

Uneasy allies: pro-choice physicians, feminist health activists and the struggle for abortion rights

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Abstract Abortion represents a particularly interesting subject for a social movements analysis of healthcare issues because of the involvement of both feminist pro-choice activists and a segment of the medical profession. Although both groups have long shared the same general goal of legal abortion, the alliance has over time been an uneasy one, and in many ways a contradictory one. This paper traces points of convergence as well as points of contention between the two groups, specifically: highlighting the tensions between the feminist view of abortion as a women-centred service, with a limited, 'technical' role for the physicians, and the abortion-providing physicians' logic of further medicalization/professional upgrading of abortion services as a response to the longstanding marginality and stigmatisation of abortion providers. Only by noting the evolving relationships between these two crucial sets of actors can one fully understand the contemporary abortion rights movement. We conclude by speculating about similar patterns in medical/lay relationships in other health social movements where 'dissident doctors' and lay activists are similarly seeking recognition for medical services that are controversial.

Keywords: abortion, social movement, pro-choice physician, feminist activist, boundary movement, medication, abortion, antiabortion violence

Introduction

While most health-related social movements consist of consumer groups mobilised against the biomedical establishment and/or the state, the 'Abortion Rights Movement' represents a particularly interesting case because of the

involvement of both feminist activists and a segment of the medical profession. Although both groups share the same general goal – legal abortion – their alliance has over time been an uneasy one, and in many ways a contradictory one. This paper will trace the activities of each group on behalf of legal abortion (before *Roe v. Wade*) and accessible abortion (after legalisation). We will show points of convergence as well as points of contention between the two groups. Specifically, we will highlight the tensions between the feminist view of abortion as a women-centred service, with a limited, ‘technical’ role for the physicians, and the abortion providing physicians’ logic of further medicalization/professional upgrading of abortion services as a response to the longstanding marginality and stigmatisation of abortion providers.

We think it especially important to focus on the relationship between physician and feminist wings of the Abortion Rights Movement, because, with a few notable exceptions (Luker 1984, Garrow 1994), the former have been left out of discussions of abortion activism. The dominant social movement analyses of abortion typically focus on ‘pro-life’ vs. ‘pro-choice’ activists (McCarthy 1987, Ferree *et al.* 2002, Saletan 2003) or anti-abortionists (Blanchard 1994, Risen and Thomas 1998, Mason 2002, Maxwell 2002, Wagner 2003). Even leading sociological studies that focus exclusively on the pro-choice movement (*i.e.* Staggenborg 1991) tend to leave out physicians as key actors. Our argument is that only by noting the evolving relationships between these two crucial sets of actors can one fully understand the contemporary abortion rights movement.

We will further argue that the abortion situation, while unique in some respects, offers an interesting perspective on an aspect of health social movements more generally, namely the relationships that can evolve between ‘dissident’ physicians and their lay allies. Abortion represents an instance of a ‘boundary movement’ (Brown *et al.* in press) in which not only have the boundaries between professionals and lay activists become blurred, but to a certain extent, these two groups have arguably over time changed places, with the physicians becoming more politicised and the lay activists more professionalised. We will point to three distinct phases in this relationship between doctors and lay activists: the first in which physicians were reluctant reformers in an often tense relationship with feminist activists; the second in which physician and lay activists came together in a relationship of mutual dependence during the development of the first-generation of legal abortion facilities; and the present moment, in which physicians themselves engage in grassroots work, helped to a considerable degree by prochoice feminists who are now themselves considerably ‘bureaucratized’.

History of physician mobilisation around abortion

The physician campaign to criminalise abortion in the 19th century

The first instance in the United States of physician mobilisation around abortion was actually a campaign to criminalise the procedure. Until the

beginnings of this campaign in the mid-19th century, abortion was largely unregulated in the US (Mohr 1978, Luker 1984, Petchesky 1984, Smith-Rosenberg 1985). Though a number of groups participated in this criminalisation campaign, physicians were the leading force. The American Medical Association (AMA), formed in 1847, quickly made the criminalisation of abortion one of its highest priorities, a move based not on moral objections to abortion, but rather because the issue served so well as the centre of the new organisation's professionalising project (Starr 1982). Because abortion provision in the 19th century drew so heavily on nurses, midwives and other 'irregular' healthcare providers, mobilisation around this issue provided a highly suitable vehicle to differentiate 'regular' or 'elite' physicians from the wide variety of other groups also making claims to be legitimate healthcare providers in that period (Mohr 1978, Luker 1984).

The goal of the AMA campaign, however, was not simply to ban all abortions. Rather, the ultimately successful AMA position was that physicians should control the terms under which any 'authorized' abortions took place. By 1880 all states had regulated abortion but many states continued to permit abortions when there was a threat to the life of the mother, or a serious threat to her health as determined by a physician (Mohr 1978).

Physician responses to the 'century of criminalization'

The major result of this physician-led campaign around abortion was a 'century of criminalization' (from 1880 until the 1973 *Roe v. Wade* decision) whose chief feature was a flourishing market of illegal abortion. This long period of illegal abortion in the US in turn has had important consequences for the issues under consideration in this paper. The first of these is the legacy of the 'back alley abortionist' concerning mainstream medical circles. Similarly, the difficulties women experienced in obtaining an abortion before legalisation had helped shape the way that a generation of feminist activists had perceived the need for abortion to be controlled by women.

