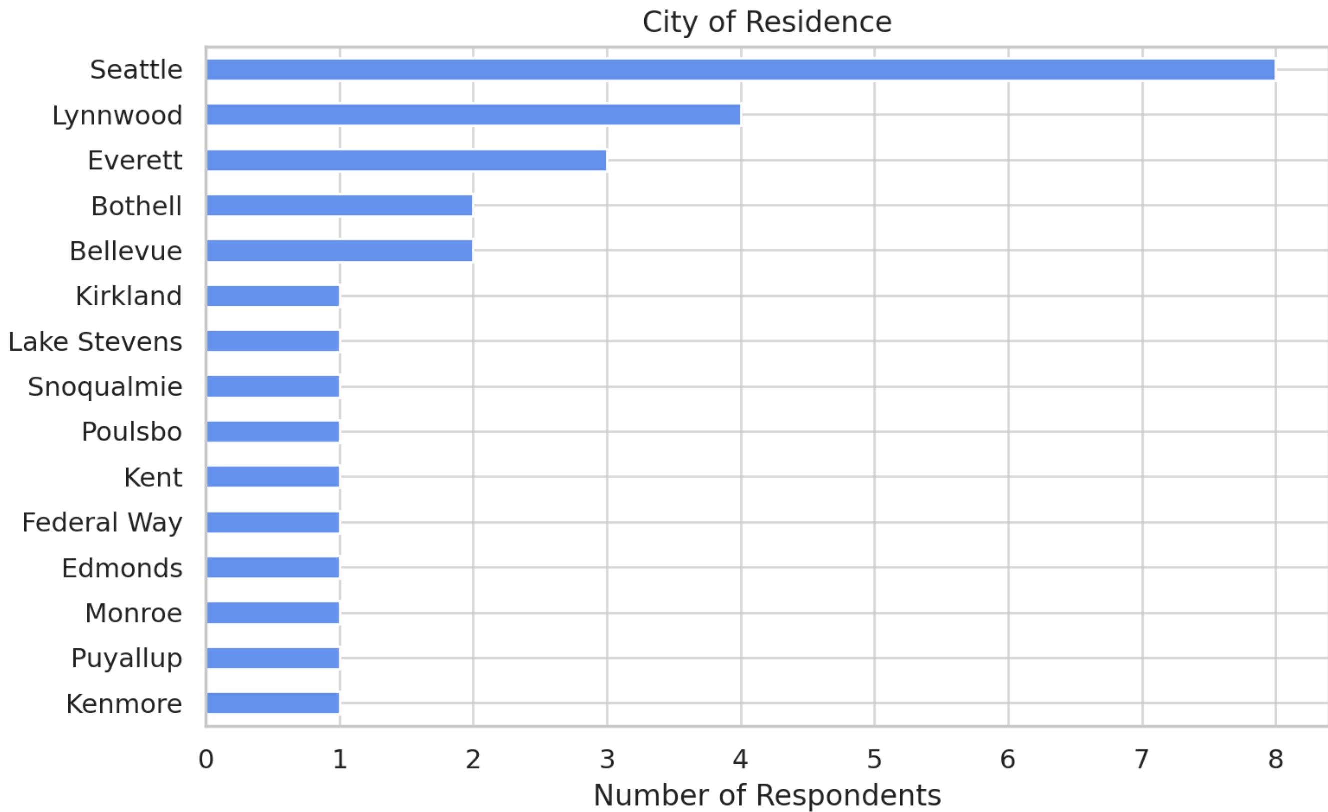
Participant Demographics (Table 1, *Gender Identity*)

- ➔ **Total Respondents:** 31 (28 able to use)

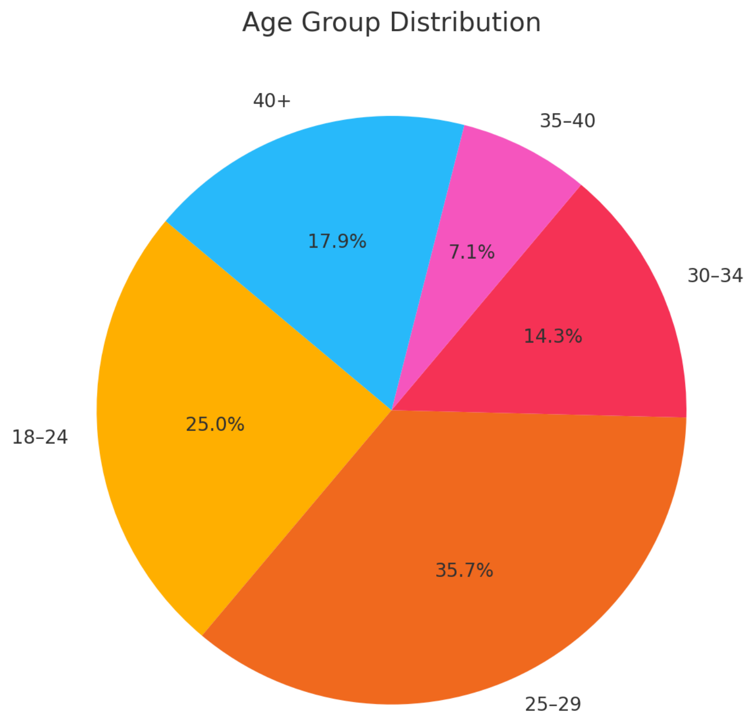
- ➔ **Gender Identity:** Predominantly female-identified respondents



