

**From experience to evidence:
When digital abortion stories become health information**

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Abstract

In recent times, digital patient narratives circulate around clinical and public health information. This article reads two Planned Parenthood YouTube narratives, *Alex My Story* (2021) and *Lucky* (2023), to ask what a personal account of abortion can offer someone who has not yet had an abortion. The study begins with the words, form, and presentation of the two videos and uses research in medical humanities, digital health communication, and experiential evidence to frame the reading. The stories can be useful without becoming representative evidence. They give particular experiences a public form that allows another person to recognise possibilities and imagine what an abortion might be like. At the same time, the setting of the stories can bring a personal account close to other kinds of health information. This proximity can make a possible experience seem more likely than the story itself can establish. The article calls this movement epistemic scaling and uses it to distinguish between evidence of an experience and evidence of the experience. Digital abortion stories are most useful when they help people imagine possible experiences while leaving questions of frequency, risk, and clinical expectation to evidence that can answer them.

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INTRODUCTION

Recent developments in digital health communication show that these narratives are not confined to the representation of experience. Once they circulate through searchable platforms, they become part of the informational environment in which people may seek to ascertain what an abortion might be like. The narrator, however, is speaking after the event but the viewer may be listening before it. This difference is crucial because the same story can serve two very different purposes. For the narrator, it records something already lived, but for a prospective viewer, it can become a way of thinking about something that has not yet happened. A statement such as “this is what happened to me” may therefore be heard

besides “What might happen to me?” The article begins with this gap between the two positions.

People seeking abortion information do not look only for procedural facts. They may also want reassurance, preparation, recognition, or a sense of how another person managed uncertainty, bodily sensations, relationships, stigma, and recovery. An individual story can offer that kind of orientation because it gives an experience a human scale. Its details can make an unfamiliar situation easier to picture. The same details can also invite generalisation. In this sense, a viewer may remember one person’s experience as an image of what abortion is like, even when the narrator has described only what abortion was like for them. The question is therefore not simply whether the story is accurate, but whether the story’s place in a

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larger informational setting makes clear what kind of claim it is making.

Experiential evidence illuminates what a patient story can contribute. Then, a patient story is not valuable because it contains information. Its value also comes from the position from which that information is known and communicated. The two videos select particular details, arrange them into stories, and address viewers through a recognisable institutional setting. I therefore read them as mediated testimony, paying attention to the language through which a singular experience is presented to people beyond the person who lived it. Wickman (2025) similarly treats patient narrative as a site where personal experience can enter wider conversations about health.

This approach also avoids reducing experiential knowledge to something merely anecdotal. Halloy et al. (2023) locate experiential knowledge in questions of who knows, what is known, and how that knowledge is produced and communicated. A patient account, in this sense, matters precisely because it comes from a lived experience and can be understood without claiming that the same experience is universal. Charon (2005) likewise emphasises attention, representation, and affiliation as central to the work of narrative. These perspectives make it possible to value the knowledge in a personal story without asking the story to answer questions it was never designed to answer.

The article focuses on two Planned Parenthood videos, *Alex My Story* (2021) and *Lucky* (2023). They provide a useful comparison because both are first person accounts presented by the same health organisation, yet they organise personal experience differently. Their titles, pronoun choices, retrospective judgments, and institutional presentation make it possible to follow how a singular account enters public communication. The videos are not treated as representative samples of abortion experience, and their clinical accuracy is not evaluated. Instead, the study asks what their language and presentation allow a personal account to do once it is placed in a public health setting.

This article argues that the central movement in these stories is a change in scale. A first-person account begins with one person's experience, but it can enter a public landscape

where another person may use it to think about a possible future experience. The key distinction is therefore between 'evidence of an experience' and 'evidence of the experience'. A narrative can establish that a particular response, feeling, or sequence happened to one person without illustrating that the same response is typical, probable, or even clinically predictive. The problem arises when the scale of the claim changes without that change being made visible. A story can say, legitimately, "I felt relief." And public health evidence can address how commonly people report relief but neither kind of statement becomes stronger by being made to look like the other. I use the term *anticipatory understanding* for this more limited role that narrative can play. A story can widen what someone is able to imagine while leaving questions of probability, safety, and clinical expectation to evidence suited to those questions. In this article, *anticipatory understanding* spells out the process by which a narrative makes an unfamiliar experience available for imaginative comparison without establishing that the narrated experience is typical or probable.