Those involved in performing abortions during this 'century of criminalization' were a very diverse group, who varied with respect both to their medical training, and to their motivations. Some of those providers were trained; others were not. Some were highly competent; others caused hundreds of thousands of injuries and thousands of deaths. Some performed illegal abortions because of immense compassion for women in a desperate situation; the motivation of others was greed. But in spite of the diversity of the actual universe of abortion providers in the pre-*Roe* era, it is the back alley 'butcher' or 'abortionist' (terms that have been used interchangeably) that has most strongly captured the imagination of the medical profession. The most egregious stories tell of men (some physicians, some not) who performed abortions in filthy settings, under the influence of alcohol, and who demanded sexual favours from their terrified and vulnerable patients (Messer and May 1988, Miller 1993) The figure of the abortionist came to

symbolise a potent combination of professional ineptness, ethical lapses and, of course, an association with the controversial issues of sexuality and gender (Jaffe, Lindheim and Lee 1981, Joffe 1995). This aversion to the abortion provider – even while increasing support for legal abortion was growing within medical ranks – sets the stage for the considerable challenges that would lie ahead for the medical wing of the abortion rights movement.

Physician experiences of illegal abortion

Throughout the era of criminalisation, US physicians faced an ambiguous, and increasingly, untenable situation vis-à-vis abortion. The state statutes that the AMA had so vigorously promoted did not make all abortions illegal; rather, as suggested above, they authorised the medical profession to decide which abortions would be authorised. But in many instances there was no uniform agreement on which conditions posed a true threat to the woman's life, or what degree of threat to her health merited an authorised abortion. As the work of Luker (1984) has shown, the medical profession in the years leading up to *Roe* split into two factions with respect to abortion: the 'strict constructionists', those morally opposed to abortion, who wanted their colleagues to adhere to the most rigid interpretations of the laws governing authorised abortions, and the 'broad constructionists', who pushed for a far more expansive and discretionary interpretation of abortion policies.

The ambiguous nature of approved abortion created difficulties for physicians in practice in the 1950s and 1960s. Those who worked with women of reproductive age faced requests for abortions in a legal 'grey area' where it was often not entirely clear what constituted a 'legal' abortion and what did not. Moreover, as medical management of pregnancy improved throughout the 20th century, fewer and fewer of their patients qualified under the 'threat to life' or even 'health' guidelines (Luker 1984). In most American hospitals, abortion decisions were made informally, with inevitable tensions rising between the strict and the broad constructionists.

Even those doctors who did not directly deal with adult women in their professional practices typically had encountered in hospital emergency rooms, during their internship or residency periods, the ravages of illegal abortion. Women who were seriously injured, either as a result of attempted self-abortion, or at the hands of an inept practitioner, so overwhelmed hospital facilities in the pre-*Roe* era that some hospitals established special wards to care for them, sometimes referred to, sardonically, as 'septic tanks' (a reference to the life-threatening sepsis infections in the bloodstream that often resulted from illegal abortion). One respected estimate put the number of deaths from illegal abortions in the years leading up to *Roe* at 5,000 (Leavy and Kummer 1962). This situation of abortion in the decades before legalisation was instrumental in moving a generation of US physicians towards increasing discomfort with the status quo.

Abortion rights physicians begin to mobilise

Although there had been earlier discussions of legalising abortion within the medical profession, mobilisation around this issue began in earnest in the 1950s. Planned Parenthood, an organisation that had till then studiously avoided the abortion question, took the unprecedented step of hosting a conference on the subject in 1955 (Calderone 1958). Many sympathetic physicians of that era became involved shortly thereafter with the efforts of the American Law Institute (ALI), which in 1959 proposed a model abortion reform bill permitting the procedure on certain limited grounds (Garrow 1994). Abortion reform was framed as a desire to give expanded discretion to the medical profession (Stetson 2001). This initial physician interest in abortion law reform, rather than outright repeal of existing law, would shortly put them at odds with 1960s feminist activists.

In 1964, one of the first explicitly abortion-reform organisations, the Association for Humane Abortion [shortly to change its name to the Association for the Study of Abortion (ASA)] was founded in New York by a mixed group of physicians and laypeople. The group very deliberately elected a physician, Robert Hall, as its head, because of the belief that 'the future of the organization can best be served by a physician in the role of chairman' (Garrow 1994: 297). In 1968 the ASA hosted an international conference on abortion in Hot Springs, VA at which US physicians were exposed for the first time to the vacuum suction machine, a new technology for performing first trimester abortions that was considerably safer than the previously-used technique of dilation and curettage (D&C) (Hall 1970a).

Two key events occurred in the 1960s that further moved both the general public and the medical profession, respectively, in favour of legalised abortion. The first was the case of Sherri Finkbine, a well-known children's television personality in Phoenix. In 1962 Finkbine, while pregnant with her fifth child, took thalidomide, a drug she shortly learned was strongly associated with severe birth defects. Because of the public nature of her case, she was unable to arrange a legal abortion in Arizona and ultimately went to Sweden to have an abortion. The case received widespread attention in the national media, and was instrumental in alerting the public about the difficulties of obtaining an abortion in a situation – *e.g.* a high likelihood of birth defects – that many Americans found justified the procedure (Luker 1984).

