



Am J Public Health. 2003 November; 93(11): 1810–1819.

PMCID: PMC1448057

## The American College of Obstetricians and Gynecologists and the Evolution of Abortion Policy, 1951–1973: The Politics of Science

[Nancy Aries](#), PhD

The author is with the School of Public Affairs, Baruch College, City University of New York, NY.

Requests for reprints should be sent to Nancy Aries, PhD, Box C-301, School of Public Affairs, Baruch College, 17 Lexington Ave, New York, NY 10010 (e-mail: [nancy\\_aries@baruch.cuny.edu](mailto:nancy_aries@baruch.cuny.edu)).

Accepted May 13, 2003.

Copyright © American Journal of Public Health 2003

This article has been [cited by](#) other articles in PMC.

### Abstract

[Go to:](#)

The autonomy granted to physicians is based on the claim that their decisions are grounded in scientific principles. But a case study of the evolution of the American College of Obstetricians and Gynecologists' abortion policy between 1951 and 1973 shows that decisions were only secondarily determined by science. The principal determinant was the need to preserve physician autonomy over the organization and delivery of services.

As a result, the organization representing physicians who specialized in women's reproductive health was marginal to the struggle for legalized abortion. But, the profession was central to decisions about whether physicians would perform abortions and how they would be done.

This case study finding has implications for understanding the role that organized medicine might take in the ongoing debates about national health policy.

---

**RECENT DEVELOPMENTS IN** health care, including President Clinton's failed health reform package, the rapid growth of managed care, and efforts to pass a patients' bill of rights, suggest that physicians are entering a period of reduced institutional autonomy or control over the health care agenda in the United States. For most of the 20th century, the medical profession operated as a "monopoly" that was allowed to define, organize, deliver, and regulate the vast scope of health care services.<sup>1</sup> Both at the level of institutional arrangements and the doctor–patient relationship, the medical profession had secure authority over the design of its services.<sup>2</sup> Medicine sheltered itself in its self-regulatory schema based on an appeal to scientific criteria that appeared to be above the politics of everyday life. In exchange for this autonomy, there was the expectation that physicians would advance medical knowledge, monitor their practices, and serve the public, regardless of the ability to pay.

Today, there is evidence that the profession's institutional monopoly is eroding, as various stakeholders demand a greater role in determining how services will be organized and delivered.<sup>3</sup> The apparent shift in the institutional autonomy of the profession to chart its own course, free of political demands, appears as a diminution of the "professional dominance" that physicians enjoyed for most of the 20th century.<sup>4</sup>

A case study of abortion-related policymaking by the American College of Obstetricians and Gynecologists (ACOG) from 1951 to 1973 demonstrates that despite the theoretical model of science-driven medical care, science was the ideological veneer for the profession's political position. While its leadership sought to appeal to a familiar,

professionally dominant, scientifically justified foundation in support of abortion guidelines for practicing physicians, a close reading of the history demonstrates that the policymaking process was deeply politicized and forced to respond to social demands beyond the medical establishment. The contours and details of ACOG's story regarding abortion before *Roe v Wade* provide guidance for explaining the current framework for health care policymaking. This history challenges the notion that the scientific foundation of the profession can lead to policy decisions that are devoid of political content and points to the profession's political interest in maintaining its autonomy.

Data for this study were drawn from the archives at ACOG. These include verbatim transcripts of all Executive Board meetings, committee reports and correspondence that was distributed to the Board as part of the official record. The Executive Committee minutes are no longer on file at the College. All correspondence from this period has also been destroyed.

In addition, committee files, personal files, and correspondence donated to the College library or shared with me by persons affiliated with the College were also reviewed as part of the project. Warren H. Pearce, MD, former Executive Director of ACOG, conducted videotaped oral histories with men who had been active in the College's governance between 1951 and 1973.

Also, I conducted open-ended interviews with 8 physicians who had been active at the College during this period.

## MEDICALIZATION OF ABORTION

[Go to:](#)

The literature on professional dominance asserts that physicians determine the scope of medical practice, the basis for those practices, and the basic structures through which services are provided and financed.<sup>5</sup> According to the literature, physician authority is based on scientific expertise, and it is sanctioned by law. Implicit in this bargain between the state and the profession is the principle that physicians' practices will be guided by narrowly defined principles. As a result, physicians use scientific rationales to validate their position on issues that are medically as well as socially and politically driven.

Pregnancy termination falls into this latter category. The profession claimed that scientific principles underpinned the laws relating to abortion that were developed in the late 19th century.<sup>6</sup> Abortions could be categorized as being therapeutic or criminal. Therapeutic or legal abortions were limited to those cases where the woman's life was at medical risk. Criminal abortions referred to all other uses of the procedure.

### Figure 1



Pro Abortion Rally, Lansing, Michigan, early 1970s. Photo courtesy of Sara Krulwich.

Although physicians used science to rationalize their support of laws limiting use of the procedure, there were no objective criteria determining what comprised medical risk. Physicians explained their support of the illegalization of abortion in the late 19th century as a way to protect the health of women.<sup>7</sup> Other analyses view that historic, political activism as a way to ensure their professional monopoly and control women and their fertility.<sup>8</sup> By outlawing abortions, physicians potentially sheltered themselves from the loss of patients and revenues to alternative practitioners who did not adhere to the Hippocratic Oath that banned the procedure.<sup>9</sup> In addition, their actions coincided with passage of the Comstock laws that prohibited the distribution of both contraceptives and contraceptive information.<sup>10</sup> Taken together, these actions drastically limited women's ability to control their reproduction.