METHODS

The corpus consists of two publicly available Planned Parenthood YouTube narratives, *Alex My Story* (2021) and *Lucky* (2023). Both are first person abortion narratives published by the same health organisation, but their different presentations make the relationship between personal testimony and public health communication visible. The corpus is intentionally small and purposive rather than representative. The study therefore does not generalise from these two videos to abortion narratives as a whole, rather it examines closely what becomes possible when a personal account is placed in an institutional health setting.

The interpretive procedure is deductive and comparative. It works across three connected levels, drawing on discourse level analytic attention to language, genre, and the social organisation of meaning (Fairclough, 1992; Wodak & Meyer, 2016). At the micro discursive level, the analysis examines lexical choice, pronoun reference, possessive grammar, tense, modality, evaluation, and shifts between "I," "my," "you," "we," and more generic references

to abortion. At the meso discursive level, it considers genre and circulation, including the relation among personal testimony, advocacy discourse, institutional description, video title, and YouTube's searchable public interface. At the macro discursive level, it asks how these choices affect the distribution of epistemic authority and how a singular account can participate in wider discussions of health care, normalisation, and public legitimacy. The analysis is deliberately narrower than a comprehensive critical discourse analysis of Planned Parenthood or abortion discourse. It traces a specific movement of epistemic scaling while remaining attentive to the institutional and cultural conditions visible in the two videos and their presentation. Four questions organise the reading. How does each narrative mark the limits of individual experience? How might institutional and platform circulation alter those limits? How does the narrative make prospective comparison available without proving that such comparison occurs? What communicative practices can preserve narrative usefulness without allowing vividness to become an accidental measure of probability? The comparative procedure moves from textual feature to discourse function and then to epistemic implication, testing whether the same feature performs the same function across the two narratives. Audience reception is not inferred from the videos. Where reception research is used, it provides context for what the close reading makes possible rather than evidence of what viewers actually think or do.

I distinguish three parts of the communicative situation as what the narrator says, how the institution presents the account, and what the platform allows viewers to encounter. These are not treated as three independent meanings. Their relationship becomes visible in small details. A possessive such as "my" marks ownership at the level of grammar. In a title, it also presents the video as a personal story. When that story appears on a health organisation's channel, the personal account sits within a wider discourse about care. The platform then makes that account searchable and available beyond the immediate context in which the narrator originally experienced the event. The point is not that the institution or platform determines what viewers think, but that

these settings affect the circumstances in which the story is encountered.

The study does not assess the clinical accuracy of the narrators' accounts or treat the two videos as representative evidence about abortion outcomes. Those questions require clinical or population-based evidence. The question I ask is what kind of knowledge these videos offer and how an account of something already experienced may become useful to someone thinking about what might happen in the future. Secondary research on reception, online health information, and experiential knowledge provides context for that question. The videos themselves remain the primary evidence for the analysis, and claims about actual audience reception are not inferred from them. The close reading instead identifies what the narratives make available as a possible form of understanding.

The materials are publicly available institutional videos and contain no private participant data collected by the researcher. The study does not involve interviews, intervention, or contact with human participants. It therefore involves no participant recruitment or intervention. Institutional human subjects review was not sought for the textual analysis conducted here.