The second event – the case of the 'San Francisco Nine' – occurred in 1966 and involved nine San Francisco obstetrician/gynecologists who were abruptly threatened by the California Board of Medical Examiners with the loss of their medical licences because they had been performing abortions in local hospitals on women who had been exposed to rubella (German measles), which was also associated with birth defects. The case, however, had an unintended effect, in that it galvanised the members of the medical community, both in San Francisco and nationally, to defend their colleagues. This defence of the accused physicians can be explained by their professional stature (all held positions in prestigious local medical institutions) – unlike

the infamous back alley abortionists of the day who did not receive medicine's support when they faced criminal charges (Lader 1973, Garrow 1994). Leading figures from the medical community, joined by prominent citizens in law and other fields, formed a defence committee to pay their legal expenses. Most noteworthy, over two hundred physicians from across the country, including the deans of 128 medical schools, signed an amicus brief that was filed on their behalf (Joffe 1995, Dynak *et al.* 2003).

Both the Finkbine and the SF-Nine case did not concern the rights of women to end an unwanted pregnancy, but rather the issue of fetal deformities (Hull and Hoffer 2001). These abortions, called 'therapeutic abortions' to distinguish them from abortions for other reasons, had greater support among both physicians and the general public. However, growing requests for other abortions not meeting these explicit criteria continued to grow, and by 1970, the cumulative effect of all of the above-mentioned events further pushed many in the medical profession to join the larger social movement to legalise abortion, and to repudiate the limited reforms represented by the ALI proposal. Many of these pro-choice physicians became involved in campaigns then underway to legalise abortion in various states, including New York, which narrowly passed such legislation in 1970. Also in that year, the AMA at its annual meeting voted in favour of legal abortion, thereby reversing its campaign of some 100 years earlier to criminalise the procedure.

The discussion at that meeting, however, foreshadowed some of the problems to occur in the future relationship between abortion rights physicians and feminist pro-choice activists. The first of these was the challenge to the traditional relationship between doctor and patient that resulted from the demedicalization of the abortion procedure. As one doctor said at the AMA gathering, 'Legal abortion makes the patient truly the physician: she makes the diagnosis and establishes the therapy' (Jaffe, Lindheim and Lee 1981: 67). Similarly, even physicians deeply committed to legal abortion voiced hesitation about what legal abortion would imply about the role of the physician in this new health service. As Robert Hall said, in a statement that was to prove quite prophetic, 'When it comes to the doctor, I think he is eventually going to be no more than a technician. This may be humiliating to him. But it is his unavoidable plight if we are to grant women their inherent right to abortion' (Hall 1970b: 109).

Reflecting these concerns, the AMA resolution that was passed by its House of Delegates contained the statement that doctors should not provide abortions 'in mere acquiescence to the patient's demand' (American Medical Association House of Delegate 1970: 388), a more conservative position than many of the most committed pro-choice physicians of the era (Halfmann 2003). Halfmann argues that the AMA passed the 1970 resolution because the group did not perceive legal abortion as a threat to doctors' material interest and only a minimal threat to their clinical autonomy. The AMA position framed abortion reform as a way to ensure professional autonomy

and was at odds with the vision of feminist abortion rights groups mobilising on behalf of women's rights.

This frame of professional autonomy was reflected in the very language of the *Roe v. Wade* decision itself, further contributing to the uneasy relations between medicine and feminist activists. Justice Harry Blackmun, the chief author of the decision, had spent considerable time as counsel to the Mayo clinic, and in the eyes of observers (Garrow 1994, Reagan 1997), this experience led to a decision that stressed the prerogatives of the medical profession, rather than the 'rights' of women. Leading constitutional scholars including Lawrence Tribe (1985) and Ruth Bader Ginsburg (1985) have noted with concern the privileging of the physician within the *Roe* decision. As the *Roe v. Wade* [410 US 113 1973] decision reads:

The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician (1973: 166).

The feminist critique of the *Roe* decision, however, goes beyond a simple critique of the role of physician authority, it also includes a questioning of the privacy basis for the decision. Privacy is a negative right, *e.g.* 'freedom from' intervention rather than a positive rights approach which ensures 'freedom to' something. This distinction would become meaningful as future court cases would find that women do not have the actual right to get an abortion, only the right to choose an abortion. Thus, the State is not obliged to pay for abortion or to ensure that one is available for women. Feminists' expansive view of abortion rights would come into conflict with the rights of physicians to not perform abortion, a power that they would use extensively as abortion became more controversial (Halfmann 2003).

The disengagement from abortion after Roe v Wade

In 1972, in anticipation of the imminent legalisation of abortion, one hundred professors of obstetrics and gynaecology (ob/gyn) published an open letter to their colleagues calling for an equitable sharing of the anticipated abortion patient load (AJOG 1972). Estimating (accurately) that there would be about one million abortions requested in the first year after legalisation, the statement confidently predicted, 'If only half the 20,000 obstetricians in this country do abortions, they can do a million a year at a rate of two per physician per week' (AJOG 1972: 992). In sharp contrast to this statement, however, the period after *Roe* is noteworthy for what did *not* occur within medical institutions. With the exception of a few organisations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Public Health Association (APHA), medical organisations

did not establish standards for abortion care, resident education bodies in the field of ob/gyn did not mandate abortion training, most hospitals did not establish abortion services (Jaffe Lindheim and Lee 1981) and nowhere near half of all practising ob/gyns took up abortion care after *Roe*. The reluctance of so many medical institutions and individual physicians to engage with abortion can best be understood as a reaction to the legacy of the pre-*Roe* era, and especially the stigma associated with the illegal abortionist.