## ORGANIZATION OF ACOG

Go to:

The organization of ACOG in 1951 provides a good example of how a medical specialty switched its focus from broad issues of public health to narrow issues of medical practice. Up to that time, there had been several invitational societies for physicians who were at the top of the obstetric and gynecologic profession, but no organization representing the general interests of doctors practicing in the field. In addition, physicians could belong to the American Committee on Maternal Welfare (ACMW), a physician-chaired organization whose membership included all professional groups that provided care to women of childbearing age. Physicians, nurses, and public health personnel, as well as representatives of provider and governmental organizations, were eligible for membership. In forming ACOG, physicians chose to take an independent stand on professional issues regarding women's reproductive health.

Although the ACMW attempted to be responsive to the clinical issues that interested its physician-based membership, its primary focus was on the larger issues of public health. Its initial objective was to “awaken and stimulate the interest of members of the medical profession in cooperating with public and private agencies for the protection of the health of mothers and their offspring.”<sup>11</sup> This concern for the social and economic causes of health and disease conflicted with the narrower practice-related concerns of the medical specialists associated with the ACMW. These were medical issues over which physicians had control.

After a brief attempt to form a representative organization of specialty societies in obstetrics and gynecology, a group of physicians founded the American Academy of Obstetrics and Gynecology in 1951.<sup>12</sup> It was later renamed the American College of Obstetricians and Gynecologists. ACOG ultimately became the voice of physicians who specialized in obstetric and gynecologic care. These were the doctors who had the largest stake in defining women’s reproductive health services. In contrast to the ACMW’s social mission, ACOG’s mission addressed individual medical practice. The college sought to support the profession in its efforts to establish and maintain “the highest possible standards for obstetric and gynecologic education in medical schools and hospitals, obstetric and gynecologic practice and research.”<sup>13</sup> Four years after its founding, ACOG broke its affiliation with the ACMW.

## THERAPEUTIC AND CRIMINAL ABORTIONS

[Go to:](#)

ACOG’s policy on abortion derived from the view that professional standards should be based on scientific evidence. When state law asserted that the provision of abortion services was limited to those cases where continuation of the pregnancy might be life threatening, “life threatening” was narrowly construed to mean physiological conditions that put a pregnant woman’s life at risk. It eliminated a wider range of psychosocial conditions that could also be life threatening. During the 1950s, scientific advances eliminated many of the medical indications for therapeutic abortion.<sup>14</sup> Rheumatic heart disease and cardiac failure were probably the only conditions about which there was medical consensus concerning the need for a therapeutic abortion.<sup>15</sup> ACOG’s executive board tried to uphold the principle of medical indication, but it would not go on record stating precisely what those indications might be. Recognizing that science could provide no hard rules about a politically contentious issue, it focused on controlling the organizational context in which abortion services were performed.

In 1959, ACOG issued *The Manual of Standards in Obstetric–Gynecologic Practice*. The section on abortion advised that abortions “cover only those cases where the death of the mother might reasonably be expected to result from natural causes, growing out of or aggravated by the pregnancy, unless the child is destroyed.”<sup>16</sup> By putting forth a narrow definition of medical necessity, the standards codified a distinction between medical necessity and psychosocial need in the decision to terminate a pregnancy. In addition, therapeutic abortions were to be performed only in hospitals accredited by the Joint Commission on the Accreditation of Hospitals. These hospitals were urged to establish therapeutic abortion committees to review all applications by the medical staff who sought permission to perform therapeutic abortions. The committees would help limit physician practices that defined medical necessity using broader concepts of health and disease.<sup>17</sup>

ACOG’s board publicly affirmed this position twice. Immediately after the college broke its affiliation with the ACMW, ACOG’s Committee on Maternal Welfare moved that an ad hoc committee be appointed to “consider definition relating to the problems of therapeutic abortion and sterilization.”<sup>18</sup> The committee’s final report is instructive for 2 reasons. First, the committee concluded that “The indications for this procedure are steadily decreasing and it is hoped that they may reach an absolute minimum within the foreseeable future.”<sup>19</sup> The implication was that the need for abortions would be entirely eliminated. Second, the committee did not include a list of medical indications for a therapeutic abortion. The statement made to the Executive Board was that the committee feared that such a list might inadvertently liberalize access to the procedure. The committee felt that individual case review by knowledgeable physicians was a better safeguard against the potential misuse of the procedure.<sup>20</sup> The Executive Board accepted the report without taking further action.



The reasons for accepting the report without discussion were best summed up by Dr Duncan Reid, chairman of the Department of Obstetrics and Gynecology at Harvard Medical School. He observed that the medical profession should not become actively involved in debates about social mores. His larger concern was that the emergence of abortion and sterilization as political issues would challenge the scientific basis on which physicians' decisions were based. "If it [abortion] becomes a social problem then the medical profession has to settle the social problem, and I think we, as doctors, are placed in a position where we do not belong. I think we had better be very hesitant about taking that attitude."<sup>21</sup>

In 1961, a second request was made to establish an Ad Hoc Committee on Therapeutic Abortion.<sup>22</sup> This was an effort to have ACOG respond to the American Law Institute's model abortion law that sought to broaden the concept of medically indicated abortion.<sup>23</sup> Rather than engaging in the debate that was being held in the public arena, the board continued to follow Reid's advice and kept the issue off its agenda. Once again, science was used to justify the lack of involvement. The board referred the request to the Committee on Medico-Legal Problems. The committee reported later that year "that (1) this [abortion] was an extremely controversial matter, (2) that the laws of the states varied considerably, (3) that the College was not in the position to enter into local legislations, and (4) that our actions could be misunderstood or distorted in the public's mind."<sup>24</sup>

The decision to maintain distance from the issue was reiterated by the board in its discussion. Two members asserted that ACOG was primarily a scientific organization and would be adversely affected if it became involved in controversial social issues. They denied the connection between science and politics, although their continued failure to list the medical indications for an abortion could be interpreted as an implicit recognition of the connection.