RESULTS AND DISCUSSION

The two videos provide different but related forms of retrospective testimony. In *Alex: My Story*, Alex reflects on her abortion from the position of having already lived through it. The narrative begins with the personal nature of that experience and then turns toward the decision to speak about it publicly. She explains that she had not initially thought that she needed to talk about her abortion, but that speaking about it allowed other people to talk about theirs and gave her something valuable to connect with others through. The movement is therefore from an experience held as personal toward an experience made shareable. *Lucky* follows a similar retrospective structure but gives the experience a more explicitly evaluative shape. Looking back, Lucky describes her abortion as one of the greatest acts of compassion she had committed and as one of the best decisions she had made. The narrative then moves beyond the

description of her own experience toward the question of how abortion is spoken about in health care. She argues that abortion needs to be talked about in a health-care setting because silence can make it appear uncommon and isolated, whereas sharing experiences places it within the range of things people go through. Taken together, the two stories move outward from particular experiences through different forms of relational and public address. Alex foregrounds the movement from “my” experience toward “other people,” while Lucky moves from retrospective judgement toward a broader claim about sharing and the place of abortion in health-care discourse. These movements provide the textual basis for examining how a situated account can acquire wider informational relevance without becoming representative evidence.

Situated testimony and the limits of “my”

The first narrative establishes an epistemic boundary before it begins to cross one. *Alex My Story* places possession at the centre of its title. The possessive “My” personalises the video and limits the grammatical scope of the claim. Here “My” and “My story” refer to the video title rather than to a separate quoted utterance; the title itself is the object of analysis. The title consequently performs a modest but important epistemic task. It tells the prospective viewer that what follows is situated knowledge. The title does not say “the abortion story” or “what abortion is like.” It announces an account from within a life. Yet the account does not remain closed within that possession. Alex herself explains what happens when she makes the experience public:

It never really occurred to me that i needed to talk about my abortion by talking about it I was allowing other people to talk about theirs it impacted me in a way that gave me something valuable to connect with people on. (Planned Parenthood, 2021, 0:13–0:24)

When Alex says that talking about her abortion was “allowing other people to talk about theirs” (Planned Parenthood, 2021, 0:19–0:22), she does not claim to speak for every abortion experience. She describes what her own story made possible for others. Someone with a similar experience may find language or recognition in it,

while someone without that experience may find it easier to picture. The story therefore reaches beyond the narrator without becoming representative. Its value lies in the possibility of recognition and imagination, not in establishing how common the experience is.

Speaking also gives the testimony an advocacy function. Alex is not just reporting what happened to her. By making the experience public, she creates an opening through which another person may recognise, articulate, or imagine an experience. That use remains prospective and contingent. The video can make an experience more speakable or imaginable, but it cannot establish how common that experience is or what another person will experience. Relational reach therefore does not require representativeness, and anticipatory usefulness does not require probability.

The point, then, is not to treat the word “my” (Planned Parenthood, 2021, 0:13–0:24) as a boundary that closes the story. Rather, that small grammatical marker remains present as the narrative enters a much larger informational world.

The movement from “my” (Planned Parenthood, 2021, 0:13–0:24) to “other people” (Planned Parenthood, 2021, 0:19–0:22) therefore does not erase the situatedness of the testimony. It changes what the situated account can do in circulation. It can become a resource for recognition, articulation, and anticipation while remaining an account of one person’s experience.

Institutional adjacency and evidentiary compression

The institutional setting changes what surrounds the personal account. Once *Alex: My Story* and *Lucky* appear on an official Planned Parenthood channel, they enter the communicative environment of a recognised health-care organisation while remaining first-person accounts. The institution does not necessarily erase the narrators’ situatedness, but it changes the cues surrounding the testimony. A story selected, hosted, and presented by a health organisation may be encountered alongside the organisation’s wider knowledge claims even when the story itself makes no clinical claim. This is what

is meant here by epistemic adjacency. The analysis therefore asks what happens when different kinds of information become visually and digitally proximate even though their evidentiary bases remain different.

The videos do not become clinical evidence through their association with Planned Parenthood. What changes is the setting in which testimony, advocacy, and health information are encountered together. In *Alex My Story*, the title and first-person language keep the account close to the speaker's experience. In *Lucky*, the personal account later moves into broader statements about abortion and health care. These details make it possible to examine provenance in practice, including who is speaking, what experience the speaker draws on, and how far the wording appears to reach. The analysis treats that provenance as part of the epistemic work of digital storytelling rather than as a merely bureaucratic detail.

