Intersections

Volume 2023 | Number 57 Article 13

2023

The Duty to Teach and Restore Bodily Autonomy: Reflections from the Classroom

Cynthia Richards

Follow this and additional works at: https://digitalcommons.augustana.edu/intersections

Part of the Higher Education Commons, and the Religion Commons

Augustana Digital Commons Citation
Richards, Cynthia (2023) "The Duty to Teach and Restore Bodily Autonomy: Reflections from the Classroom," *Intersections*: Vol. 2023: No. 57, Article 13.
Available at: https://digitalcommons.augustana.edu/intersections/vol2023/iss57/13

This Article is brought to you for free and open access by Augustana Digital Commons. It has been accepted for inclusion in Intersections by an authorized editor of Augustana Digital Commons. For more information, please contact digitalcommons@augustana.edu.

CYNTHIA RICHARDS

The Duty to Teach and Restore Bodily Autonomy: Reflections from the Classroom

The recent Supreme Court decision *Dobbs v. Jackson* overturned *Roe v. Wade*, and in doing so, rendered mute an individual's knowledge of their bodily needs and forestalled their ability to act upon what is best for their health and well-being during pregnancy, planned or unplanned. Those decisions will now be the province of individual state legislatures, and the freedom to exercise responsibly one's personal judgment, informed by "support and counsel from family members, pastors, professionals, and confidants" as recommended by the Evangelical Lutheran Church of America (ELCA), ceased to be protected by federal law. To use a well-known phrase, it stole from all our students, especially our female students, their bodily autonomy. This decision should be a call to action for all of us, but especially for college educators who believe that knowledge is power and that being able to make responsible decisions is central to what makes us human.

Yet this wake-up call should not mask the fact that full bodily autonomy, as it relates to self-knowledge and to unrestricted access to reproductive health care, has not been a reality for many of our students for quite some time. When we lose access to the complex, well-informed conversations that allow us both to make and then act on difficult choices, then we lose our autonomy, and our very selfhood.

As an English professor at a Lutheran-affiliated institution, I knew these conversations were important prior to this last year, but the Dobbs decision and a recent course I taught underscored for me their significance and how much my students have already lost.

Bodily autonomy has not been the norm for students at Wittenberg University, a Lutheran-affiliated Liberal Arts College in Ohio, for many years now. In April 2019, the Ohio State Legislature passed Senate Bill 23, otherwise known as the Heartbeat Bill, which bans abortion after a fetal heartbeat can be detected, usually around six weeks. What this law means in practice is that many women lose the opportunity to exercise their judgment, much less seek the support and counsel recommended by the ELCA, before they even know they are pregnant. Moreover, the law itself, by representing women as having a choice prior to six weeks, assumes a normative standard for menstruation that is inconsistent with the reality of women's periods, which can range from 21 to 45 days and, for individual women, can vary from month to

Cynthia Richards, PhD, is the Veler Endowed Chair in English at Wittenberg University in Springfield, Ohio. The recipient of Wittenberg's Distinguished Teaching Award, Cynthia teaches courses in Narrative Medicine, Reading the Body in Eighteenth-Century Literature, Making Romance and British Literary Genealogies, among others, and her research interests include disability studies, trauma theory, and health humanities. crichards@wittenberg.edu

month. The name of the bill is also misleading and medically inaccurate. It relies on the false assumption, one politically potent, that if there is a heartbeat, there must be a heart. Yet medically, what is heard at six weeks is not a heartbeat but rather electrical impulses that will eventually become a heart. In other words, the bill deliberately employs a well-known metaphor for what it means to be human—to have a heart—to simplify a complex medical and emotional reality. Currently, that bill is under temporary injunction as its impact on women's civil liberties in Ohio is investigated, but its negative effect on female bodily autonomy has already occurred. The bill forestalls a complex conversation by offering up a simplistic metaphor: one that renders a woman with a heart heartless if she acts in her own best interest.

Currently, Ohio's legislative docket includes another bill that would further simplify the conversation by defining life as beginning at conception. The passage of such legislation would erase the diversity of positions on this issue among religious faiths and would ignore established medical opinion. That such a restrictive bill could pass may seem alarmist, but the reality at my Lutheran-affiliated institution is that such policy already modifies the on-site health care our students can receive. In 2016, to maintain its on-campus health clinic, Wittenberg partnered, for economic reasons, with our largest area health care provider, one that ascribes to the Ethical and Religious Directives for Catholic Health Services prohibiting any medication specifically intended to prevent pregnancy. In reaching this agreement, Wittenberg understood how this decision might impact students and sought a careful balance between the economic need for this partnership and its historic mission as a Lutheran institution. It would honor the ethical directives of its Health Services partner while working to provide access to contraceptives to students by other means. Students could procure condoms, for example, at various locations across campus and referrals for off-campus contraceptive services could be provided by our on-campus clinic. Students could even be prescribed hormonal birth control if they reported, or knew to report, painful menstrual cycles, as such medication did not explicitly violate our partner's ethical directives. What Wittenberg couldn't do, however, was advertise professional, medical consultation about a range of birth control options. These important conversations might still happen at our health clinic, through coded language that reframed menstruation as a medical condition or through confidential exchanges, but Wittenberg could not officially assure students that these opportunities would be provided. Claiming agency over one's body through openly seeking knowledge about reproductive health care options had to be outsourced to a different medical locale.