## THE INCONSISTENCIES OF MEDICAL PRACTICE

[Go to:](#)

Despite efforts to limit the provision of therapeutic abortion to a set of narrowly defined conditions, a number of studies began to document serious racial and class disparities in access.<sup>25</sup> These biases in providing medically approved abortions put the college in a politically awkward position. Science supposedly was objective, but there was nothing objective about who received an abortion. The medical profession was failing to regulate the delivery of services in accord with its own medical standards.<sup>26</sup> The lack of objectivity and the resulting negative consequences suffered by Black and low-income women led civil rights and women's advocates to challenge the service ideal of the profession.<sup>27</sup>

Problems were documented in several areas. First, the rates of approval by therapeutic abortion committees and the number of therapeutic abortions being performed at different hospitals varied tremendously.<sup>28</sup> Second, those hospitals that performed higher rates of therapeutic abortions increasingly did so for mental health reasons.<sup>29</sup> The use of psychiatric illness as a medical indication also exposed a bias toward White, middle-class women.<sup>30</sup> Approval of therapeutic abortions for ward patients was based on physiological conditions such as rheumatic heart disease and hypertensive cardiovascular disease. Mental health was a more common indication for private patients. It was also the case that Black and low-income women were more likely to be admitted to a hospital for complications related to abortions performed illegally than were White women.<sup>31</sup> This underscored the fact that the primary cause of maternal death was infection attributed to induced or what was labeled "criminal" abortions.<sup>32</sup>

White, middle-class women also had greater access to medically safe abortions. While no good numbers exist, it is known that many women went to England, Scandinavia, Puerto Rico, Mexico, and Japan, where abortion was legal.<sup>33</sup> It was also recognized that a large number of physicians illegally provided safe abortions in office-based medical practices and that other physicians willingly referred patients to these practitioners. These physicians were well-known, but not publicly acknowledged by the profession.<sup>34</sup>

Despite the growing evidence of inequities in access and outcomes, the profession limited the discussion to improving the regulatory process. Hospital therapeutic abortion committees were urged to be more rigorous in

reviewing applications for abortions for what seemed to be psychosocial reasons.<sup>35</sup> Discussion of illegal abortions focused on the medical management of complications.<sup>36</sup> No recorded discussions of the social forces that influenced women's decisions to seek an abortion, the risks of having an unsafe medical procedure, or the service ideal that underscored the doctor–patient relation are recorded in ACOG's records. To raise these issues was to create conflict in a professional organization that sought to achieve consensus among its membership.

While the data demonstrated the disparities, it did not suggest a solution in terms of policy and practice because these issues were dictated by social belief, and organized medicine ruled that out of order. Differences in opinion were quietly resolved by leaving medical practice decisions to the discretion of individual practitioners. ACOG publicly affirmed existing laws and privately recognized the range of practices undertaken by its membership.

## ACOG AFFIRMS PHYSICIAN AUTHORITY

Go to:

ACOG found itself unable to avoid the growing political controversy surrounding abortion. While the college had managed to keep abortion off its agenda, its position did not satisfy individuals and groups who sought the college's support to advance their political positions. Many constituencies, including the Catholic Church and the public health profession, began to pressure ACOG to articulate an abortion policy.<sup>37</sup> Such a policy might prove decisive given the profession's role in determining what comprised acceptable medical practice. To develop an abortion policy, however, put ACOG at risk of being pulled apart by political conflict. This was ultimately avoided by narrowing the issue to physician autonomy. ACOG spent a year and a half developing a policy whose most striking features were its limited scope and ambiguity. By focusing solely on the physicians' role, the college managed to remain marginal to the growing social and legal controversy.

In 1966, leaders from 2 of ACOG's administration districts requested that the Executive Board review the college's implicit policy upholding criminal abortion laws. As with the earlier request in 1961, these district leaders were looking for guidance in responding to proposed state legislation liberalizing abortion laws. Both requests assumed that the review would lead to a liberalization of the college's policy in accordance with the American Law Institute's model abortion law. In his remarks to the board, Dr Brooks Ranney, chairman of District VI, argued that ACOG's failure to respond implicitly allowed high rates of criminal abortion and maternal death to persist.<sup>38</sup> At the meeting, the Executive Board voted to form an Ad Hoc Committee to study and make recommendations concerning model sterilization and abortion laws.