Temporal scaling and anticipatory possibility

The possibility of prospective use is visible in the way people seek experiential information online. Wilson-Lowe et al. (2024) found that people seeking abortion support online valued information, preparation, and the opportunity to encounter other people's experiences. That finding provides context for the present reading, but it does not establish how viewers of these two videos actually respond. The videos themselves show how a retrospective account can be presented in a form that a prospective viewer could use while imagining care. A description that is retrospective for the narrator can therefore become anticipatory for the viewer. What happened to someone else can become material for imagining what might happen next.

Lucky makes the transition from situated experience to anticipatory possibility more explicit. The narrator retrospectively evaluates the abortion in strongly affirmative terms.

The statement, "I was like, oh, no. My abortion was one of the greatest acts of compassion I had ever committed" (Planned Parenthood, 2023, 0:17–0:27), derives its authority from its location inside Lucky's own history. It is a retrospective judgement about what the experience

meant to her, not a clinical claim about what abortion generally produces. Yet, its specificity can still be useful to a prospective viewer because it demonstrates that compassion is one possible way an abortion experience may be understood. The narrative thus offers an experiential possibility without turning that possibility into an expectation.

Lucky's language brings retrospective judgment, testimonial speech, and institutional health discourse into the same communicative object. The statements "greatest acts of compassion" (Planned Parenthood, 2023, 0:17–0:27) and "best decisions" (Planned Parenthood, 2023, 0:43–0:52) are judgments about what the experience meant to the narrator. Later, Lucky explains why she thinks abortion stories should be shared. The analysis follows this movement from a personal account toward a broader public claim. A person recounts what happened, the video presents that account within an institutional setting, and a viewer encounters the two together. The risk lies in treating the wider setting as if it changed the evidentiary status of the original judgment. It does not.

The usefulness of that possibility depends on keeping its singularity intact. *Alex* foregrounds the boundary of situated testimony, whereas *Lucky* foregrounds the social work that testimony is asked to perform. If Lucky's retrospective judgment is read as evidence that abortion is generally compassionate or that people should feel certain after an abortion, the narrative has been asked to perform a task it was never equipped to perform. Yet if it is read as evidence that compassion and certainty are possible responses, the account becomes genuinely useful. This is an important distinction because experiential knowledge does not become valuable by becoming general. Its value often lies in giving language and form to experiences that may otherwise remain difficult to imagine. The story can therefore widen the viewer's expectations without dictating where within that range the viewer should find themselves.

Lucky nevertheless widens its grammar when she explicitly describes why abortion stories should circulate:

It's important to talk about abortion in a health care setting, because I think that when we don't, we see abortion as this very, very uncommon, isolated thing. And it's not. It needs to be shared and it needs to be out there just like any other thing that people go through. (Planned Parenthood, 2023, 0:57–1:19)

Here the story is doing both social as well as testimonial work. Lucky frames sharing as a way of making an experience less isolated and more publicly speakable. The move is toward advocacy because the personal account is being used to alter how abortion is understood collectively. Yet the distinction between possibility and probability remains. Making an experience visible, or giving people a language through which to recognise it, does not establish how frequently that experience occurs.

This double function helps explain why digital abortion narratives can seem more authoritative than a conventional patient story. The platform places the account within an institutional setting devoted to health communication. Guidance, education, advocacy, testimony, and anecdote can consequently appear within the same stream, making differences in evidentiary status less conspicuous. Han et al. (2020) found substantial variation in the trustworthiness and bias of abortion related web content; Madathil et al. (2015) and Drewniak et al. (2020) likewise show that online health narratives can combine professional, experiential, and anecdotal material. The point is not that viewers necessarily confuse these forms. Rather, the interface can make their differences less noticeable. Institutional branding may strengthen that proximity by placing an individual account alongside the organisation's wider health communication.