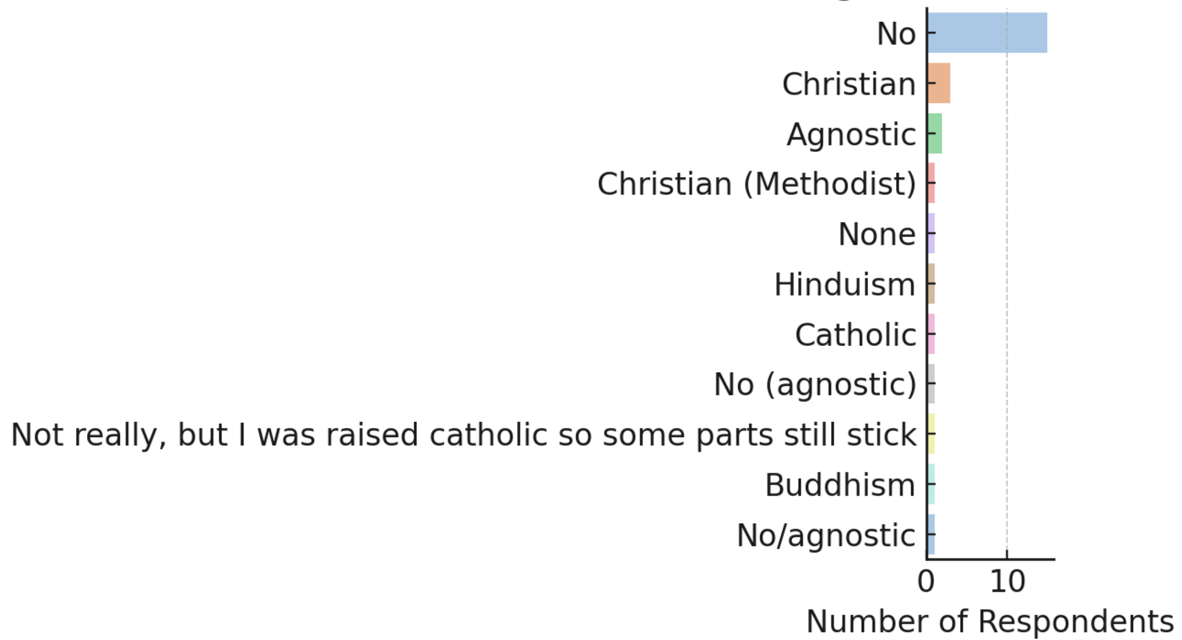
➔ **Location:** Majority confirmed residence in Washington State; two respondents reported living in other states (one respondent left the residence section empty). Those responses were all excluded from usable datasets. **(Table 2, *City of Residence*)**



➔ **Age Range:** Primarily between 18 - 35 years **(Table 3, *Age Group Distribution*)**

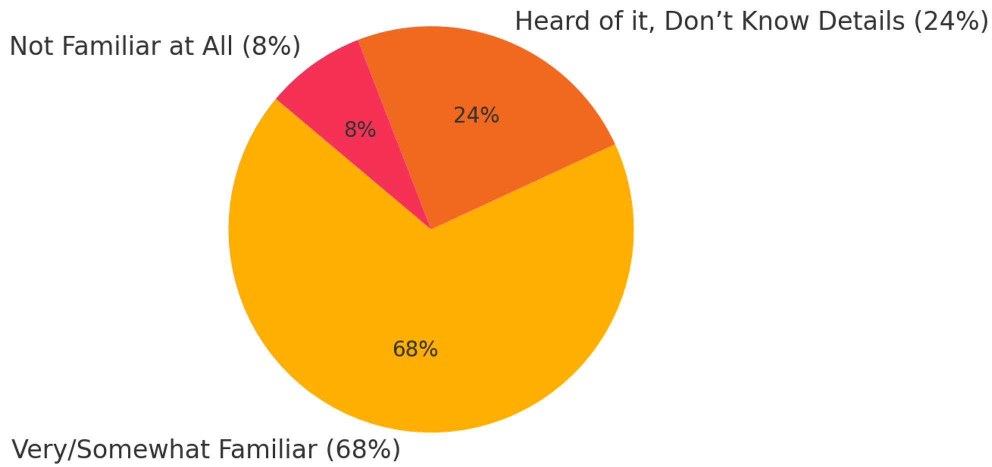


➔ **Racial Identity & Religious Affiliation:** Responses varied but leaned toward secular and multiracial identification **(Table 4, *Religious Identification*)**



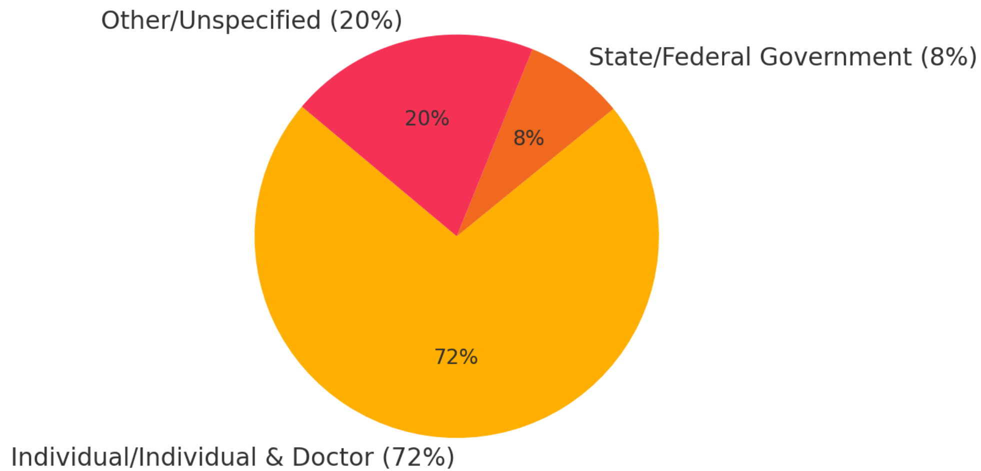
Familiarity with the *Dobbs v. Jackson* Decision (Table 5, *Familiarity with the Dobbs v. Jackson Decision*)