Howard Taylor, ACOG's chairman and chairman of the Department of Obstetrics and Gynecology at Columbia University, named Duncan Reid chair of the Ad Hoc Committee and selected committee members with wide-ranging political views. Taylor hoped that the committee would come to a consensus on the issue. Without consensus, it would be difficult to promulgate any abortion policy. The committee tried to achieve this consensus by limiting its discussion to questions related to the content and organization of medical practice. These were the fundamental issues that distinguished medicine as a profession.<sup>39</sup> The remaining records of the committee's deliberations indicate that there was no discussion of women's rights or the growing challenge to the paternalistic ethic that underpinned the doctor–patient relation.<sup>40</sup>

The committee never questioned the validity of the distinction between therapeutic and other abortions. The members debated what constituted medical indications for a legal abortion. The committee's first report to the Executive Board laid the groundwork for liberalizing existing abortion practices by noting that broadening the medical grounds for legal abortions might result in decreased maternal deaths due to criminal abortions.<sup>41</sup> The introduction to the policy which was submitted a few months later, begins, "It is firmly stated that the College will not condone nor support the concept that an abortion be considered or performed for any unwanted pregnancy or as a means of population control."<sup>42</sup> By not specifying the medical indications, what constituted a legal abortion remained ambiguous. However, it was clear that physicians, not women, were to make this decision.

The committee listed 3 "established medical indications" for therapeutic abortions.<sup>43</sup> The first, "When continuation

of the pregnancy may threaten the life of the woman or seriously impair her health,” was the most relevant to this discussion.<sup>44</sup> In determining what might seriously impair the health of a woman, the following addendum was ultimately supported by the fellowship and included in the policy: “In determining whether or not there is such risk to health, account may be taken of the patient’s total environment, actual or reasonably foreseeable.” Inclusion of this statement appeared to liberalize the conditions that might be considered medically valid. At the same time, the committee continued to support the requirement that “a consultative opinion must be obtained from at least two licensed physicians other than the one who is to perform the procedure. This opinion should state that the procedure is medically indicated.” Here the intent was to regulate individual decisionmaking by means of professional review. The last recommendation was that therapeutic abortions “be performed only in a hospital accredited by the Joint Commission on Accreditation of Hospitals.”<sup>45</sup> The rationale for this requirement was that hospitals had the appropriate backup if there were complications during the procedure. However, this stipulation also effectively regulated physician practice because abortions could not be performed in facilities where there might be less oversight.

The draft abortion policy was sent to ACOG’s membership in 1968, one month before the annual meeting, with a questionnaire asking whether they supported this policy statement. Sixty-five percent of the membership responded. Eighty-six percent of those responding favored the indications for abortion outlined by the committee. Seventy-seven percent favored the additional statement that “account may be taken of the patient’s total environment.” While most interpreted the vote as widespread support for the proposed policy, a minority noted that these responses represented only 56% and 50% of the total membership. Their objections were ignored.<sup>46</sup> The statement was approved and the addendum was accepted.

## Figure 2



ACOG Executive Board, 1973. Courtesy of ACOG.

At the Executive Board meeting, the discussion centered, not on the policy, but on how best to maintain goodwill across the membership given the controversial nature of the topic and a policy that relied less heavily on scientific rationales. There was agreement on the need for a minority report, and a subcommittee consisting of 3 committee members who opposed the majority report agreed to draft it.<sup>47</sup> These physicians wanted to shut the loophole that permitted physicians to take “the patient’s total environment” into account. The minority report concluded that “[t]hese factors cannot be evaluated with sufficient accuracy in terms of documented medical evidence to be included, specifically, in the medical indications for therapeutic abortion.”<sup>48</sup> They did not want women to use abortion as a means to control their reproduction.

ACOG’s 1968 abortion policy reaffirmed the role of physicians in the decisionmaking processes as opposed to a woman’s right to choose. At the same time, the policy put appropriate checks in place over physician behaviors that might be interpreted as exceeding the bounds of medical practice. The ambiguity of the policy meant that ACOG had not actually clarified the boundaries of medical practice. It also had not dropped the distinction between therapeutic and criminal abortions that was at the heart of the growing political controversy. The college managed to find a middle ground between the inaction that had characterized its position up to that point and action that would have put it in the forefront of abortion politics.

## REDEFINING THE DOCTOR–PATIENT RELATION

[Go to:](#)

During the year and a half it took to promulgate an abortion policy, the Executive Board and the Ad Hoc Committee appeared oblivious to the mounting political strife about the legalization of abortion. While the Executive Board debated the physician’s role, abortion politics moved rapidly toward legalization. Advocates were fighting to overturn the distinction between therapeutic and criminal abortions on the basis of the concept of women’s rights. They were lobbying to repeal abortion laws on a state-by-state basis, and they were looking for a test case to take to the Supreme Court.<sup>49</sup>

In 1970, New York became the first state to repeal its abortion laws and assert a woman’s right to decide. For ACOG, whose organizational purpose was to maintain physician authority, this presented a quandary. If physicians no longer controlled decisionmaking, what was their responsibility? The 1968 policy did not address this issue, but events in New York and later in California pushed ACOG to affirm the professional authority of physicians, given political decisions that fundamentally changed the doctor–patient relation.

Less than a week after Governor Rockefeller signed the repeal of New York State’s abortion law, ACOG’s Executive Board discussed its implications. Dr Daniel Beacham, ACOG’s first president and a practicing physician from New Orleans, recommended on behalf of the Committee on Obstetric–Gynecologic Practice that “the Board reemphasize that the policies now in effect as related to therapeutic abortions be extended to cover abortion for social indications.”<sup>50</sup> Despite efforts to forestall a vote, the recommendation was passed in April 1970. ACOG extended its existing abortion policy to cover what at that time was termed elective abortions. The Executive Board supported the requirement that approval be obtained from 2 doctors before an abortion was performed in a hospital accredited by the Joint Commission on the Accreditation of Hospitals.