The distinction becomes especially important when stories are used to anticipate bodily experience. Guidance can describe expected bleeding, pain, warning signs, medication, and follow up, whereas narrative can show how such events are embedded in waiting, conversation, fear, secrecy, or relief. That additional texture is not redundant. Sherman et al. (2017), in their evaluation of Lara's Story, found that women valued experiential information and often wished they had encountered it before abortion. Yet some participants also found that the account's depiction

of pain, bleeding, and nausea did not resemble their own experiences and wanted several stories rather than one. The finding clarifies the epistemic role of narrative. One story can prepare a viewer by widening expectation, but it can misprepare a viewer if it is treated as a template. The problem is not simply factual mismatch. Therefore, a single narrative can also create an affective benchmark against which viewers measure themselves, potentially making an ordinary variation feel abnormal or an unexpected symptom feel falsely reassuring.

Recent research suggests that this mismatch is pertinent. Mackay et al. (2025) found that online stories could be reassuring when viewers recognised their own experiences in them, while differences between the story and a viewer's experience could produce unnecessary fear or a false sense of preparedness. This does not mean that stories should be stripped of difference. A collection of varied accounts can make the range of possible experiences visible and reduce the pressure on any one narrative to function as a norm. Variation itself becomes informative when a communication environment shows different emotional, bodily, temporal, and social trajectories, and it becomes harder to treat one trajectory as the expected one.

Possibility and probability

Research on decision making helps clarify a limit already visible in the videos. Narrative information can influence preferences differently from statistical information, and first person accounts can be especially memorable and persuasive (Winterbottom et al., 2008). Reviews of personal stories in decision aids show that narratives can improve engagement and recall while also influencing values and choices in ways that are difficult to predict (Bekker et al., 2013; Shaffer et al., 2021). The updated International Patient Decision Aid Standards therefore emphasise evidence informed decision support and transparency about the basis on which choices are made (Volk et al., 2026). These studies do not show that viewers of *Alex My Story* or *Lucky* will respond in a particular way. They help explain why a vivid account can affect what feels likely without changing how likely an event actually is. The

distinction is therefore between persuasive force and evidentiary force.

The difference between possibility and probability becomes clearer when the narrative is placed in the context of broader health information. Then, a personal story gives access to something that happened to a particular person. A viewer may encounter that story within the same search or communicative setting as information about abortion more generally. The two kinds of knowledge can then appear more alike than they are. The wording of the videos provides the textual evidence for the distinction. A story can show that something happened but it cannot, by itself, show how often it happens. Epistemic scaling spells out the point at which the singular account begins to invite a broader reading.

Discourse analysis helps clarify why this distinction is not only about how people think. Possibility and probability are also shaped by the way claims are worded. Modal expressions, evaluative certainty, generic nouns, and institutional statements can broaden the apparent scope of a claim without changing its factual content. A first person statement such as “I felt relief” remains tied to a particular speaker and past event. A general statement about “abortion” removes that anchor and invites a wider reading. The shift from anchored language to generic reference therefore changes the apparent reach of the statement. A small grammatical change can matter because it changes who or what the statement seems to describe.

Possibility and probability answer different questions. The two narratives can establish the possibility of a particular experience because each records something that happened to a particular person. They cannot establish how frequently that experience occurs or how likely it is under particular conditions. A guideline, clinician, or population study is better suited to those questions. The two forms of knowledge therefore complement each other. A viewer can learn something meaningful from a story while still needing other evidence to determine likelihood.

Perhaps this is where the quiet value of narrative becomes clearest. A story does not have to tell someone what will happen in order to help them imagine that several things might happen.

Sometimes that widening of the imaginable is itself a form of preparation.

