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and identities**

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# Recognizing medicalization and demedicalization: Discourses, practices, and identities

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**Abstract**

Scholars of the medicalization of social problems have paid inadequate attention to medicalization's multiple dimensions – discourses, practices and identities – and to the multiple levels of analysis at which it occurs – macro, meso and micro. As a result, scholars of a given social problem typically examine only a few aspects of its medicalization, fail to recognize changes in medicalization, and miss occasions where medicalization and demedicalization occur simultaneously. Moreover, by conceptualizing medicalization as a category or state rather than a continuous value, and failing to specify the threshold at which a phenomenon becomes 'medicalized' or 'demedicalized', scholars have discouraged attention to demedicalization. The article provides a new typology of medicalization and illustrates its utility through an analysis of two episodes in American abortion history. Previous analysts of these episodes miss many aspects of medicalization and disagree about whether these episodes involve medicalization or demedicalization. The typology helps resolve these differences.

**Keywords**

abortion, demedicalization, medicalization

Scholars of the medicalization of social problems often fail to examine the multiple dimensions of medicalization and the multiple levels of analysis at which it occurs. Often they conceptualize medicalization as a category rather than as a continuous value and they fail to specify the threshold at which a given phenomenon becomes 'medicalized' or 'demedicalized'. For both of these reasons, scholars often miss instances of

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medicalization, and especially demedicalization. They also miss moments when the two processes occur simultaneously. Here, I offer a typology that identifies three dimensions of medicalization – discourses, practices, and identities; at three levels of analysis – macro, meso, and micro. Below, I review prominent definitions of medicalization and demedicalization, outline the typology, apply to it to two periods of abortion history, and compare my own analysis of these periods with those of other scholars.

## Medicalization and demedicalization

Scholars of medicalization have produced hundreds of studies over the past 40 years (for reviews and prominent examples, see Clarke et al., 2003; Conrad, 2005, 2007; Davis, 2009; Foucault, 1991; Freidson, 1970; Illich, 1977; Rose, 2006; Zola, 1972). In one of the earliest attempts to define medicalization, Conrad (1975: 12, emphasis added) argued that the process required both the medical *definition* of a social problem and medical *jurisdiction* over that problem: ‘By medicalization we mean defining behavior as a medical problem or illness *and* mandating or licensing the medical profession to provide some sort of treatment for it.’ In a later review article, however, Conrad (1992: 211) de-emphasized the jurisdictional aspect of medicalization and highlighted the definitional one:

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.

In this new formulation, medical treatment was one possible mechanism of medicalization but was not required for medicalization to occur. This definition soon became the most prominent one in the medicalization literature (for a critique of this definition, see Davis, 2006).

Most scholars define *demedicalization* simply as the obverse of medicalization (Conrad, 1992: 224). Research on medicalization far outweighs that on demedicalization or on limits or resistance to medicalization (for exceptions, see Adler and Adler, 2007; Conrad, 2007; Fox, 1977; Lee, 2003; Strong, 1979; Williams and Calnan, 1996). As Davis (2009: 231) writes, ‘after reading this literature, one could easily come away with a picture of medicalization as an inexorable juggernaut’. On its face, this disparity makes sense because there is probably more medicalization than demedicalization in western societies. But, as I argue below, at least some of the inattention to demedicalization is the result of conceptual weaknesses in the medicalization literature.

## Levels of medicalization

Conrad and Schneider (1980b) elaborate on Conrad’s (1975) definition of medicalization by offering a useful but under-utilized typology of medicalization. They write that medicalization can occur at multiple levels – the conceptual level, the institutional level (which they also call the organizational level) and the level of doctor–patient interaction.

At the conceptual level, ‘a medical vocabulary (or model)’ is used to ‘order or define the problem at hand’ but medical professionals and treatments may or may not be involved (Conrad and Schneider, 1980b: 75–76). This may occur at the elite level of medicine in terms of ‘discoveries’ published in medical journals, through the adoption of medical definitions and explanations by non-medical groups (such as Alcoholics Anonymous) or ‘through government or court-mandated definitions of human problems and who is to control them’ (1980b: 75–76).