- ➔ 68% reported being “very familiar” or “somewhat familiar” with the *Dobbs* decision
- ➔ 24% had “heard of it but didn’t know the details”
- ➔ 8% were “not familiar at all”



Views on Legal Authority Over Abortion Decisions (Table 6, *Views on Legal Authority Over Abortion Decisions*)

- ➔ 72% believed the individual or the individual and their doctor should have decision-making power
- ➔ Only 8% selected “State Government” or “Federal Government” as the appropriate authority.

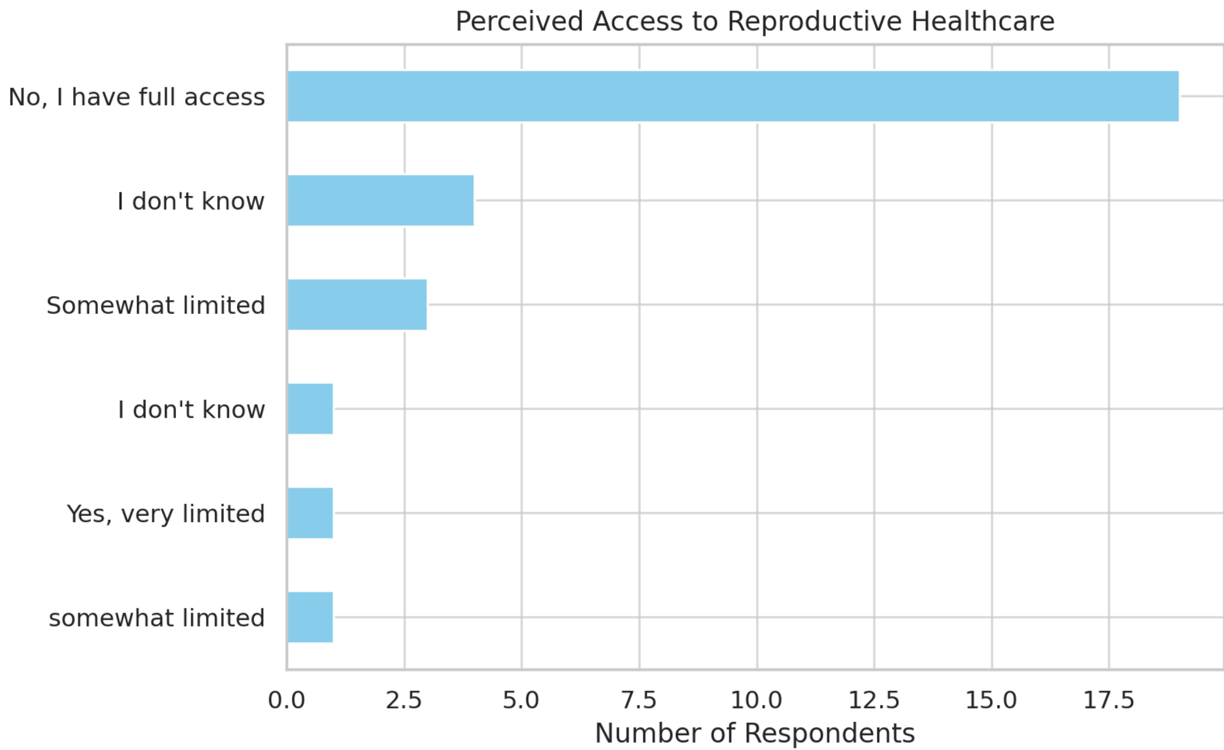


Access to Reproductive Healthcare (Table 7, *Perceived Access to Reproductive Healthcare*)

➔ 56% reported full access to reproductive healthcare in their area

➔ 32% reported "somewhat limited" access

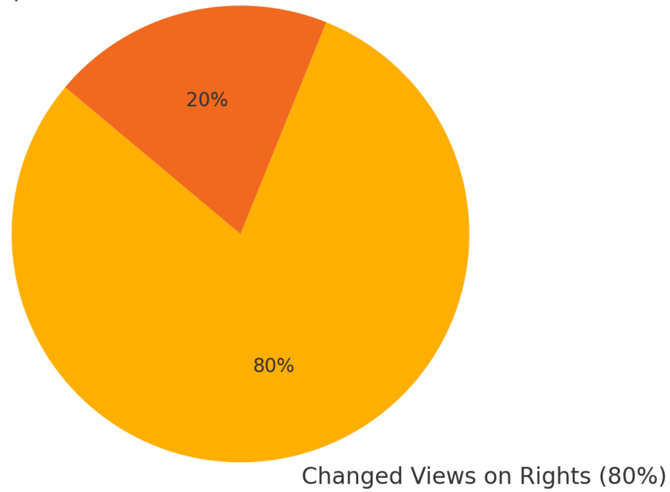
➔ 12% were unsure or indicated "very limited" access



Impact of *Roe v. Wade* Overturn (Table 8, *Impact of Roe v. Wade on Perception of Rights*)

➔ 80% said the *Dobbs* decision did change how they think about their rights

➔ Themes in open-ended responses included: fear, loss of autonomy, urgency, disillusionment, and mistrust in government systems.