Several factors, including this hands-off approach to abortion on the part of the medical community, came together in the 1970s to facilitate the development of the 'freestanding clinic', which remains to this day the predominant form of abortion delivery in the US (Henshaw and Finer 2003). These clinics had been pioneered in Washington, DC and in New York City, places that had legalised abortion several years before *Roe*, and to which women came from all over the country. The model reflected an uneasy collaboration between abortion-sympathetic physicians and feminist pro-choice activists who sought an alternative model for the provision of healthcare. The clinic model was facilitated by several technological advances of that period, including the introduction of the vacuum suction machine into US medicine and reliable means of local anaesthesia which meant that abortions could be safely and comfortably delivered outside a hospital. This model not only lowered the cost of the procedure, but also meant that staff could be selectively hired who were abortion supporters. The clinics have amassed an excellent safety record and continue today to offer abortion care at remarkably low cost (Grimes 1992). An unintended consequence of the success of the freestanding clinic, however, is that abortion care has become further marginalised from mainstream medicine. The existence of the clinics arguably helped relieve many abortion-sympathetic physicians from the perceived burden of becoming an abortion provider themselves (Joffe 1995).

Responding to the anti-abortion movement

A newly energised anti-abortion movement began a wide-ranging campaign in response to the *Roe v. Wade* decision. Anti-abortion legislators won numerous successes at both the state and federal levels in regulating abortion provision; an early and significant victory was the passage in 1976 of the Hyde amendment, which prohibited the use of Medicaid funds to pay for abortions. Because so few physicians were offering abortion, they did not represent a large enough constituency to mobilise the professional medical community to address this policy change.

Over the next two decades, abortion providers became bound by myriad state laws governing their practice, including biased information requirements, waiting periods, parental involvement, bans of use of public funds or facilities, facilities requirements, reporting mandates, and abortion procedure bans. These regulations have no analogue elsewhere in medicine. Most challenges to these regulations have been rejected despite the long safety

record of outpatient abortion and the lack of proof that such regulations improve patient care, safety, or health (Centre for Reproductive Rights 2003).

In addition to growing regulation of abortion, a grassroots anti-abortion movement began aggressively to confront abortion patients and providers at abortion facilities. Throughout the 1980s, there were rising incidents of clinic blockades and sieges, vandalism, firebombings, harassment and stalking of providers at their homes as well as workplaces (Risen and Thomas 1998, Feminist Majority Foundation 2003, National Abortion Federation 2003). In 1993, David Gunn, a doctor in Florida who was shot as he entered a clinic, became the first abortion provider to be murdered by an anti-abortion extremist. To date (Autumn 2003), six additional members of the abortion-providing community have been killed and thousands more terrorised. It is now routine for abortion providers to wear bulletproof vests, and for clinics to resemble armed fortresses, with thick walls and constant video surveillance.

By the late 1980s, the combination of the historically-marginalised status of abortion provision and the upsurge in violence by the anti-abortion movement created an evident crisis in the supply of abortion providers. From 1984 to the present, the number of abortion providers continued to decline and currently there are fewer than 2,000 identifiable abortion providers (Finer and Henshaw 2003). Some clinics found that they had to rely on flying in doctors from elsewhere in the country to provide these services. Local doctors, even if sympathetic to abortion, found that they would become pariahs in their local medical communities if they provided abortion (Gorney 1989, Joffe 1995). Some clinics reported that they were simply unable to find enough doctors to staff an abortion service at all.

In response to these developments, the National Abortion Federation (NAF), the major professional association for abortion providers in North America, and ACOG jointly organised a 1990 symposium, 'Who will provide abortions?'. Various speakers, who were long-time providers and observers of abortion work, confirmed not only the nation-wide problem of a provider shortage, but also the low status of this work in the eyes of many medical professionals. They cited the perception of abortion work as tedious and unchallenging, even among those who were ideologically committed to it (National Abortion Federation 1991). Participants also focused on the failure to routinise abortion training into ob/gyn residency programmes after *Roe v Wade*. The normal mechanism by which such training would have become required – adoption by the Committee on Residency Education in Obstetrics and Gynecology (CREOG) – had never taken place. The final report of the symposium called for ob/gyn residencies to mandate training in first and second trimester abortion techniques. Recognising that many ob/gyns would continue not to provide abortion care, the Symposium also called for the use of mid-level health professionals – physician assistants, nurse midwives, nurse practitioners – to perform first trimester abortions, under physician supervision. As a result of this Symposium and

follow-up work by attendees, CREOG for the first time in 1995 passed a resolution mandating routine training. In an unprecedented intrusion into medical accreditation activity, Congressional anti-abortion legislators quickly moved to nullify this action by CREOG, by passing a resolution stating that no residency programmes would lose federal funding if they did not comply with the new training requirements (Gray 1995).

