
Nancy Aries, PhD

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.

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. 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.

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

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. 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. 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.

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. Other analyses view that historic, political activism as a way to ensure their professional monopoly and control women and their fertility. 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. In addition, their actions coincided with passage of the Comstock laws that prohibited the distribution of both contraceptives and contraceptive information. Taken together, these actions drastically limited women’s ability to control their reproduction.

“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 patients’ ability to pay.”

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

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.” 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. 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.” Four years after its founding, ACOG broke its affiliation with the ACMW.

THERAPEUTIC AND CRIMINAL ABORTIONS

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. Rheumatic heart disease and cardiac failure were probably the only conditions about which there was medical consensus concerning the need for a therapeutic abortion. 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.” 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.
and sterilization.” The committee’s final report is instructive for several 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 in the foreseeable future.” 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. 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.”

In 1961, a second request was made to establish an Ad Hoc Committee on Therapeutic Abortion. 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. 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 legislation, and (4) that our actions could be misunderstood or distorted in the public’s mind.”

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**

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. 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. 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.

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. Second, those hospitals that performed higher rates of therapeutic abortions increasingly did so for mental health reasons. The use of psychiatric illness as a medical indication also exposed a bias toward White, middle-class women. 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. This underscored the fact that the primary cause of maternal death was infection attributed to Dr Duncan Reid observed that the medical profession should not become actively involved in debates about social mores.”
induced or what was labeled “criminal” abortions.\textsuperscript{32}

White, middle-class women also had greater access to medically safe aborti-
on. While no good numbers exist, it is known that many women went to Eng-
land, Scandinavia, Puerto Rico, Mexico, and Japan, where abortion was legal.\textsuperscript{33} It was also recog-
nized that a large number of physicians illegally provided safe abortions in office-based medical practices and that other physi-
cians willingly referred patients to these practitioners. These physicians were well-known, but not publicly acknowledged by the profession.\textsuperscript{34}

Despite the growing evidence of inequities in access and out-
comes, the profession limited the discussion to improving the regu-
latory process. Hospital therapeutic abortion committees were urged to be more rigorous in re-
viewing applications for aborti-
on for what seemed to be psy-
chosocial reasons.\textsuperscript{35} Discussion of illegal abortions focused on the medical management of compli-
cations.\textsuperscript{36} No recorded discus-
sions of the social forces that in-
fuenced women’s decisions to seek an abortion, the risks of having an unsafe medical pro-
dure, or the service ideal that un-
derscored the doctor–patient rela-
tion are recorded in ACOG’s records. To raise these issues was to create conflict in a profes-
sional 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 deci-
sions to the discretion of individ-
ual practitioners. ACOG publicly affirmed existing laws and pri-
vately recognized the range of practices undertaken by its membership.

\textbf{ACOG AFFIRMS PHYSICIAN AUTHORITY}

ACOG found itself unable to avoid the growing political contro-
versy surrounding abortion. While the college had managed to keep abortion off its agenda, its position did not satisfy indi-
viduals 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 pres-
sure ACOG to articulate an abortion policy.\textsuperscript{37} Such a policy might prove decisive given the profession’s role in determining what comprised acceptable med-
ical practice. To develop an abor-
tion policy, however, put ACOG at risk of being pulled apart by political conflict. This was ulti-
mately 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 focus-
ing 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 im-
plicit policy upholding criminal abortion laws. As with the earlier request in 1961, these district leaders were looking for guid-
ance in responding to proposed state legislation liberalizing abor-
tion 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, chair-
man of District VI, argued that ACOG’s failure to respond im-

cipitely allowed high rates of criminal abortion and maternal death to persist.\textsuperscript{38} At the meet-
ing, the Executive Board voted to form an Ad Hoc Committee to study and make recommenda-
tions concerning model steriliza-
tion and abortion laws.

Howard Taylor, ACOG’s chairman and chairman of the Department of Obstetrics and Gynecology at Columbia Univer-
sity, named Duncan Reid chair-
man and chairman of the Ad Hoc Committee and selected committee members with wide-ranging political views. Taylor hoped that the committee would come to a con-
sensus on the issue. Without consensus, it would be difficult to promulgate any abortion pol-
icy. The committee tried to achieve this consensus by limit-
ing its discussion to questions re-
lated to the content and organi-
zation of medical practice. These were the fundamental issues that distinguished medicine as a pro-
fession.\textsuperscript{39} The remaining records of the committee’s deliberations indicate that there was no dis-
cussion of women’s rights or the growing challenge to the paternalistic ethic that underpinned the doctor–patient relation.\textsuperscript{40}

The committee never ques-
tioned the validity of the distinc-
tion between therapeutic and other abortions. The members debated what constituted med-
ical indications for a legal aborti-
on. The committee’s first report to the Executive Board laid the groundwork for liberalizing exist-
ing abortion practices by noting that broadening the medical
null
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. 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.

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.” 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. 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-socioeconomic maladjustment of a patient” be designated a valid medical indication for a legal abortion. The recommendation was moved and carried with no discussion. 

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. The signing of the *amicus* brief must be re-considered 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.” 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.”

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.”

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.”

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 Execu-
tive Board supported the Executive Committee’s decision to sign the *amicus* brief in a 13 to 4 vote.

**CONCLUSION**

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.” 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 policies. 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 forgo 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. The law and the social mores surrounding abortion may have changed, but physician control over the practice of medicine remains consistently strong.

**About the Author**

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).

This article was accepted May 13, 2003.

**Acknowledgments**

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. Richworth, 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.

**Endnotes**


13. Ibid, 133.