Emotions Reported in Response to Abortion Restrictions (Table 9, *Emotions About Reproductive Rights in the U.S.*)

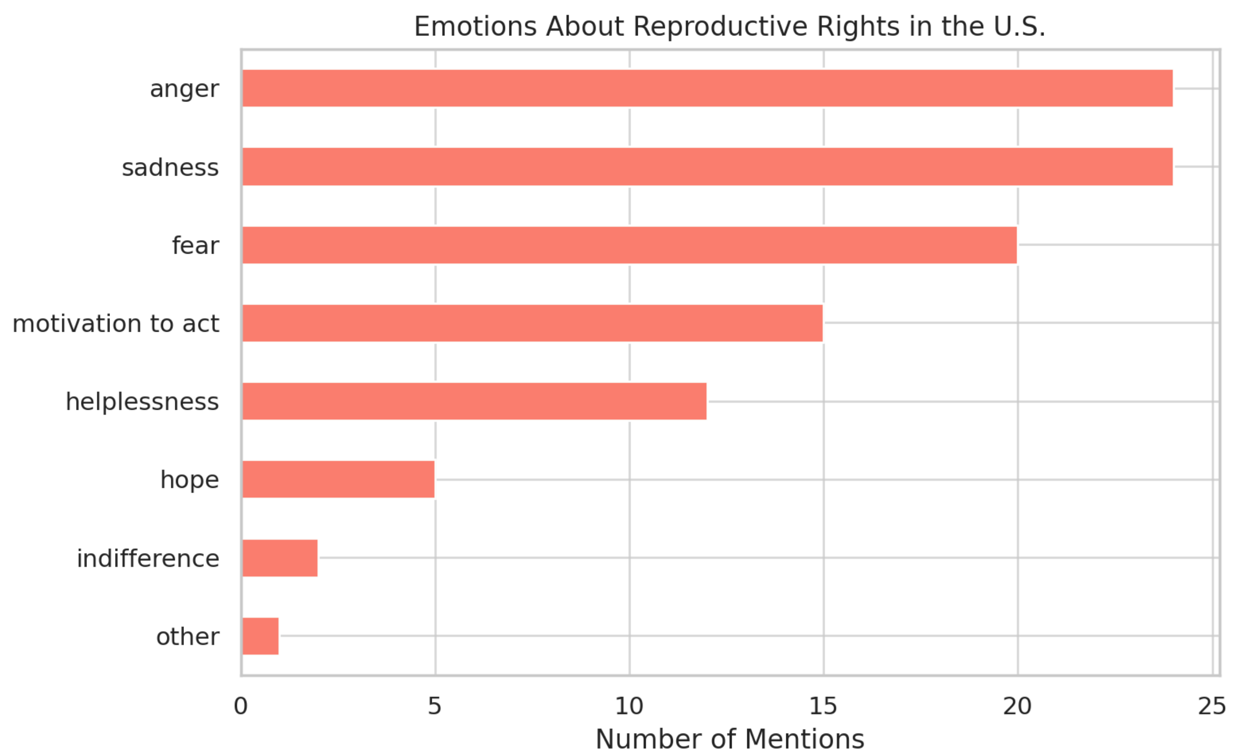
Respondents could select multiple emotions:

- **Anger:** 76%
- **Fear:** 64%
- **Sadness:** 60%
- **Motivation to Act:** 44%

➔ **Helplessness:** 36%

➔ **Hope:** 20%

➔ **Other responses included:** *“Exhausted,” “burnt out,” “disillusioned,” and “violated.”*



4.2. Personal Experiences

➔ 40% reported being personally affected by abortion restrictions or bans

- Several respondents shared direct or close experiences with abortion, miscarriage, or protest-related harassment.

Example quotes:

- *"I've had an abortion and had to obtain the medication anonymously using a friend as a third-party."*

- *"A friend had to fly to another state to get an abortion done."*

- *"Protesters screamed at us when I accompanied someone to Planned Parenthood for an IUD, not even an abortion."*

4.3. Civic and Political Engagement

- 84% reported taking action in response to abortion restrictions

- Actions included voting, protesting, donating, advocating on social media, and engaging in informal organizing.

Illustrative quotes:

- ➔ *"Most of my advocacy happens on the backlines... I speak out when it matters, support others behind the scenes, and use what I know to push for change."*
- ➔ *"I've protested, voted, and donated to organizations supporting abortion access."*
- ➔ *"I intend to work in the women's health field to educate patients on their rights."*

4.4. What Participants Want Policymakers to Know

Participants were invited to share messages for decision-makers. A common thread was the demand for autonomy, respect, and intersectional awareness.

Selected quotes:

- ➔ *"To take away one's bodily autonomy is taking away their personhood."*
- ➔ *"This is state-sanctioned violence, bought and sold as morality."*
- ➔ *"Reproductive freedom is about basic human rights. It's not political."*
- ➔ *"If you don't have a uterus, you shouldn't have an opinion."*

4.0.1. Results and Discussion

4.0.2. Introduction

This chapter presents the key findings from the anonymous online survey conducted as part of this study, *"Bodily Autonomy in Crisis: Peer and Community Narratives After Roe's Overturn."* The results are organized thematically to reflect patterns that emerged from both the quantitative and qualitative responses. Following the presentation of data, each theme is discussed in relation to the hypotheses and existing literature on reproductive autonomy, policy backlash, and post-Dobbs public sentiment.