At the institutional level, organizations (such as alcohol programs) ‘adopt a medical definition and approach to a problem’ (1980b: 75–76). A few physicians may be formal supervisors in these organizations, acting as gatekeepers of state benefits and legitimating the medical definition of the problem, but treatment is often provided by non-medical providers. Finally, at the level of doctor–patient interaction, ‘a physician defines a problem as medical (i.e. gives it a medical diagnosis)’ or ‘treats a “social problem” with a medical form of treatment (e.g. prescribing tranquilizers for an unhappy family life)’ (1980b: 75–76). Conrad and Schneider’s typology is an excellent start. It is a good heuristic for helping scholars to identify multiple sites and mechanisms of medicalization, and it usefully suggests that medicalization may occur unevenly across these sites. But I revise and expand the typology in a few ways.

### *Discourses, practices, and identities*

Conrad and Schneider’s typology focuses mainly on discourses – the conceptualization and definition of a problem through a medical vocabulary or model. It implicitly recognizes medical practices and actors as mechanisms of medicalization but conceptualizes these narrowly, referring only to practices of ‘diagnosis and treatment’ and to doctors. My own approach refers not only to these practices and actors, but to other biomedical practices, such as measurement, normalization, and laboratory testing, and other individual and collective biomedical actors, such as researchers, nurses, hospitals, and medical schools.

In addition to considering a broader range of biomedical actors, I argue that these actors medicalize not only through their involvement with a given problem but through their conformity with broadly recognized biomedical identities. Physicians vary in the degree to which they conform to cultural expectations about what it means to be a ‘doctor’. One doctor might belong to the American Medical Association, wear a white lab coat, and insist on being addressed as ‘Dr. Marcus Welby, M.D.’ while another might reject mainstream professional associations, dress in street clothing, and go by her first name. Finally, lay people may embrace biomedical identities such as ‘patient’, ‘high-risk’, or ‘health-conscious’.

### *Multiple levels of analysis*

Conrad and Schneider’s typology contains an implicit division between macro, meso, and micro levels of analysis (for a similar division, see Morgan, 1998: 86–87). Its ‘conceptual’ level refers mainly to macro-level actors – medical researchers and journals, governments, courts, and national organizations. Its ‘institutional’ level refers mainly to meso-level actors – organizations such as alcohol programs. Its ‘doctor–patient

interaction' level refers mainly to micro-level actors – doctors who diagnose and treat social problems and the patients who receive those diagnoses. I make this macro–meso–micro division explicit and this allows for two expansions. First, I attend to conceptualization at all levels of analysis, not just the macro level. Medical discourses are constructed, disseminated, and deployed not only by macro-level actors such as universities and government bureaucracies, but by meso- and micro-level actors, such as hospital administrators, frontline medical personnel, and patients themselves. Second, I examine micro-level medicalization beyond doctor–patient interaction. Such medicalization can occur through the interactions of lay people with hospital and clinic personnel other than doctors and through their interactions with a variety of non-medical actors such as employers, teachers, and counselors. Micro-level medicalization can also occur through the identity construction of these various actors, including that of patients (Rose, 2007).

### *Medicalization as a continuous value*

Finally, most scholars treat medicalization as a state or category (i.e. a problem is medicalized or demedicalized) rather than a continuous value (i.e. the medicalization of a problem increases or decreases). The treatment of medicalization as a category poses three analytical problems: First, it requires the analyst to establish a threshold for determining how much medicalization is required before a problem is 'medicalized'. Most analysts fail to do this. Second, it minimizes the importance of significant increases or decreases in medicalization that are too small to produce a categorical change. Third, it obscures the fact that medicalization and demedicalization often occur simultaneously. This simultaneity has important theoretical and practical implications. It undercuts the notion that medicalization is ubiquitous while demedicalization is rare, and suggests that even when one of these two processes appears dominant, such dominance is often incomplete. There may be crosscurrents and interstices in which change runs in the opposite direction and these may provide opportunities for actors to resist medicalization, or alternatively, disguise medicalization by suggesting that change is moving in many directions at once and things are not quite as bad as they seem.