As the violence and harassment against abortion providers intensified in the 1990s, countermovements (Lo 1982) arose among previously unaffiliated physicians and medical students. Medical Students for Choice (MSFC) formed in the summer of 1993 in direct response to the killing of Dr. Gunn and the mailing of a vulgar and threatening pamphlet about abortion providers to US medical students by Life Dynamics, an anti-abortion group in Texas (Joffe, Anderson and Steinauer 1998). MSFC spoke out forcefully for the need to incorporate material on abortion into medical school curricula as well as the need for greater protection of abortion providers (Hitt 1998). Shortly thereafter, a group of physicians in New York founded a national organisation, Physicians for Reproductive Choice and Health (PRCH). Unlike NAF, a group composed almost exclusively of abortion providers, PRCH is composed of abortion doctors as well as physicians committed to supporting abortion providers and addressing their long-standing stigmatisation. PRCH sought to include in its membership physicians with recognised authority in the medical profession, such as leaders of medical societies, renowned researchers, and academic chairs and deans.

Finally, efforts have been undertaken to institutionalise abortion training and research within mainstream medical institutions. With the help of a private donor, the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning was established in 1999 to offer financial and technical support for ob/gyn residencies committed to establishing abortion training. The same donor has also funded a postgraduate Fellowship in Abortion and Family Planning. The intent of these programmes is to assure an abortion presence at leading medical schools in the United States, and to facilitate a new generation of physician researchers committed to a career in various facets of abortion care.

More recently, a group of family practice doctors, mostly centred in New York City, has organised to form the Access Project, which is committed to bringing abortion training to family practice and other primary care physicians. This group has worked assiduously to have abortion training incorporated into residency programmes other than those in ob/gyn. The Access Project's leaders have also mounted what can only be called a political campaign to persuade some reluctant leaders within family practice to allow abortion-relevant material at professional meetings and in the specialty's professional journals. The following fragment of an e-mail, sent by one of the leaders of the Access Project (and received by one of the authors) conveys the flavour of this group: 'What a great meeting we had last night in Boston! There were about 30 of us, from as far as Maine and

Rhode Island, gathered together to figure out how to offer medical abortion in their practice sites. . . . The meeting provided such a great sense of . . . solidarity around working to overcome the barriers. . . .' (Anonymous 2002a).

In sum, the response of medical activists to the twin crises of provider shortages and anti-abortion harassment has been to counter the historic marginality of abortion provision. The activities listed above share the same goal of the integration of abortion care into mainstream medicine. Once again, abortion is at the core of a professionalising project for physicians. Unlike their 19th-century predecessors, however, contemporary physicians involved with abortion often engage in 'high-risk activism' (Taylor and Raeburn 1995), allied closely to feminist activists in the ongoing movement to secure abortion rights. Such effort, however, is ongoing within the changing context of healthcare in the US, in which physicians as a whole find that they have less authority. Increasingly, for-profit healthcare organisations run by administrators rather than physicians are the major political force behind healthcare policy. The reduction in physician dominance is exacerbated for the already marginalised abortion providers. In October 2003, the US Congress passed the so-called Partial Birth Abortion Ban, yet another unprecedented intrusion on the rights of physicians to practice medical care in accordance with their assessment of the needs of their patients (Stolberg 2003). In fighting this new law, as well as other limitations on practice, abortion providers look mainly to their feminist pro-choice allies, rather than to the healthcare system for support.

History of feminist involvement

Feminist health activists of the 1960s and 1970s

The earliest groups that had organised the mid-20th century on behalf of legalised abortion in the US were composed mainly of elite physicians, and their supporters from within the law, public health and other professional groups. As such, these groups operated in a quite staid, non-confrontational manner. Both the substance and style of abortion mobilisation changed dramatically in the 1960s with the emergence of the 'second wave' of American feminism. Unlike the 19th century US feminist movement (Gordon 2002), women's health generally, and abortion rights in particular, were key concerns of the second wave feminist movement (Ruzek 1978, Petchesky 1990, Rosen 2000, Morgen 2002). Similar to other oppositional healthcare movements of the 1960s, the women's health movement was concerned with the demystification of medical knowledge, bringing healthcare as much as possible under the control of patients, and changing the physician-patient relationship (Weisman 1998). But the unique aspect of the feminist health movement was its critique of medicine in 'patriarchal' terms. Ob/gyn, the subspecialty of medicine most concerned with adult women, and the male ob/gyn, were subjected to particular scrutiny by the women's health activists

and came to symbolise for some feminists of that period all that was wrong with medicine, and indeed, with men's power over women (Ehrenreich and English 1978). As Starr (1982), commenting on the healthcare movements of the 1960s and 1970s, has observed, 'Perhaps nowhere was the distrust of professional domination more apparent than in the women's movement' (1962: 381, see also Epstein 1996).

Feminist activists in the field of abortion worked simultaneously on two fronts: making abortion legal, and helping women gain access to safe illegal abortions in the meantime. But though ostensibly joined with the physicians of that era who had similar goals, feminist activists were dismayed at the former's acceptance of reform – rather than outright repeal – of abortion laws. Moreover, the tactics used by feminist groups in that period were quite different from those used by physician groups.