4.0.3. Theme 1: Reproductive Freedom as Autonomy and Safety

One of the core hypotheses of this project was that respondents would define reproductive freedom primarily in terms of individual autonomy. The data strongly support this: overwhelmingly, respondents described reproductive freedom as the ability to make decisions about one's own body without interference from the state, medical institutions, or other social forces. Phrases such as "the freedom to choose your medical decisions," "my body, my life, my choice," and "having the right to make personal/medical choices about my body and family planning without barriers" were echoed across responses. Others added, "Reproductive autonomy... means having the power to make choices about my own body... not being controlled by laws or systems that think they know better than I do," pointing to a broader demand for dignity and agency.

Beyond this anticipated emphasis on autonomy, a significant theme of safety emerged. Respondents articulated not only a desire for choice but also a need for emotional and physical security. One participant wrote, “It makes me fearful and makes me wonder how I could safely get the care I needed… which feels incredibly problematic to have to even think that.” Another stated, “It’s scary. I’m scared for my daughter, my nieces. I’m scared of getting pregnant and being forced to carry a pregnancy to term.”

Additional responses deepened this theme: “It is terrifying to not know what options we have anymore,” and “I constantly worry about what will happen to my daughter if she needs help and can’t get it.” Several described reproductive freedom as essential to navigating their lives safely: “Without this right, I feel like I’m in danger just existing as a woman in this country.”

These narratives reveal a connection between legal policy and personal vulnerability, extending reproductive freedom into the realm of basic safety. This aligns with post-Roe literature (e.g., Sisson et al., 2023), which argues that reproductive access is inseparable from emotional health and a sense of personal security. Here, reproductive autonomy is not an abstract legal principle but a lived necessity, tied to daily experiences of risk, fear, and protection.

4.0.4. Theme 2: Fear, Mistrust, and Emotional Toll

A second hypothesis suggested that respondents would report heightened emotional distress in the aftermath of the Dobbs decision. This was powerfully supported by both qualitative and quantitative data. Emotions such as anger, fear, sadness, and helplessness were frequently cited, often intertwined with feelings of betrayal and vulnerability. One respondent stated, “It makes

me feel as though my body is not mine," while another wrote, "The overturning of Roe didn't just take away a right that my grandmother and mother had… it changed the way I move through the world."

One person reflected: "I've had to make different choices, not always because they're what I want, but because I'm trying to survive in a system that no longer sees my autonomy as worth protecting." Another stated plainly: "The government now has control over my body, and that is absolutely horrifying."

These statements were echoed in other submissions: "I cried the day the ruling came out," and "I was so angry I couldn't sleep. I didn't feel safe in my own country." Another shared, "I feel anxious anytime I go to the doctor, like I have to be on guard."

Respondents described not only sadness but an existential loss of control, trust, and belonging. As one participant summarized: "To take away one's bodily autonomy is taking away their personhood."

These emotional landscapes mirror what Foster (2023) describes as "legal trauma," where restrictive policies lead individuals to feel unsafe in medical settings and distrustful of public institutions. Another participant expressed: "I feel so helpless. I feel stuck. I feel like this country doesn't care about me or people like me." Their voices remind us that public policy reverberates not just through laws, but through the lived psychological experience of those affected.

One participant stated, *"I feel like we've lost the right to be human if we're pregnant. It's like we're vessels now, not people."* Another respondent wrote, *"I worry every day that I'll be arrested for something I didn't even realize was illegal, just for taking care of myself."* These

responses reflect a profound emotional toll. The fear of surveillance, the uncertainty of legality, and the pressure to remain silent are all part of the new normal.

This is not theoretical; it's already affecting health outcomes. Belluck (2024) reported that states with strict bans have seen increases in both births and infant mortality, outcomes that contradict anti-abortion rhetoric about “protecting life.” Meanwhile, abortion rates have increased nationally, even among residents in the most restrictive states, due to travel, telehealth access, and abortion funds (Belluck, 2024). This demonstrates that bans do not reduce demand; they merely raise the cost, in every sense, for the most vulnerable.

Journalist Apoorva Sengupta (2024) noted that the women most affected by abortion restrictions are already mothers, low-income, and often women of color, many juggling multiple jobs, a lack of transportation, and inadequate healthcare. One survey respondent shared, *“I had to choose between feeding my kids or traveling out of state for an abortion. That shouldn’t be a choice anyone has to make.”* These testimonies, echoed in both media and academic findings, point to the compounding effects of race, class, and geography under Dobbs-era governance.

4.0.5. Theme 3: Disparate Impact and Marginalization

Another key finding was the disproportionately intense concern expressed by marginalized participants, particularly disabled individuals, LGBTQ+ respondents, and people of color. One respondent emphasized, “As a disabled woman, reproductive rights mean everything for mine and my potential future children’s wellbeing.” Others explicitly named intersecting identities and

the compounded risk they may face. As one participant explained, “It makes me realize how little women (and trans women and born female nonbinary folx) are protected.”

Structural inequality was repeatedly highlighted. One respondent wrote, “People with more money will find a way. It’s the rest of us who are being left behind.” Another participant said, “As a queer woman of color, I’m used to being at risk, but this made it feel even worse.” These comments reinforce the idea that access alone is not justice.

Other participants described encounters with protestors and stigma: “Although this person was not restricted access to healthcare, all of the protesters clearly showed that the belief that people should not have access to reproductive care is alive and well.” Someone else wrote, “I worry what this means for trans people like me who already struggle to get basic care.”

These narratives affirm Ross and Solinger’s (2017) call to view reproductive rights through a justice-based lens, centering those most at risk of state violence and medical abandonment. Participants’ reflections reveal that the Dobbs decision has both amplified and exposed long-standing disparities rooted in racism, ableism, classism, and gender oppression.