Mackay et al. (2025) show why the distinction matters when people search for stories during an abortion. Participants in their study did not only read stories afterwards. Some searched for other people’s experiences while the abortion was taking place. Their question could therefore change from “What happened to you?” to “Is what is happening to me normal?” The present videos cannot establish that viewers make this comparison, but the finding helps identify a possible use of narrative. A retrospective account can become an informal point of comparison for a present bodily experience. That use makes the difference between possibility and probability especially important because another person’s account may begin to look like a standard against which the viewer reads their own body.

Experiential evidence and ethical coordination

Research on online communities helps explain why experiential information remains important. Lands et al. (2023) found that abortion seekers used online spaces for information, reassurance, and connection, while Valdez et al. (2024) showed that abortion related Reddit forums also support medical information seeking and discussion of personal worldviews. Pleasants et al. (2024) showed how narratives of waiting can make uncertainty and delay visible. These studies provide context for what the two Planned Parenthood videos can offer, but they do not turn the videos into representative evidence. The textual evidence suggests a more limited role. A story can provide temporal, emotional, and social detail that formal clinical information may leave implicit. It can therefore offer experiential knowledge without replacing population evidence or clinical advice.

That clarification also matters for the people who tell these stories. Public sharing can create connection, but it can also create exposure. Woodruff et al. (2020) found that 60% of people who had publicly shared abortion stories reported harassment or other negative incidents, although positive experiences were also common. The familiar institutional phrase “giving patients a voice” is therefore inadequate. The voice already belongs to the narrator. Institutions provide the

infrastructure through which that voice becomes searchable, editable, reproducible, and publicly available. Once a story enters that infrastructure, its later uses cannot be fully controlled by the person who told it. Ethical health communication must therefore consider not only how stories may function for audiences but also what institutional circulation asks of storytellers. Treating the narrator as an epistemic contributor rather than a communications asset also requires attention to consent, context, editing, discoverability, and the possibility that a story will reach audiences far removed from the circumstances in which it was told.

The institutional response should not be to remove personal narratives from health communication but to make their authority clear. The distinction can be seen in the two videos themselves. Testimony supplies situated experience; clinical guidance is suited to medically actionable questions; population evidence is suited to claims about frequency, risk, and expected variation. When a narrative touches on symptoms, risks, or decisions that require validated information, it should therefore appear alongside clearly signposted clinical resources rather than carry that medical burden itself. Several accounts can also reduce the pressure on one narrator to stand in for a population. This approach is consistent with findings that abortion seekers want different kinds of experiential information and that mismatches between stories and lived experience can matter (Mackay et al., 2025; Sherman et al., 2017).

This creates a practical distinction between communicative functions rather than between the value of different kinds of knowledge. Clinical evidence is not “better” because the patient story is less meaningful. It is better suited to questions of prevalence, safety, and standard practice. The patient story is not “better” because it is more authentic. It is better suited to questions of felt experience, recognition, and imaginative preparation. Once these functions are distinguished, the apparent competition between evidence types becomes weaker. The task is coordination. Each form of knowledge should answer the questions for which it has the appropriate evidentiary reach.

Narrative can remain valuable in public health without being treated as statistical evidence. Research on storytelling and first-person health communication links narrative with changes in knowledge, attitudes, behaviours, and some health outcomes, although those effects vary across settings and intervention designs (Lipsey et al., 2020; Perrier & Martin Ginis, 2018). Those studies explore broader effects and do not establish how these two videos affect viewers. The present analysis claims a story can give someone a way to picture an experience that formal health information may describe only in general terms. That is a different kind of usefulness from providing evidence about prevalence, risk, or clinical expectation.

Medical humanities is useful here because it draws attention to what can be lost when a singular life is made to carry a general message. Narrative medicine has long treated attention to stories as part of how clinicians encounter the particularity of illness rather than as a substitute for biomedical knowledge (Charon, 2005). More recent scholarship places narrative medicine across clinical practice, education, and patient experience, while work in public health narrative ethics considers the ethical questions that arise when stories enter collective health communication (Palla et al., 2024; Barrett et al., 2022). Public health needs to work at scale and therefore formulate recommendations that extend beyond individual cases. Narrative brings back what such scale can abstract away, including the particular body, the interval of waiting, the emotional sequence, the uncertainty, and the retrospective meaning attached to a decision. The two forms of knowledge need not be opposed. While narrative can show what those claims mean when they are encountered within a life, public health can provide evidence for general claims. The problem begins when one form is asked to perform the work of the other. Medical humanities is valuable here not because it replaces evidence with interpretation, but because it helps show how evidence becomes meaningful to a person. This matters in digital settings, where interface design can place different forms of knowledge within a single stream.