An example of these difficulties can be found in Conrad's critique of those who argue that childbirth has undergone demedicalization. Conrad (2007: 120–121) notes that childbirth has changed considerably since the 1950s, middle-class births often occur in birthing rooms, with partners or friends present, often without medication or episiotomies, and they are sometimes attended by midwives rather than physicians. But Conrad does not view these changes as instances of demedicalization. To be so, 'the birth would take place at home with a lay attendant, and without medical monitoring.' Here, Conrad argues that childbirth is only 'demedicalized' if doctors and hospitals are completely excluded from births – a very high threshold. He notes that such births occur, but because they are rare, childbirth is not demedicalized. This high threshold obscures significant changes in childbirth. A more nuanced approach would be to conceptualize medicalization in terms of an increase or decrease rather than a presence or absence. The medicalization of childbirth has decreased in various ways but it has increased in other ways, such as rising rates of electronic fetal monitoring and caesarean sections. The question of whether childbirth is 'medicalized' or 'demedicalized' should be left aside.

**Table 1.** Levels and dimensions of medicalization and demedicalization

	Macro	Meso	Micro
	Legislation, rulings, reports, and debates of national and international organizations such as government bureaucracies, courts, legislatures, corporations, markets, universities, journals, foundations, non-profit organizations, and the media	Mission statements, reports, advertising, and procedures of local and regional organizations such as workplaces, hospitals, medical groups, clinics, nursing homes, schools, social service agencies, and prisons	Face-to-face interaction and physical contact between providers (medical and non-medical) and clients Client self-management
<i>Discourses</i>	Biomedical vocabularies, models, and definitions – symptom, syndrome, disease, illness, contagion, etc.		
<i>Practices</i>	Biomedical practices and technologies – testing, measurement, normalization, surveillance, risk assessment, insurance coverage, examination, lab testing, imaging, hygiene, surgery, pharmaceuticals, medical devices, etc.		
<i>Identities (and actors)</i>	Individual and collective biomedical actors – physicians, biomedical researchers, hospitals, insurance companies, medical groups, drug and device makers, medical schools, professional associations, etc.		

## Dimensions and levels of medicalization

Below, I outline my own typology of medicalization (see Table 1) – examining discourses, practices, and identities at macro, meso and micro levels of analysis. I do not seek to establish rigid distinctions between these dimensions of medicalization and levels of analysis. Discourses, practices, and identities are mutually constitutive so any distinction among them is analytical rather than empirical. Macro, meso and micro are relative terms and many phenomena occur at multiple levels of analysis. Real life is messy while the typology is neat. The point is not to stuff processes and phenomena into boxes but to offer a sensitizing tool for identifying and analyzing medicalization and demedicalization in their many potential variations. Below, I use the terms *biomedicine* and *biomedical* to refer to western professional medicine and its reliance on the biological sciences but I should note that biomedicine is far from monolithic. It includes individual and collective actors beyond physicians, and physicians themselves differ by specialty, locale, and practice setting. Moreover, many biomedical actors embrace alternatives to the ‘biomedical model’ such as humanistic or holistic medicine (Engel, 1977; Gaines and Davis-Floyd, 2004; Good, 1998; Rose, 2007).

*Discourses: medicalization increases when biomedical vocabularies, models, and definitions become more prevalent in discourses about social problems*