4.0.6. Theme 4: Action and Resistance

Despite the emotional toll of Dobbs and the personal impact many respondents described, a powerful counter-narrative emerged: one of resistance, engagement, and collective action. A majority of participants reported taking steps to advocate for change, through voting, protesting, donating, community education, or direct support. One respondent shared, “I’ve protested and had my fair share on the frontlines, but most of my advocacy happens on the backlines… I try to

use what I know to push for change, even if I'm not always front and center." Others wrote, "Voted," "Protested," "Donated," or "Attended community events and educated through social media."

Several participants described helping others: "I've done what I can to help people who might need it. It feels good to be a source of information or comfort when everything else feels so messed up." One person noted, "I'm tired, but I'm still here. I'm still helping when I can." Another respondent wrote, "I've tried to stay informed, speak out, and encourage others to vote and get involved-even when it feels like no one's listening."

These findings resonate with Williams's (2022) framework of "resistant citizenship," wherein people resist exclusion not by retreating from civic life but by asserting their place within it. Resistance included not only traditional political acts but also storytelling, emotional labor, and digital activism. This multifaceted engagement reflects a resilience that challenges narratives of passivity and affirms the value of grassroots advocacy.

4.0.7. Limitations and Reflections

It is important to acknowledge that the sample of 31 respondents was not fully demographically balanced. Most were in their early 20s, identified as female, and lived in Western Washington, though responses also came from individuals in states such as Texas and Nevada (which I had to sadly not include). I do wish I had received a wider range of ages with my respondents, as most were in their early 20s, and that could create a skewed result set, as those in their early 20s will have different experiences than those in their 40s, 50s, and more. One respondent used obvious

AI software to answer the qualitative questions, which required me to exclude that dataset. This left 28 responses with substantial qualitative depth.

Given the anonymous and digital nature of this survey, I also acknowledge some interpretive limitations. I could not ask follow-up questions, observe tone, or clarify ambiguous answers. That said, the consistency of themes, particularly around fear, resistance, and the framing of autonomy, suggests that these are not isolated experiences. As a researcher who shares some of the social identities reflected in this sample, I also recognize how my own perspective informs how I interpret these narratives. Rather than a neutral observer, I approached this analysis as a participant within a broader community navigating these policy changes.

4.0.8. Conclusion

The findings of this study reinforce prior research showing that reproductive freedom is deeply intertwined with identity, health, and civil rights. Participants' reflections reveal that the Dobbs decision was not experienced as a legal shift alone but as a cultural and emotional rupture. Their responses underscore the personal and political stakes of abortion policy and the urgency of developing public policy that reflects the lived realities of those most affected.

These findings also point toward an important insight: in the face of systemic failure, people continue to resist, care, and act. Whether on the frontlines or behind the scenes, participants refuse to accept erasure passively. Their narratives demand that we listen and that we build reproductive policy that is not only legal but just.

Chapter 5: Conclusions

5.0. Conclusion

This capstone project explored the contemporary landscape of reproductive autonomy in the United States, with a specific focus on the perspectives of Washington State residents following the U.S. Supreme Court's 2022 *Dobbs v. Jackson Women's Health Organization* decision. The research sought to understand:

- ➔ How individuals currently perceive their reproductive rights,
- ➔ What factors (age, gender, student status, religious identification) influence these views, and
- ➔ What emotional, political, and personal reactions have emerged in the wake of shifting abortion laws?

Survey data from 28 respondents, complemented by rich open-ended responses and visual analysis, revealed that a strong majority of participants believe abortion should be legal in all or most cases. Respondents expressed high levels of emotional engagement, most frequently reporting feelings of anger, sadness, and motivation to act. Many described taking concrete actions in response to policy changes, including voting, protesting, and donating.

5.1. Key Findings:

- **Reproductive Autonomy Is Deeply Valued**: Respondents defined reproductive freedom as the ability to make personal medical decisions free from governmental interference. As one participant stated, “The freedom to choose your medical decisions.”

- **Impact Is Both Personal and Political**: Multiple respondents shared experiences, ranging from needing out-of-state care to witnessing friends navigate legal or logistical barriers. One noted, “My mom had a D&C that made it possible for her to have me.”

- **A Call to Action Emerged**: Many wrote directly to policymakers through the survey, urging them to recognize reproductive rights as essential. One respondent asserted, “To ban abortion is to act unconstitutionally and un-Americanly.”

5.2. Suggestions for Future Research

Future studies could expand the sample size to include a more diverse array of geographic, political, and cultural contexts. It would also be valuable to explore how evolving abortion laws affect specific communities, such as people with disabilities, transgender individuals, or undocumented persons. Incorporating interviews or focus groups would allow for deeper qualitative insights and a more nuanced understanding of respondents’ lived experiences.

5.3. Policy Recommendations (with Legislative Precedents)

1. Strengthen Reproductive Health Protections in Washington

Washington should move to codify the right to abortion in its state constitution to ensure long-term protection. This aligns with California's Proposition 1 (2022), which amended the California Constitution to explicitly guarantee the right to reproductive freedom, including abortion and contraception. Similarly, Michigan's Proposal 3 enshrined abortion rights after Roe was overturned.

> "I feel lucky to be in a state [Washington] where I don't have to worry as much, but that could change."

By following these models, Washington can fortify protections against shifting political winds and judicial threats.

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2. Invest in Public Education Campaigns

Comprehensive, inclusive reproductive education is vital. Washington could draw from Oregon's Reproductive Health Equity Act (RHEA) (2017), which supports culturally responsive care and mandates access to reproductive health services and information, particularly for vulnerable populations. States like New York have also piloted public information campaigns about abortion rights post-Dobbs.