In New York State, feminist demonstrations at legislative hearings and courtrooms were frequent. One of the best known of such actions was the disruption of a 1969 New York State legislative hearing by a recently formed 'radical feminist' group, the Redstockings. The group was enraged that the witness list of this hearing included 14 men and only one woman – a Roman Catholic nun. In a pattern that was to become familiar, the feminists were denounced by the mainstream pro-choice forces present, as well as those opposed to abortion (Garrow 1994). Other similar events took place in courtrooms where abortion was under discussion. For example, three feminist lawyers wrote of the courtroom atmosphere in 1969, where an early challenge to New York abortion law was being heard, 'It was a fun demonstration, something other movements have been using all along. A substantial number of women came to court and brought two things with them: babies, crying babies, and coat hangers. When they left, they took the babies along with them but left the coat hangers scattered all over the courtroom' (Goodman, Schoenbrod and Stearns 1973). One observer, writing of the period leading up to the New York law, spoke of pro-choice legislators' dismay at the 'counterproductive "strident" demonstrations and public testimony by militant feminists' (Moore 1971: 17).

The Jane collective, established in Chicago in 1969, was perhaps the most famous of the feminist-related abortion activities of the pre-*Roe* period; certainly it is the one that best captures the profound disconnect between the medical and feminist wings of the abortion rights movement of that period. The collective was a group of women, mostly in their twenties, who were connected to the leading local feminist group, Chicago Women's Liberation Union. The group initially operated an underground abortion service, making use of a provider whom they thought was a physician. The abortions took place in members' apartments and members of the collective assisted in the procedure. The name Jane was used in response to all phone calls, both as a security measure and as affirmation of the group's communal identity (Kaplan 1995). Upon finding out that their provider was not in fact a physician, some members of the collective asked to be taught by him and

became providers themselves. The collective operated until 1973, when *Roe v. Wade* made their services no longer necessary. The group performed about 11,000 abortions in all, with no fatalities, and only one serious confrontation with the police (Garrow 1994, Kaplan 1995, Reagan 1997). The Jane collective attained legendary status within some sectors of the women's health community, not only for its bravado, but also for its demonstration that abortions could be done by women for women – in short, abortion could be demedicalized.

It was thus an atmosphere of wariness, if not distrust, in which abortion rights physicians and feminist health activists came together to form the first freestanding clinics in New York state and Washington, DC, both of which had legalised abortion before *Roe*. Some of the clinics of this era were established as for-profit ventures, others were nonprofit enterprises, with a physician acting as medical director, but a lay person as executive director, and a board consisting of both medical and nonmedical members. It was in these clinics that the new occupational role of 'abortion counselor' was developed (Joffe 1986). As an early edition of *Our Bodies, Ourselves* (1973), the pre-eminent document of the women's health movement stated, in a section written for those considering abortion, 'Probably the most important person you would come in contact with during an abortion would be the abortion counselor' (Boston Women's Health Book Collective 1973: 147).

These counsellors were typically women who had worked in the abortion rights movement, and who often themselves had undergone an illegal abortion. Their role was to advocate for the patient, which meant both explaining the technical aspects of the abortion procedure, accompanying her throughout the process, and intervening on her behalf, if she had any difficulties during her stay at the clinic, including difficulties with the attending physician. Thus, the counsellors monitored the doctors carefully, to make sure they were not causing undue pain and also that they were treating patients and staff with due respect. As a counsellor in one of the first New York clinics reminisced, some years later, about those heady first months of clinic operations:

It blows my mind, thinking about it now, about how much power we [the counsellors] had . . . The doctors were just terribly nervous about the whole thing and were willing to listen to us – about what kinds of counseling services there should be, lots of things. If one of the doctors they hired was causing too much pain or saying disgusting things to patients, we'd run into the director's office and get him fired. Unfortunately, the honeymoon period didn't last too long though (Joffe 1986: 36).

Besides their work in clinics, feminists in that period set up abortion referral services, which involved visiting the various clinics emerging after legalisation, and making their recommendations – both positive and negative – widely available through movement networks. The costs of abortion in

the different facilities were of key concern to the feminist investigators, as was the quality of the physicians. In one well-publicised event, feminist activists sat in the lobby of one New York area clinic and handed patients leaflets stating the quality of services there was poor, and offered a list of recommended facilities (Ruzek 1978).

From the doctors' perspective, participation in such a different kind of medical setting could be very challenging, despite their commitment to legal abortion. Some male doctors (and most providers were male at that time) resented the covert, and sometimes overt, tone of 'male bashing' that they sensed from some of the counsellors. One male veteran of the early days of the freestanding clinics recalled that he felt very isolated from both the rest of the (female) staff and from the patients themselves, who were counselled either by nurses or lay counsellors. As he put it, 'I felt like a fool at the end of the curette' (Joffe 1995: 148). But even some women doctors found working in this new environment difficult, at least initially. Jane Hodgson, an ob/gyn in private practice for many years in Minnesota, worked at one of the first freestanding clinics in Washington in the early 1970s; her commitment to legal abortion was such that she put her licence in Minnesota in jeopardy by openly challenging that state's abortion laws in a test case (Garrow 1994). Nevertheless, she recounted her Washington experience, 'I'd never worked in a clinic. I'd always had my own practice and run my own show. I was not accustomed to counselors participating in medical decisions. . . . They had music playing all the time during procedures, very casual, no uniforms . . .' (Joffe 1995: 19).