(The discussion below refers only to increases in medicalization but, of course, medicalization can decrease as well.) Some key biomedical concepts include sign, symptom,

syndrome, disorder, disease, illness, pathogenesis, pathology, contagion, and 'normal function'. Some key features of the 'biomedical model' include scientism, mechanism, mind-body dualism, naturalism, individualism, biological reductionism, therapeutic activism, technocracy, and a preference for cure over prevention (Gaines and Davis-Floyd, 2004; Gordon, 1988; Hahn, 1996; Morgan, 1998). At the macro level, discourses about social problems can be found in the legislation, rulings, reports, and debates of national and international organizations such as government bureaucracies, courts, legislatures, corporations, markets, universities, journals, foundations, non-profit organizations, and the media. At the meso level, such discourses occur in the mission statements, reports, advertising, policies, and procedures of local and regional organizations such as workplaces, hospitals, medical groups, nursing homes, schools, social service agencies, and prisons. At the micro level, such discourses occur in face-to-face interaction between providers (physician and non-physician) and clients. Clients also use these discourses in their own self-management (for discussions of micro-level medical discourse, see Mishler, 1985; Scambler and Britten, 2001; Waitzkin, 1989, 1993).

***Practices: medicalization increases when biomedical practices and technologies become more prevalent in the administration of social problems***

Some of these practices include measurement, normalization, surveillance, risk assessment, medical insurance coverage, examination, lab tests, imaging, hygiene, surgery, and the use of pharmaceuticals and medical devices. As with discourses, these practices can be found at macro, meso, and micro levels of analysis. At the macro level, states may use biomedical practices such as examination, normalization, and surveillance to manage populations (Foucault, 1973, 1995). At the meso level, organizations may use biomedical practices to treat social problems and to gain legitimacy by mimicking medical organizational forms and settings (e.g. the fluorescent lights, wide halls, and hygiene of the hospital). At the micro level, providers (both biomedical and non-biomedical) and clients may use biomedical practices and technologies to treat social problems and to gain the legitimacy and status that such practices convey (McClean, 2003; Pinto, 2004).

***Identities (and actors): medicalization increases when (individual or collective) biomedical actors and identities become more prevalent, powerful or salient in addressing social problems***

Biomedical actors (individual and collective) include physicians, biomedical researchers, hospitals, insurance companies, drug and device makers, medical schools, and professional associations. Some collective actors or organizations are more biomedical than others (hospitals vs. birthing centers or hospices) (Ruef, 2000). And some provider identities are more biomedical than others (doctors vs. midwives). There is also variation among doctors in the degree to which they fulfill cultural expectations about what it means to be 'a doctor' through dress, behavior and the management of emotions (Hafferty, 1988; Lief and Fox, 1963; Light, 1979; Lutfey, 2005; Parsons, 1951). Clients can also construct biomedical identities such as 'patient', 'cancer survivor', 'high-risk', or 'healthy'. They may also use biomedical discourses and practices to construct and evaluate identities such as

‘parent’, ‘beautiful’, or ‘sexually potent’ (Clarke et al., 2003; Foucault, 1988, 1991; Rose, 2007). As with discourses and practices, these actors, identities and organizational forms may be mobilized at macro, meso and micro levels of analysis. At the macro level, biomedical actors (both individual and collective) may lead or advise states, corporations, universities, foundations, or the media. (I consider individuals to be macro-level actors when they act as representatives of macro-level organizations.) At the meso level, medicalization increases with the prevalence of biomedical organizational forms and identities and the power of doctors and other biomedical actors within organizations. At the micro level, medicalization increases when doctors and other biomedical actors (nurses, medical technicians) are more prevalent and when providers and clients construct or are defined by biomedical identities. In the next section, I demonstrate the utility of the typology by applying it to two key episodes in American abortion history.

## **The medicalization and demedicalization of abortion**

I examine the medicalization and demedicalization of abortion in the United States during two key periods – 1860–1900 and 1960–1973. Given space constraints, my accounts of these episodes are necessarily simplified and schematic but they help to demonstrate the utility of the typology for identifying various dimensions of medicalization and demedicalization.

## **The anti-abortion campaign of the late 19th century**

Before the civil war, most Americans believed that fetuses were not alive before ‘quickening’, the moment when the pregnant woman first felt the fetus move (at 16 to 21 weeks gestation).<sup>1</sup> Abortions before quickening were considered morally and legally unproblematic (and most people did not consider them to be abortions) while abortions after quickening were morally and legally proscribed. However, in the late 18th century many ‘regular’ (formally trained) physicians began to argue that fetuses were alive from the moment of conception, that fetal development was a continuous process, and that ‘quickening’ had no biological significance. During the last half of the 19th century, the regulars campaigned to enshrine this view in law (Gavigan, 1986; Luker, 1984; Mohr, 1978).