So, going into this academic year, I knew how tenuous claims of bodily autonomy were for my students, but I didn't fully realize how much they had been eroded until I taught a course on Narrative Medicine this past fall. Narrative Medicine is a new discipline, one that uses the skills taught in English—close reading, reflective writing, critical analysis—to teach medical professionals to better understand both the stories of their patients as well as their own experiences with illness, death, and the rigors of a demanding profession. Studies show it improves medical care for patients and reduces burnout for providers. It does so largely by promoting self-knowledge and deeper awareness of what it means to be human. Part of the methodology is to examine metaphors of the body, and how the language used to describe physical conditions can impact cultural understandings. In 2020, when I taught the course, I created a unit that looked at the metaphors of pandemics; this year, given the Dobbs decision, I created one on the reproductive body. I also asked students to write and reflect on when they first realized they had a reproductive body, what that experience was like, and if they would have liked that experience to happen differently. The responses I received were not unexpected, but shocking, nonetheless. Only two in the class reported talking about their reproductive bodies with their parents. In fact, most actively hid knowledge that their bodies were changing from others, and for the women in the class, that change typically evoked shame. One student still did not mention menstruation around her mother but relied instead on references to menstrual products to share this information with her. Women, in general, experienced this recognition as a period of alienation, even betrayal. The emergence of breasts, visible to others through training bras or evidence of developmental growth, often initiated this disconnection. They found themselves and their bodies read one way by others —as sexually mature—while their own experience was the opposite. They became sexualized at a time when they knew little to nothing about their own bodies or desires.

Most remarkably, almost none of them had a way of talking about these feelings. Ohio has no state-mandated comprehensive, science-based sex education requirement. What it has instead, since 2009, is a mandate to teach about venereal disease, with an emphasis on abstinence as the best way to avoid it. Most of my students grew up in Ohio, and hence for many their first encounter with the reproductive body was to view it as vulnerable to disease. Their reproductive bodies became something to be afraid of, something gross or scary. These lessons were reinforced through pictures, and conversations about who they were, what they wanted, and how they could make good choices were not part of the lesson plan. Most of what they learned about sex came from talking with friends or researching via the internet. "Outsourcing" these important conversations had already been a reality for many of my students from an early age. Exercising bodily autonomy was at best an abstraction; the only option was to opt out.

Reading the materials assigned in class helped. What they found was that their experience was not unique. Those materials included a series of culturally important "first recognitions" of reproductive bodies—the Judeo-Christian creation story; Aristotle's "scientific" writings on gendered sexual differences; the creation scene from Mary Shelley's *Frankenstein* (1818), and Simone de Beauvoir's philosophical reframing of the female reproductive body in *The Second Sex* (1949). Alienation was the theme of these readings as well, especially for women: alienation from God manifesting as pain in labor in *Genesis*; Frankenstein's alienation from his creation once he realizes the fruits of his labor; and alienation from one's body as women's existential state in *The Second Sex*. Aristotle resonated most powerfully for the students in my class, as it was clear that his empirical methodology in *History of Animals* (332 BC) made the male reproductive body the normative one, and the female body one that must be policed. Reading such a dated text, it was easy for my students to see what was wrong with his logic, whereas, as adolescents, it had been so hard to decipher why they felt so bad about their bodies. Obviously, this list of "firsts" was far from comprehensive, but it was representative of both a shared cultural history and their own personal stories. Being able to openly talk about these texts and share insights was liberating for them. We concluded this unit by meeting with a professionally trained sex educator who gave us a historical overview of sex education in the US and explained how she introduces the reproductive body and human sexuality to her students. When we reflected on her visit the following class, the relief in the room was tangible. They loved how direct she was, how without shame, how focused on simply explaining how things work. They found her knowledge, and the access she provided, healing. They also realized how politicized access to such knowledge has historically been and came to view their own narratives of alienation more compassionately.

Bodily autonomy only happens when we can talk openly about our reproductive bodies and when we understand all the options available to use. I learned this as well in college, the hard way. I too grew up in a state without comprehensive, science-based sex education and very little in my developmental trajectory was about knowing what I wanted and how to act on it. Not surprisingly, then, as a junior in college, I experienced an unplanned pregnancy. That pregnancy, in many ways, was a result of not knowing what I needed to know. Yet when faced with this unexpected crisis, I found for the first time, what I would call, bodily autonomy. The physician at my university health clinic laid out all my options without judgment or agenda. She only wanted to honor my wishes, and to help me understand my choices. Her supportive response allowed me to share my situation with friends and our university chaplain, and they too gave me space to make the decision that was right for me. Ironically, after deciding not to terminate the pregnancy, I had a miscarriage. I felt both relief and disappointment. My response to this outcome was as complex as the decision itself. What was not complicated was how important it was to have the space to talk about my decision and to understand all the options available to me, including abortion.

We have a moral duty, as educators, to create spaces where individuals can make complex decisions and where they can learn to make the decisions that are right for them. We have an obligation to fight for our students' bodily autonomy. Understanding their alienation from that reproductive agency and knowing how when and how it gets lost is where we must begin.