To be sure, not every doctor who worked in the clinics in the years immediately surrounding *Roe* reported such difficulties. And both the doctors mentioned above went on to work for many satisfying years in such clinics. But whether the encounters were tense or pleasant, the point is that in the earliest years of legal abortion, there was a mutual dependency between physicians and activists. Activists needed the doctors, in most fundamental terms, because *Roe v. Wade* and subsequent decisions had made clear that abortions could not be performed by anyone other than a physician. But the doctors needed the feminists as well because the medical community as a whole had no idea what it meant to deliver abortion legally, in outpatient settings, to a large group of healthy women. The prior experience of most abortion-providing physicians, it should be recalled, was caring for women with serious health issues in a hospital setting, with an abortion performed under general anaesthesia. This first generation of feminist activists helped establish how outpatient abortion was to be done – for example, what kind of pre- and post-abortion counselling was needed – and also served as an important source of referrals for women flying in from all over the country. As such, clinic-based abortion further blurred the boundaries between lay and professional activist communities (Brown *et al.* in press). Doctors and women's health advocates worked together in a context where neither professional autonomy, nor activist ideology, reigned supreme. This uneasy

alliance was born out of a commitment to provide women safe access to abortion, but ultimately demanded more: both doctors and feminists had to negotiate the lay/professional divide.

1980 to the present: the bureaucratisation of the pro-choice movement

After the *Roe* victory, like the larger women's movement of which it was a part, the feminist abortion rights movement gradually changed from being primarily a collection of local grass roots activist groups to coalescing into several larger 'social movement organisations' (SMOs) (Staggenborg 1991, Ferree and Martin 1995, Ruzek and Becker 1999). NARAL ProChoice America, originally founded in 1969 as the National Association for the Repeal of Abortion Laws, became the dominant single-issue group in the US dedicated to abortion (Garrow 1994). Other SMOs connected to the feminist movement, such as the National Organization for Women (NOW) and the Feminist Majority, though they work on a variety of issues, are heavily involved with abortion-related issues. These groups function with paid staffs, with Washington, DC headquarters (and in many instances, state and local chapters) and are sustained by a combination of membership dues, and large individual and foundation fund raising. The staff operate as Washington insiders, developing relationships with sympathetic politicians (Staggenborg 1991). The organisation's membership is mobilised to take various actions – such as writing to Congressional representatives and participating in voter registration drives, largely through mail, faxes and e-mail. One of these SMOs' remaining sixties-style activities is periodically to summon their membership, and the public at large, to huge marches in Washington to protect legal abortion. These marches are traditionally orderly and focus on protecting the *Roe v. Wade* decision.

While many women joined the early pro-choice feminist social movement out of their experience with illegal abortion, young women today, especially recent college graduates, typically join these SMOs through internships and entry-level employment. In contrast to the earlier generation, who engaged in civil disobedience and other forms of direct action, these new recruits are often assigned administrative tasks. As the authors heard one such young employee complain at a meeting, 'I joined the movement to make a difference and all I've been allowed to do is paste labels' (Anonymous 2002b).

To the extent that grass roots activism still exists in pro-choice circles, it is mostly at the site of clinics, where local groups have organised 'clinic defense' operations and 'escorting' of patients in response to anti-abortion disruptions. Though in most cases this support is highly welcomed by the clinic administration, it can at times be problematic, as some clinic defenders respond too emphatically to their opponents. One clinic manager said to one of the authors, 'A 15-year-old coming to the clinic, hearing all the screeching – she doesn't know or care if it's our side, or anti – she's just terrified' (Anonymous 1999).

A marked change in both rhetoric and style has accompanied this shift to more formalised organisational forms. ‘Doctor bashing’ and calls for ‘demedicalized’, ‘woman-controlled’ abortions are largely absent from contemporary abortion rights circles. (Indeed, somewhat ironically in light of the past, some of the major pro-choice organisations use the occurrence of anti-abortion attacks on doctors as part of their fundraising appeals.) This discursive shift is, of course, partly a reflection of the journey from ‘60s radical’ to ‘movement bureaucrat’ or ‘femocrat’ undertaken by many feminist activists (Booth 1998). The less incendiary rhetoric also reflects that political culture more generally now in the United States is less receptive to such language – including, we might add, the donors on whom these SMOs rely for survival. But this retreat also reflects profound changes in the abortion landscape. First, there has been a huge increase in the number of women who have become doctors in the 30 years since the *Roe* decision (Morgen 2002), and a number of them have become abortion providers, thus blunting the earlier polarisation between the male doctor and the woman patient. Second, and most importantly, the combination of the shortage of abortion providers and the violence that abortion doctors have received at the hands of anti-abortion terrorists has made such rhetoric simply unfeasible.

Conclusion: accommodations and remaining contradictions

We suggest that there have been three distinct phases in the relationship of physicians and feminist activists: the first, in the years immediately preceding *Roe v. Wade*, where many abortion-sympathetic physicians were reluctant reformers, at odds not only with their colleagues but with feminists who had a far more expansive vision of abortion rights; the second, extending from the passage of *Roe* in 1973 until the early 1990s, where both parties existed somewhat tensely in a situation of mutual dependence; and the third, in which a far more activist group of doctors and their feminist supporters reached considerable accommodation with one another. The unanticipated strength and scope of the anti-abortion response to *Roe* has pushed these formerly uneasy allies into a tighter bond, in response to such a formidable opponent. Indeed, we can argue that as one observes the activities of each of these groups over time, it would appear that they have to a considerable degree blurred roles (Brown *et al.* 2004). Comparing the 1970s with the present, feminist supporters of abortion have changed in the direction of becoming less activist and more bureaucratic; physicians, on the other hand, have taken on the role of political activists within medicine.