In the 19th century, when a woman missed her menstrual period it was considered the result of either pregnancy or ‘menstrual blockage’. But because there were no good tests for pregnancy (the first was developed in 1928), she did not know which was the case until quickening. Moreover, the methods for treating menstrual blockage and inducing abortion were identical. Women learned about drugs and techniques for ‘restoring the menses’ through folk traditions and home medical guides, and extensive advertising for mail-order medications. These sources often warned (though not always sincerely) against ‘abortion’ by which they meant the restoration of menstruation after quickening (Luker, 1984; Mohr, 1978; Reagan, 1997).

‘Regular’ and ‘irregular’ physicians provided treatment for menstrual blockage as well. Regulars (allopaths) were typically upper-class men trained in universities. Irregulars (homeopaths, herbalists, midwives, empirics, and druggists) were typically women or lower-class men with little or no formal training. Both regulars and irregulars



often called themselves physicians, doctors, or doctresses, but the regulars complained that the irregulars had no right to do so. Prior to 1870, the regulars were no more medically effective than their competitors. Both groups used many of the same remedies and the regulars often used more harmful ones. Most irregulars were willing to provide abortions both before and after quickening and often gained new permanent patients by doing so. Although many regulars, and especially their leaders, opposed abortion at all stages of pregnancy, some regulars still provided abortions in order to compete with irregulars, to preserve the health of their patients, or because they had no way of knowing for certain whether they were treating menstrual blockage or providing abortions (Burns, 2005; Luker, 1984; Mohr, 1978; Thomson, 1998).

Beginning in the late 1850s, regular leaders waged a successful campaign against abortion through the recently formed American Medical Association (AMA). Historian James C. Mohr (1978) argues that this was, in part, an attempt to discipline and professionalize their own ranks while depriving their competitors of a lucrative specialty. Because the regulars were unable to demonstrate their superiority to irregulars through clinical effectiveness, they sought to do so through opposition to abortion. They claimed scientific expertise about fetal development, derided the concept of 'quickening', and claimed ethical and moral superiority through their purported observance of the Hippocratic Oath (which proscribed abortion). They also defended traditional gender roles (including denying women entry into their ranks) and warned that the birth rate of native Protestants was falling behind that of Catholic immigrants. The regulars often accused women and immigrants of providing most abortions (Beisel and Kay, 2004; Burns, 2005; Luker, 1984; Mohr, 1978; Reagan, 1997; Thomson, 1998).

In 1860, abortion before quickening was legal in all but three of the 33 states, but by 1900, every state but Kentucky had prohibited abortion at all stages of pregnancy. Courts also began enforcing abortion laws more strictly. Most state abortion laws included a therapeutic exception that allowed regulars to perform abortions when they felt it was necessary to preserve the 'life' of a pregnant woman. But 'life' was not defined in the statutes, and it was often interpreted broadly to include physical and mental health. As a result, regular physicians had broad discretion over abortion provision and utilized widely varying definitions of what constituted proper grounds for abortion. Even the most ardent anti-abortion physicians resisted attempts to better specify this exception (Luker, 1984; US Public Health Service, 1970). Anthony Comstock's anti-obscenity movement dovetailed with the anti-abortion movement, and in 1873, he persuaded Congress to outlaw obscene and immoral literature and goods and this included abortion advertising and abortion medications not prescribed by a doctor (Burns, 2005; Luker, 1984; Mohr, 1978; Thomson, 1998).