The point is not to choose between the intimacy of the story and the authority of evidence,

but to remain attentive to what each makes visible and what is lost when one is asked to stand in for the other.

Anticipatory understanding and coordinated evidence

The videos show what anticipatory understanding can mean without showing that it changes viewer behaviour. A digital health story does not need to predict what will happen to a viewer. It can give someone language for recognising that several kinds of experience are possible and for thinking about what those possibilities might mean. Questions about what is common, what may signal a problem, and what can be expected clinically still require other forms of evidence. The value identified in the close reading is therefore limited but practical. The story can help a person approach those questions with a fuller sense of what an experience might involve.

The two videos make the value of keeping situatedness visible particularly clear. *Alex: My Story* does this through its possessive title. *Lucky* does it more ambiguously as the personal account expands into a broader public health message. These textual differences show how a narrative can move from a particular experience toward a wider claim. Alex's possessive grammar keeps the boundary of the account visible, while *Lucky* shows how quickly that boundary can widen when personal testimony becomes an argument about abortion in general. The movement is not necessarily a failure. What matters is whether the change in scope remains visible. When it does, the narrative can support recognition, imagination, companionship, and experiential orientation while claims requiring clinical or population level authority are directed to appropriate evidence.

The reading of these videos suggests four practical questions for digital health narratives. First, does the speaker remain with one person's experience, or does the communication move toward a broader claim about abortion? Second, where does the information come from, and is it testimony, clinical guidance, or population evidence? Third, what does the surrounding presentation make available for interpretation? Fourth, when a story is used prospectively, does it leave room for individual variation? These

questions arise from the textual differences examined above. They do not require personal narratives to become less vivid. They help keep the limits of what a story can establish visible.

CONCLUSION

The two narratives show how situated experience can acquire wider informational relevance. *Alex: My Story* (2021) begins by marking experience as possession, while *Lucky* (2023) begins from a similarly situated account and then moves toward a broader proposition about sharing stories and understanding abortion as health care. Together, these different movements reveal the central epistemic problem. A story can move from experience toward a wider informational function, but the distinction between experiential testimony and other forms of evidence should remain visible.

The distinction between evidence of an experience and evidence of the experience remains central. A personal account can show that a response, feeling, or sequence was possible for the person who describes it. It cannot show that the same response is typical or clinically predictive. Keeping this distinction visible does not weaken narrative authority. It clarifies what narrative evidence can offer. Stories can give particular lives a public form and make an unfamiliar experience easier to imagine without turning that experience into a prediction.

For digital health communication, the practical principle is anticipatory understanding. Stories can help viewers imagine possibilities, recognise heterogeneity, and find language for experience, while clinical and population evidence can address questions of risk, expected symptoms, treatment, and prevalence. When these forms of knowledge are presented together, their different sources of authority need to remain legible. The movement from "my story" or "my abortion" (Planned Parenthood, 2021, 0:13–0:24) toward "abortion" in general marks the point at which this distinction becomes especially important.

The value of these narratives, then, does not come from turning personal experience into a stronger form of evidence. It comes from making experience available to others without detaching it from its situatedness. The narrator's words, the organisation's presentation of the story, and the

setting in which viewers encounter it all shape this availability. Personal testimony can help someone imagine what an experience might involve, while clinical and population evidence can address questions of frequency, risk, and clinical expectation. The usefulness of digital abortion narratives therefore lies not in making individual experience representative, but in allowing situated experience to contribute to a wider field of understanding while keeping its epistemic limits visible.

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