But this increased activism among pro-choice physicians carries its own contradictions in several respects. First, activism on behalf of increased professionalism is inherently problematic – because professionalism and activism are viewed by many in medicine as incompatible with one another (Wynia *et al.* 1999) especially when the activism concerns such a contested

social issue as abortion. Some of the pro-choice physicians who work energetically to promote abortion services and education within relevant medical organisations have told the authors of their concern that they are perceived by colleagues as 'fanatics' or 'single-issue types'.

Second, the professionalization agenda of pro-choice physicians is in conflict in key respects with the goal of increased abortion access. Nowhere is the conflict between these two goals more evident than in current developments around medication abortion. The preferred method for medication abortion involves the use of the mifepristone/misoprostol regime. Mifepristone, also known as RU-486 or the 'French abortion pill', was approved for use in the US in 2000 only after a protracted 12-year campaign mounted by both physician and feminist health activists. The legality of mifepristone was widely seen as an at least partial solution to the crisis in abortion access (Talbot 1999). Given that administering a drug requires less training than performing a surgical abortion, the pro-choice community hoped these new abortion technologies could both attract more providers, as well as integrate abortion provision into medical settings other than freestanding clinics, such as primary care practices (Talbot 1999). Immediately after approval of mifepristone by the Food and Drug Administration (FDA), pro-choice medical activists began an energetic round of trainings, across multiple primary care specialties. In particular, as discussed above, family practice doctors have lobbied heavily for inclusion of medication abortion in their residency programmes. And medication abortion has drawn considerable attention from advanced practice clinicians (APCs) – nurse practitioners, midwives, physician assistants – who see this form of abortion provision as squarely within their scope of practice. APCs are now providing medication abortion in a number of states, where this has been deemed legally permissible, and have formed their own organisation to promote such provision, Clinicians for Choice (2003).

But these medication abortion campaigns – while undeniably promoting access – nevertheless cut across the upgrading project of abortion providers. Medication abortion in several ways represents an instance of professional 'deskilling' (Haug 1973, Freidson 1984) by transforming abortion from a surgical procedure to the dispensing of a medication; by the claims that primary care physicians as well as specialists can safely provide abortion; and even more so, by the movement of APCs to become abortion providers. Additionally, medication abortion, far more than conventional vacuum aspiration abortion, puts more power in the hands of the patient herself. In the case of mifepristone, since the woman ingests the pills herself, it is arguably the woman who 'performs' the abortion. The provider, moreover, is dependent on the woman to comply with the rest of the regime, which involves inserting or ingesting the second medication, misoprostol, at home and returning to the clinic to ascertain that the abortion is complete. As research has shown, this transfer of agency to the patient is quite troubling to some contemporary providers (Simonds *et al.* 2001). Ironically, therefore, while this paper has argued that feminist activists over time have largely

accommodated changing political realities and given up old demands for 'woman-centred' abortion care, medication abortion, spurred on by physician activists, may well have the potential to resurrect this model.

What, finally, does the case of abortion described here have to tell us about physician/lay encounters in other health social movements? Abortion is in one sense unique because in no other contemporary case (or historical one for that matter) of a physician/lay movement does the former go to work in bullet proof vests; the extreme violence directed against abortion providers creates a dependence on lay allies in a way that is difficult to generalise to other situations. But in other ways the story told here does point to a promising stream of comparative research in other medical spheres where considerable social controversy exists, and therefore where both provider and patient risk stigmatisation. For example, both medical marijuana and physician-assisted suicide offer provocative cases with some key similarities to abortion. In both of the former, physicians often operate either in a grey area of legality (as did an early generation of pre-*Roe* abortion doctors) or in a situation of massive state regulation (as do contemporary abortion providers). Both of these fields have produced practitioners – 'dissident doctors' – who have become activists in the public arena, as well as within medical organisations (Quill 1993, Tuller 2003), and thus have incurred criticism from medical colleagues. Both of these fields moreover have generated intensely passionate lay adherents who have become knowledgeable about the medical components of their respective issues, and have also become sophisticated lobbyists.

Equally as significant, for the purposes of comparison, are the organised counter movements seeking to keep these activities illegal. And in the case of physician-assisted suicide, there may well be some echoes of the violence generated against abortion providers, given the opposition of the pro-life movement. In this regard, it is noteworthy that Randall Terry, the founder of one of the most militant anti-abortion groups, Operation Rescue, has surfaced as a major actor in one of the most high-profile 'right-to-die' cases in the US to date (Goodnough 2003). As researchers accumulate more case studies of health social movements in these and similar fields, we will presumably find a similar pattern of blurred boundaries between healthcare professionals and laypersons. Most particularly, the abortion story suggests that when dissident physicians become involved in arenas that are socially contested, they will find their strongest allies among lay activists, and may correspondingly jeopardise their standing among professional colleagues. Similarly, in contrast to an earlier generation of healthcare activists who sweepingly opposed 'medicine', contemporary activists will find it strategic, if not essential, to align with health professionals.

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