The new laws both increased and decreased medicalization and did so through discourses, practices, and identities, and at multiple levels of analysis (see Table 2).<sup>2</sup>

## Discourses

The regulars increased the medicalization of abortion by claiming it as an object of special medical concern. They mobilized a 'scientific' discourse against deviations from women's traditional roles, arguing that women who pursued education, employment, birth

**Table 2.** Abortion medicalization and demedicalization, 1860–1900

	Macro	Meso	Micro
<i>Discourses</i>	<p><i>Medicalization.</i> Abortion becomes object of scientific/medical concern. Regulars argue that abortion damages women's health and that 'quickening' is not a scientific concept. Therapeutic exception constructs abortion as 'treatment' for 'illness'</p> <p><i>Demedicalization.</i> Non-physician abortions are no longer 'cures' for menstrual blockage but 'crimes'</p>	<p><i>Medicalization.</i> Medical schools teach students to oppose abortion</p>	<p><i>Medicalization.</i> Regulars 'diagnose' the 'medical necessity' of abortions</p>
<i>Practices</i>	<p><i>Demedicalization.</i> Abortion incidence decreases</p>		<p><i>Medicalization.</i> 'Medical' mode of abortion provision emerges</p>
<i>Identities (and actors)</i>	<p><i>Medicalization.</i> Opposition to abortion becomes part of the 'doctor' identity</p> <p><i>Demedicalization.</i> Abortion associated with the 'midwife' or 'abortionist' identity</p>		<p><i>Medicalization.</i> Physicians monopolize 'therapeutic' abortions. Many irregulars become regulars – increasing the number of abortions by 'regulars'</p> <p><i>Demedicalization.</i> Midwives and 'abortionists' provide 'criminal' abortions</p>

control, or abortion would damage their reproductive organs and capacities, their mental and physical health, their families, and their 'true' natures (Mohr, 1978; Thomson, 1998). Doctors also argued that 'quickening' was not a scientific concept and that the development of the fetus was a continuous process without identifiable stages. If there was a good reason to prohibit abortions late in pregnancy, the same reason applied to abortions late in pregnancy. This discourse substituted a scientific/medical account of pregnancy for one based in women's own experience. The regulars argued that quickening was merely a 'sensation' and criticized the reliance of abortion law enforcement on the subjective reports of pregnant woman (Reagan, 1997). The medical discourse also defined abortion as a 'treatment' for an 'illness'. The vast majority of abortions have always been sought by healthy women who do not wish to continue their pregnancies – in other words, for purposes of reproductive control – but the new laws pathologized women who sought abortions (Luker, 1984). Of course, such pathologization was not entirely new. As I discussed above, during the 19th century, many early 'abortions' were provided as a 'treatment' for menstrual blockage. But by the turn of the 20th century, most physicians began

treating the underlying causes of absent menstrual periods, such as poor general health, rather than directly stimulating menstruation (Stevens, 1903). 'Abortion' was no longer a treatment for menstrual blockage but the 'therapeutic exception' in the new abortion laws constructed abortion as a treatment for a *new* set of conditions, such as pernicious vomiting and heart disease, that threatened the life of the pregnant woman. The new discourses also medicalized abortion at the meso and micro levels. Regulars had gained control of most medical schools and now trained their students to oppose abortion. And regulars now 'diagnosed' the 'medical necessity' of abortions for their patients. While these new discourses increased medicalization, another new discourse reduced it. Regulars and irregulars had previously provided a 'cure' for menstrual blockage (pre- and post-quickening) but this 'cure' was now a 'crime'.

### *Practices*

Changes in abortion practice also increased the medicalization of abortion. Previously, physicians and non-physicians had used similar methods of inducing abortions but now a distinctly 'medical' mode of abortion provision emerged. During the mid-19th century both regulars and irregulars had relied mainly on herbal medications of limited efficacy. But toward the end of the 19th century, physicians became more willing to perform surgery and developed new abortion methods such as dilation and curettage that were both more effective and more dangerous than previous methods if performed with poor anti-septic technique, as was often the case. Midwives used both instruments and drugs but were more likely to use rubber catheters than curettes and were thus probably less dangerous than many physicians. Pregnant women who induced their own abortions continued to rely mainly on herbal methods and drugs obtained from pharmacists (Reagan, 1997). While new 'medical' abortion techniques increased the medicalization of abortion, a decline in the incidence of abortion after the passage of the new laws would reduce medicalization, since a medical procedure had become less frequent. Scholars disagree, however, whether the incidence of abortions actually declined (Mohr, 1978) or stayed the same (Luker, 1984; Reagan, 1997).