### 1970 Revision of Abortion Policy

State regulations governing the implementation of New York’s law were issued in June, a month after ACOG’s vote.<sup>51</sup> They did not reflect ACOG’s policy. Women in New York and other states where abortion was subsequently legalized had freedom of choice. A physician’s services were required, but only to carry out the procedure. Procedures could be provided in hospitals or facilities licensed by departments of public health. ACOG risked becoming irrelevant if it did not respond to the new political framework. Physicians could not control the decision to have an abortion, but they could play an important consultative role as women considered terminating pregnancies, and they could control whether and how abortions would be performed.



Three months after ACOG's Executive Board reaffirmed its original abortion policy, advocates for providing more liberal access to abortion found an administrative means to revise ACOG's policy without a divisive debate at the Executive Board or annual business meeting. Following the repeal of New York's abortion law, the Committee on Professional Standards met to revise the college's *Standards for Obstetric–Gynecologic Hospital Services*. The guidelines needed to conform to changing state laws. The committee's revisions were presented to the Executive Committee of the Executive Board at its June meeting, were approved by mail vote in August 1970, and were reported in the college's September newsletter.<sup>52</sup>

The changes were significant because they diverged from the college's policy that had been reaffirmed in April. Most important, the term "therapeutic abortion" was dropped. This opened the way for the following statement: "It is recognized that abortion may be performed at a patient's request, or upon a physician's recommendation."<sup>53</sup> By eliminating the distinction between therapeutic and nontherapeutic abortions, the standards eliminated the logic of having medical decisions reviewed by a hospital review committee. The committee protected physician autonomy with a statement affirming a physician's right not to perform an abortion.

Promulgation of the new standards created an ambiguous situation. Did the statement from *Standards for Obstetric–Gynecologic Hospital Services* represent official college policy or did the more conservative policy that had been reaffirmed in May still hold? In February 1971, the Executive Board called for a second poll of the membership. This time, 82% of those who responded approved the standards as a revised statement on abortion.<sup>54</sup> With the poll, those board members who supported a woman's right to abortion found a method to liberalize the college's policy without debate. The poll was considered comparable to a vote by the fellowship. No further action was required by the Executive Board to acknowledge the policy change.

### Medical Indications for an Abortion

Although the distinction between therapeutic and criminal abortions had been eliminated, the concept of medical indication remained. The Committee on Health Care Delivery found that most insurance companies only reimbursed for abortions that were performed for medical indications. The most frequent indications for abortions, however, were psychosocioeconomic. These were not considered medical by either the profession or the insurers. As a result, many physicians were performing abortions that were not covered by standard health insurance policies. The committee recommended that the "psycho-socio-economic maladjustment of a patient" be designated a valid medical indication for a legal abortion. The recommendation was moved and carried with no discussion.<sup>55</sup> Ironically, the issue that had been the basis for asserting professional authority was put to rest over the issue of physician fees. There was no publicly recorded acknowledgment of the broader significance of the Executive Board's decision.

### Doe v Bolton

In June 1971, the Executive Committee approved President Clyde Randall's endorsement of the *amicus curiae* brief filed by the James Madison Constitutional Law Institute in the case of *Doe v Bolton*. The case questioned the constitutionality of Georgia's liberalized abortion law that sanctioned an abortion if 2 doctors thought the pregnancy would impair the physical or mental health of the woman, if the fetus had a serious defect, or if the pregnancy resulted from rape or incest. Although the law asserted broader grounds upon which a woman could seek an abortion, the claim was made that the law infringed on a woman's right to privacy and on a physician's right to practice in the best interest of his or her patient.<sup>56</sup> The signing of the *amicus* brief must be reconsidered both in terms of its support of physician autonomy and as an administrative means by which the college further changed its policy direction in support of the liberalization of abortion laws.

Dr Richard Schmidt, a private practice physician from Cincinnati who sat on the Executive Board, objected to this action. This was the only point at which the underlying controversy regarding abortion was raised for public discussion. Substantively, Schmidt found the brief in contradiction to ACOG's existing abortion policy. First, it

supported the principle of a woman's right to choose. According to Schmidt, ACOG had never stated that "a medically safe abortion should be an open option available to any woman who does not want to have the child."<sup>57</sup> Second, the *amicus* brief sought a ruling by the Supreme Court to override existing state laws. ACOG's stated policy, however, was to uphold existing state laws.

Finally, Schmidt objected to the absence of a formal discussion about the substance of the decision. In a letter to President Randall, Dr Schmidt wrote, "I can find nothing in any statement of College policy, nor do I know of any consideration in any of the discussions leading to these policies, relating to the constitutional rights of a mother or to the nature of, or to the status of the fetus. On the contrary, the tendency has been to by-pass these questions as matters of personal conviction. . . . Again, my point is not the relative merits of these questions, but rather that they are inherent in the issue and have never been considered by the College."<sup>58</sup>

Clyde Randall's response is instructive because he frames his actions in terms of defending physician autonomy. Randall argued that a decision to overturn Georgia's liberalized abortion law would protect physician autonomy by lifting what could be seen as work restrictions on physicians. In the President's Report to the Executive Board, he wrote, "The termination of pregnancy is one of the few areas in which laws now dictate what the physician may or may not do in the care of his patient."<sup>59(p3)</sup> Randall acknowledged that the college had not previously taken a position on national policy, but he felt it was important to do so. He saw this as a way to protect practicing physicians from the lack of uniformity across states that created "a most undesirable concentration of requests for abortion in those states in which 'liberal' abortions laws have been enacted. . . . We believe it is time the College exhibit leadership rather than indecision and/or seeming indifference to the legislation that is being considered in this regard."<sup>60(p3)</sup>

Schmidt's concern about the lack of discussion was not and could not be discussed. Such a discussion would open the Executive Board to considering whether its actions were solely a way to advance physician control over medical practice or represented a fundamental change, as Schmidt suggested. The Executive Board supported the Executive Committee's decision to sign the *amicus* brief in a 13 to 4 vote.