> "Honestly, I don't even know what's legal anymore. It changes every day, and nobody tells us anything."

> "I wish we learned this in school. We talk about sex ed but never about what to do if something happens."

Public education efforts rooted in legislative mandates can reduce fear and misinformation while empowering youth and marginalized communities.

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3. Support Cross-State Care Networks

Given Washington's proximity to restrictive states like Idaho, the state can adopt a model similar to New York's 2022 "Shield Law", which protects providers from legal liability for offering abortion care to out-of-state residents. Massachusetts and Connecticut have passed similar laws to insulate providers and facilitators involved in cross-state care.

> "If someone needed help getting to Washington, I'd do what I could. It shouldn't have to be like a secret mission, though."
> "I've already offered to help friends from other states if they ever need to come here."

Washington should consider creating a state-funded abortion support fund to aid with travel, lodging, and legal costs for patients and providers.

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4. Promote Intersectional Health Equity

Washington's public health institutions can adopt frameworks from California's Black Infant Health Program, which addresses disparities in maternal and infant outcomes by focusing on

systemic racism, housing, and access to culturally competent care. Similarly, Illinois' Reproductive Health Act (2019) recognizes abortion as a fundamental right and explicitly addresses disparities in access for LGBTQ+ and BIPOC populations.

> "As a disabled woman, it scares me. I need to know my future kids will be okay too."
> "It makes me realize how little trans women and nonbinary people are protected."
> "People with money will be fine. It's the rest of us who get left behind."

These precedents show that equity-focused reproductive health legislation is both possible and effective when paired with robust public investment.

5.4. Implications

This study reinforces that abortion access is deeply interwoven with identity, trauma, resistance, and civic engagement. Participants' narratives revealed not only fear and alienation but also agency and activism in the face of systemic setbacks. The Dobbs decision triggered what one respondent described as "an existential loss of control," while another declared, "I'm exhausted but not powerless."

These emotional, political, and legal responses demonstrate that individuals are not passive recipients of policy; they are shaping and responding to it in complex ways. Young adults in particular, who formed the majority of this study's sample, are highly attuned to the stakes of reproductive justice and actively seek avenues for resistance and care.

For policymakers, educators, and healthcare institutions, the takeaway is clear: it is not enough to merely maintain the legal right to abortion. Systems must evolve to protect, expand, and destigmatize reproductive healthcare. Washington State, as a relatively safe haven, carries both opportunity and responsibility to model what equitable, inclusive, and community-informed reproductive policy can look like in a fragmented nation.

> "To take away one's bodily autonomy is taking away their personhood."
>
> "It makes me feel like my body is not mine."
>
> "I'm exhausted but not powerless."
>
> "I feel like this country doesn't care about people like me, so we care for each other instead."

Chapter 6: References/Bibliography

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Appendix

7.0. Appendix

7.1. Reproductive Autonomy Survey

Bodily Autonomy in Crisis: Peer and Community Narratives After Roe's Overturn;

Thank you for taking the time to participate in this study. Your privacy is very important to me.

- Your responses will remain anonymous. You will not be asked to share your name, email, or any other identifying information.
- All information you provide will be kept confidential. Your answers will only be used for educational research purposes as part of a student project. They will not be shared with anyone outside the research process.
- Responses will be stored securely in a password-protected file that only the researcher (me) can access. No one else, including professors or institutions, will see your individual answers.
- Quotes from your responses may be used in a written report or presentation, but they will be anonymous and will not include any information that could identify you.
- Participation is voluntary. You can skip any question you do not want to answer, and you can stop participating at any time without any penalty.

If you have any questions or concerns about your privacy or how your responses will be used, please feel free to contact me before or after participating.

Consent Statement:

You are being asked to take part in a brief, anonymous online quiz about Reproductive Autonomy. Participation is entirely voluntary, will take approximately [5-10 minutes], and involves no more than minimal risk. Your responses will be stored securely and reported only in

aggregate. You may stop at any time without penalty. If you have questions, contact Miranda Swanson, swansm3@uw.edu.

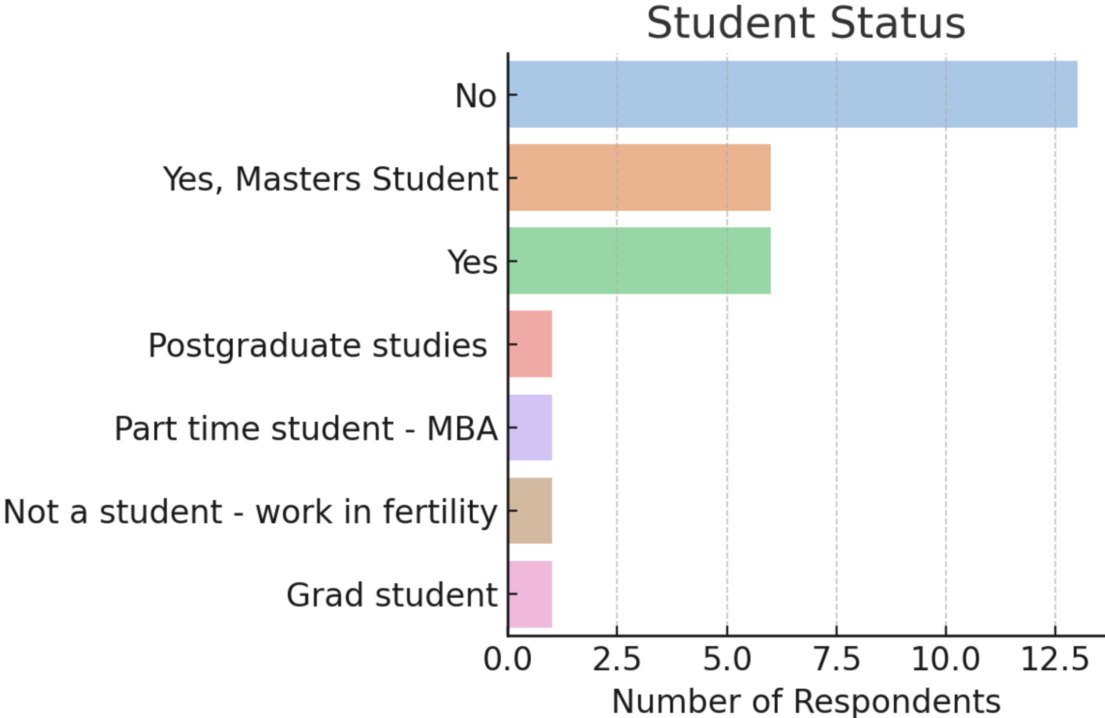
If you have selected "No, I do not agree to participate," you may now exit the survey. Thank you for your time!