## CONCLUSION

[Go to:](#)

In May 1974, over one year after the Supreme Court's decision in *Roe v Wade*, the Executive Board passed the following resolution: "The American College of Obstetricians and Gynecologists affirms its support of the right of women to unhindered access to safe abortion services and opposes proposed legislation or a constitutional amendment limiting this access guaranteed to women."<sup>61</sup> Abortion was a medical service. Women would control the decision to have an abortion with physician support. How the procedure would be done remained fully under the aegis of the medical profession.

ACOG's story raises several issues that are relevant to the model of professional dominance that has been so central to the study of health care delivery. The first concerns the seeming monopoly that physicians hold over the organization and content of their work. ACOG consciously separated itself from the ACMW in order to become a unifying voice for physicians engaged in obstetric and gynecologic practice. However, ACOG also made the decision to remain at the periphery of the growing controversy regarding the legality of abortion services. The college tried to limit its activities to issues of medical practice in order to avoid internal conflict within the organization. The net impact of its policies was to recognize physician autonomy in medical practice even as it ceded a role to patients in making the decision to terminate an unwanted pregnancy.

This history suggests the need to pay closer attention to the importance of consensus in large representative organizations where there is a diversity of views if we are to fully understand contemporary health politics.<sup>62</sup> Strategically, these organizations may be reluctant to act on issues that are politically controversial. The Ad Hoc Committee organized in 1966 to revise ACOG's abortion policy could not forge the consensus that the college's president desired. An important minority feared that ACOG granted too much leeway in deciding what constituted

medical grounds for an abortion.

Recognizing that there would be no consensus, decisions were treated in 2 ways. First, the public debate was limited to technical issues that did not address controversial social and political beliefs. In researching this article, I found no record of discussions about women’s rights and the doctor–patient relation. Second, the leadership used a limited decisionmaking structure when controversial issues were put on the agenda. The Executive Committee approved both the revisions to the *Manual of Standards* and the signing of the *amicus* brief in *Doe v Bolton*. This kept open conflict to a minimum.

Physicians care most about issues that pertain to their authority over how services are organized, delivered, and reimbursed. As a result of *Roe v Wade*, women could legitimately claim the right to be partners with their physicians in deciding to have an abortion. However, physicians retained authority over whether or not to perform an abortion, how it was to be done, and what constituted a reimbursable medical indication. As a result of ACOG’s laissez-faire stance toward this element of medical care, many residents in obstetrics and gynecology are not trained to perform abortion and 86% of counties in the United States have no abortion provider.<sup>63</sup> The law and the social mores surrounding abortion may have changed, but physician control over the practice of medicine remains consistently strong.

## Acknowledgments

[Go to:](#)

Support for this research was made possible by the American College of Obstetricians and Gynecologists in the form of an ACOG/Ortho-McNeil Fellowship in the History of Obstetrics and Gynecology.

Susan K. Rishworth, former history librarian at the American College of Obstetricians and Gynecologists, provided valuable assistance in carrying out the research. The comments of Carroll Seron and 3 anonymous reviewers are gratefully acknowledged.

**Note.** The views expressed in this article are those of the author and do not necessarily represent the official positions of the American College of Obstetricians and Gynecologists.

## Human Participant Protection

The protocol for this study was approved by the institutional review board of Baruch College, City University of New York.

## Notes

[Go to:](#)

Peer Reviewed

## Endnotes

[Go to:](#)

1. M. S. Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977); E. Freidson, *The Profession of Medicine: The Social Structure of Medical Care* (New York: Dodd, Mead, 1970); P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1983).

2. D. Stone, *The Limits of Professional Power: National Health Care in the Federal Republic of Germany* (Chicago: University of Chicago Press, 1980); D. Mechanic, “Changing Medical Organization and the Erosion of Trust,” *Milbank Quarterly* 74 (1996): 171–189. [[PubMed](#)]

3. D. Light, “Turf Battles and the Theory of Professional Dominance,” *Research in the Sociology of Health Care* 7 (1988): 203–225; D. Frankford, “The Normative Constitution of Professional Power,” *Journal of Health Politics, Policy and Law* 22 (1997): 185–221; J. Cromwell, “Barriers to Achieving a Cost-Effective Work Force Mix: Lessons From Anesthesiology,” *Journal of Health Politics Policy and Law* 24 (1999): 1331–1361; G.J. Annas, “A National Bill of Patients’ Rights,” *New England Journal of Medicine* 338 (1998): 695–699.

4. Starr, *Social Transformation*; Mechanic, “Changing Medical Organization”; R. Stevens, “Public Roles for the Medical Profession in the United States: Beyond Theories of Decline and Fall,” *Milbank Quarterly* 79 (2001):327–353; D.J. Rothman, “Medical Professionalism—Focusing on the Real Issues,” *New England Journal of Medicine* 342 (2000): 1284–1286. [[PMC free article](#)] [[PubMed](#)]
5. Larson, *Rise of Professionalism*; E. Freidson, *Professionalism: The Third Logic* (Chicago: University of Chicago Press, 2001).
6. J. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800–1900* (New York: Oxford University Press, 1978).
7. *Ibid*, 160.
8. *Ibid* 147–148; K. Luker, *Abortion and the Politics of Motherhood* (Berkeley: University of California Press, 1984); L. J. Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867–1973* (Berkeley: University of California Press, 1997).
9. Mohr, *Abortion in America*.
10. N. Himes, *A Medical History of Contraception* (New York: Gamut Press Inc, 1963).
11. American Committee on Maternal Welfare Inc, Minutes of First Meeting of Directors, 22May1934.
12. W. Mengert, *History of the American College of Obstetricians and Gynecologists: 1950–1970* (Chicago: American College of Obstetricians and Gynecologists, 1977).
13. *Ibid*, 133.
14. J. B. Imber, *Abortion and the Private Practice of Medicine* (New Haven: Yale University Press, 1986); F. Rodriguez and J. Oneto, “Negation of Therapeutic Abortion in Pulmonary Tuberculosis,” abstract from *Boletín Sociedad Chilena de Obstetricia y Ginecología* 16 (1951): 11, in *American Journal of Obstetrics and Gynecology* 64 (1952): 216; R. Craig, “Psychiatric Management of a Case in Which Termination of Pregnancy Was Recommended but Not Done,” *American Journal of Obstetrics and Gynecology* 70 (1955): 672–674; R. Gordon and K. Gordon, “Social Factors in the Prediction and Treatment of Emotional Disorders of Pregnancy,” *American Journal of Obstetrics and Gynecology* 77 (1959): 1074–1083; R. Lundstrom, “Rubella During Pregnancy,” *Acta Paediatrica* Supplement 133, (1962), abstract published in *American Journal of Obstetrics and Gynecology* 84 (1962): 1911.
15. H. A. Rosen, “Case Study in Social Hypocrisy,” in *Abortion in America*, ed. H. A. Rosen (Boston: Beacon Press, 1967), 299–321.
16. American College of Obstetricians and Gynecologists (ACOG), *Manual of Standards in Obstetric–Gynecologic Practice* (Chicago: ACOG, 1959), 35.
17. R. Solinger, “‘A Complete Disaster’: Abortion and the Politics of Hospital Abortion Committees, 1950–1970,” *Feminist Studies* 19 (1993): 240–261.
18. ACOG, Item 6.1.8 Committee on Maternal Welfare, Transcript of Executive Board Meeting, 9–10May1956:5, 114–124.
19. ACOG, Item 6.2.13 Report of Therapeutic Abortion and Sterilization Committee, Transcript of Executive Board Meeting, November1956:1.
20. *Ibid*, 507–524.
21. ACOG, Item 6.1.8.



22. ACOG, Item 9.2 Recommendation of District II That an Ad Hoc Committee on Therapeutic Abortion Be Established, Transcript of the Executive Board, 20–22 April 1961:24.

23. D. J. Garrow, *Liberty and Sexuality: The Right to Privacy and the Making of Roe v. Wade* (Berkeley: University of California Press, 1994).

24. ACOG, Item 6.16 Report of the Committee on Medico-Legal Problems, Transcript of the Executive Board, November 30–December 2, 1961:347–351.

25. Luker, *Abortion and the Politics of Motherhood*; M. S. Calderone, *Abortion in the United States* (New York: Hoeber-Harper Books, 1958), 66, 169–172; L. Lader, *Abortion* (Boston: Beacon Press, 1966).

26. Reagan, *When Abortion Was a Crime*; Solinger, “A Complete Disaster”; E. Schur, *Crimes Without Victims: Deviant Behavior and Public Policy* (Englewood Cliffs, NJ: Prentice-Hall Inc, 1965); R. Heffernan and W. Lynch, “What Is the Status of Therapeutic Abortion in Modern Obstetrics?” *American Journal of Obstetrics and Gynecology* 66 (1953): 335–345.

27. Luker, *Abortion and the Politics of Motherhood*; Garrow, *Liberty and Sexuality*; Lader, *Abortion*.

28. Heffernan and Lynch, “What Is the Status?”; H. Hammond, “Therapeutic Abortion,” *American Journal of Obstetrics and Gynecology* 89 (1964): 349–355. [[PubMed](#)]

29. C. Tietze, “Therapeutic Abortions in New York City, 1943–1947,” *American Journal of Obstetrics and Gynecology* 60 (1950): 149; K. Russell, “Therapeutic Abortion in a General Hospital,” *American Journal of Obstetrics and Gynecology* 62 (1951): 434–438; J. G. Moore and J. H. Randall, “Trends in Therapeutic Abortion: A Review of 137 Cases,” *American Journal of Obstetrics and Gynecology* 63 (1952): 28–40; L. Savel and I. Perlmutter, “Therapeutic Abortion and Sterilization Committee: A 3 Year Experience,” *American Journal of Obstetrics and Gynecology* 80 (1960): 1192–1199.

30. R. Hall, “Therapeutic Abortion, Sterilization, and Contraception,” *American Journal of Obstetrics and Gynecology* 91 (1965): 518–532; C. Erhardt, “Therapeutic Abortion in the United States,” in *Abortion in the United States*, 70–116; H. Pearse and H. Ott, “Hospital Control of Sterilization and Therapeutic Abortion,” *American Journal of Obstetrics and Gynecology* 60 (1950): 285–298; G. K. Folger, “Discussion,” *American Journal of Obstetrics and Gynecology* 60 (1950): 299–300.