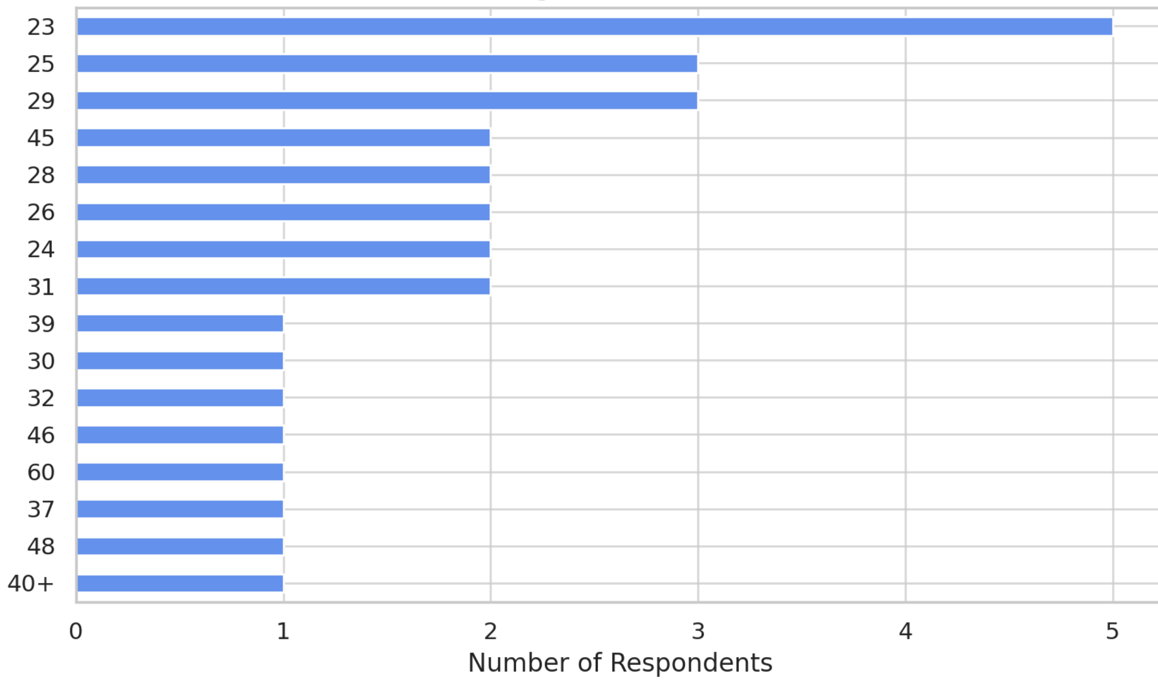
If you selected "Yes", you may continue!

- What is your age? (If you are below 18 years old, please exit this survey - thank you!)
- What is your gender identity?
- What is your race/ethnicity?
- What city do you live in?
- Are you currently a student? If so, what are you studying?
- Do you identify with a specific religious or spiritual tradition? If so, what would that be?
- How familiar are you with the Supreme Court Decision in Dobbs v. Jackson Women's Health Organization (which overturned Roe v. Wade)?
- Do you know the current legal status of abortion in Washington State?
- What does reproductive freedom mean to you?
- Do you think abortion should be legal in all or most cases?
- Who should have the authority to make decisions about abortion?
- Has the overturning of Roe v. Wade changed how you think about your rights or bodily autonomy?
- If you answered yes to the previous question, how has it changed your thoughts on this?

- ❖ Do you feel that your access to reproductive healthcare (e.g., abortion, contraception, counseling) is limited where you live?
- ❖ Have you or someone close to you been personally affected by abortion bans or restrictions?
- ❖ If you answered yes to the previous question and feel comfortable, could you possibly briefly describe how they affected you or someone close to you?
- ❖ What emotions come up for you when you think about the current state of reproductive rights in the U.S.? (Check all that apply.)
- ❖ Please list other emotions in this box if you chose 'other' and feel comfortable sharing.
- ❖ Have you taken any action? (e.g., voted, protested, donated, spoken out) in response to abortion restrictions?
- ❖ If yes to the previous question, what kind of action did you take?
- ❖ What do you want policymakers or others in power to understand about your views on reproductive freedom?
- ❖ Is there anything else you'd like to share about how these issues have affected you or people you care about?

7.2. Extra Visual - Student Status of Respondents & Age Distribution





Age Distribution
23
25
29
45
28
26
24
31
39
30
32
46
60
37
48
40+
0
1
2
3
4
5
Number of Respondents