31. Hall, “Therapeutic Abortion, Sterilization, and Contraception.” [[PubMed](#)]

32. M. D. Klien, J. Clahr, and A. B. Tamis, “Classification and Analysis of Maternal Deaths in Bronx County, New York, 1946–1957,” *American Journal of Obstetrics and Gynecology* 76 (1958): 1342–1356; A.S. Llorens, J. H. Griner, and J. D. Thompson, “Maternal Mortality at Grady Memorial Hospital: A 13 Year Survey,” *American Journal of Obstetrics and Gynecology* 87 (1963): 386–393; R. Neuwirth and E. Friedman, “Septic Abortion,” *American Journal of Obstetrics and Gynecology* 85 (1963): 24–34.

33. Lader, *Abortion*.

34. Calderone, *Abortion in the United States*; Lader, *Abortion*; Dr. X as told to Lucy Freeman, *The Abortinist* (New York: Grove Press, 1962); C. Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe v. Wade* (Boston: Beacon Press, 1995); N. Aries, unpublished data from study of physician abortion networks, 1998.

35. Hammond, “Therapeutic Abortion”; A. Mandy, “Reflections of a Gynecologist,” in *Therapeutic Abortion*, ed. H. Rosen (New York: Julian Press, 1954), 284–296.

36. R. Deane and K. Russell, “Enterobacillary Septicemia and Bacterial Shock in Septic Abortion,” *American Journal of Obstetrics and Gynecology* 70 (1960): 528–541; J. Goodno, I. Cushner, and P. Molumphy,

“Management of Infected Abortion, *American Journal of Obstetrics and Gynecology* 85 (1963): 16–23.

37. Very Reverend J. Hussey, “Raison d’Etre of a Catholic Medical School,” *American Journal of Obstetrics and Gynecology* 69 (1955): 496–501; ACOG, Item 4.3.6 Article by Dr. Louis Hellman, Transcript of the Executive Board, November 30, December 1–2, 1964:221–227.

38. ACOG, Item 9.1 Resolution re: Therapeutic Abortion Laws, Minutes of the Executive Board Meetings, 1961–1966, November 11–12, 1966:29. District VI includes Illinois, Wisconsin, Minnesota, Iowa, North Dakota, South Dakota, Nebraska, Saskatchewan, and Manitoba.

39. Freidson, *Profession of Medicine*.

40. ACOG, Files from the Ad Hoc Committee to Study the Liberalization of Laws Governing Therapeutic Abortion, 1966–1968; ACOG, Item 6.6.1 Report of Committee to Study Liberalization of the Laws Governing Therapeutic Abortion, Transcript of Executive Board Meeting, 1–2December1967:558–572.

41. ACOG, Item 6.61, 558–572.

42. ACOG, Item 6.39 Report of the Committee to Study Liberalization of the Laws Governing Therapeutic Abortion: Transcript of Executive Board Meeting, 9May1968:3.

43. Ibid, 4–5.

44. The other 2 medical indications were pregnancies that resulted from rape or incest and pregnancies that would result in the birth of a child with severe physical deformities or mental retardation.

45. ACOG, Item 6.39, 4.

46. Ibid. ACOG, Item 6.39: Final Abortion Returns; 57.

47. Ibid, 79–82.

48. ACOG, Item 6.37 Report of the Committee to Study Liberalization of the Laws Governing Therapeutic Abortion, Transcript of Executive Board Meeting, 6–7December1968:2.

49. Luker, *Abortion and the Politics of Motherhood*; Garrow, *Liberty and Sexuality*.

50. ACOG, Item 5 Report of Committee on Obstetric-Gynecologic Practice, Minutes of the Executive Board Meetings, 1967–1970, 17April1970:2.

51. M.L. Stone, M. Gordon, and J. Rovinsky, “The Impact of a Liberalized Abortion Law on the Medical Schools,” *American Journal of Obstetrics and Gynecology* 111 (1971): 728–735. [[PubMed](#)]

52. ACOG, “College Policy on Abortion and Sterilization, ACOG Newsletter 14 (September1970): 2.

53. Ibid, 2.

54. ACOG, “Results of Fellows’ Poll Favor ACOG Abortion Policy,” ACOG Newsletter 15 (May1971): 2.

55. ACOG, Item 6.2.2 Report of the Committee on Health Care Delivery, Minutes of the Executive Board Meetings, 1971–1974, 28–29April1972:13.

56. Garrow, *Liberty and Sexuality*.

57. ACOG, Item 4.1 Report of President, Transcript of Executive Board Meeting, 3–4December1971:8–31.

58. Letter from R. Schmidt to C. Randall, President, ACOG, personal files of R. Schmidt, 7September1971.

59. ACOG, Item 4.1.

60. Ibid, 3.
61. ACOG, Item 13 Resolution Re Abortion, Minutes of the Executive Board Meeting, 1971–1974, 2May1974:6.
62. N. Brunsson, *The Organization of Hypocrisy: Talk, Decisions and Actions in Organizations* (Chichester, England: John Wiley and Sons, 1989).
63. R. Ameling, L. Tews, and S. Dudley, “Abortion Training in US Obstetrics and Gynecology Residency Programs, 1998,” *Family Planning Perspectives* 32 (2000): 268–271, 320; I.B. Finer and D.K. Henshaw, “Abortion Incidence and Services in the United States in 2000,” *Perspectives in Sexual and Reproductive Health* 35 (2003): 6–15. [[PubMed](#)]

---

Articles from American Journal of Public Health are provided here courtesy of **American Public Health Association**