### *Identities*

Changes in the identities of doctors and abortion providers also increased the medicalization of abortion. Opposition to non-therapeutic abortions became a key part of the regulars' identity. And the regulars themselves had increased their numbers. After the regulars' professionalization campaign, most irregulars went out of business or joined the regulars. By 1900, 87 percent of physicians identified as regulars. Nine percent identified as homeopaths, but under pressure from the regulars, homeopaths had come out against abortion (at least in public). Midwives remained competitors however. They delivered half of the babies in Chicago and often provided abortions. Regulars claimed to be morally and scientifically superior to 'midwives', 'quacks', and 'abortionists' even though many regulars were still providing abortions. Regulars performed approximately half of all the non-self-induced abortions in turn-of-the-century Chicago (Reagan, 1997). At the micro level, physicians monopolized the provision of 'therapeutic' abortions. Because many former irregulars had now joined the regulars, there

were probably even more regulars providing abortions than before the laws changed. The therapeutic exception gave them wide discretion to provide abortions for reasons that went beyond the letter or spirit of the law. While the anti-abortion doctor identity and the monopoly of doctors over 'therapeutic' abortions increased medicalization, other identities decreased it. 'Illegal abortions' became identified with either the midwife or the 'the abortionist' – the debased physician who 'prostitutes his profession' (Reagan, 1997: 85). At the micro level, midwives performed large numbers of abortions and many women induced their own abortions. These abortions were not 'medical' or 'therapeutic' but 'criminal'.

## **Abortion reforms of the 1960s and early 1970s**

After the legal changes of the late 19th century, abortion faded from public discourse for almost 50 years. Doctors who interpreted abortion laws strictly and those who interpreted them liberally believed that the majority of their colleagues acted similarly. But in the late 1940s and 1950s, this false consensus began to break down. As medical care moved from home to hospital, abortion decisions became more visible. And as medical advances made pregnancy safer, abortions for mental health grounds outnumbered those for physical health grounds. Hospitals tried to deal with these changes by mobilizing the expertise of psychiatrists and establishing therapeutic abortion committees but these measures did not yield consensus. The committees, and individual psychiatrists, interpreted mental health grounds in widely varying ways and gradually broadened the criteria for approving abortions. This reflected both an expanding societal conception of health that went beyond the mere absence of illness and a concern that unwanted children might receive inadequate care (Imber, 1986; Lee, 2003; Luker, 1984; Reagan, 1997).

In the early 1960s, a coalition of lawyers, physicians, psychiatrists, and public health workers sought to remedy this situation through a campaign to reform 19th-century abortion laws. The American Law Institute (ALI) approved a model abortion statute that expanded abortion grounds to include physical and mental health, rape, statutory rape, incest, and fetal abnormality. The AMA was supportive of this effort but expressed concern about doctors' clinical autonomy. Association officials worried that new abortion laws might intrude on the doctor–patient relationship. They also worried that allowing abortions for 'non-medical' reasons such as economic hardship or for women's own reasons might cause women to 'expect' abortions – removing the necessity of diagnoses and turning doctors into 'mere technicians'. The AMA also sought to discourage abortion 'profiteers' who might provide 'abortion on demand' and bring the profession into disrepute. In order to ensure that individual providers would be supervised by their peers, the AMA called for abortions to be provided in hospitals rather than in freestanding clinics and supported the establishment of hospital abortion committees (Halfmann, 2003, forthcoming).

The state-level abortion campaign was modestly successful – ALI-style reforms were enacted in about a dozen states. But soon after these reforms, the initial reformers and feminist groups argued that they did not go far enough. They called for 'abortion on demand' and the repeal of all abortion laws, including ALI-style ones. In 1969, the repeal movement achieved its first victories as courts struck down abortion laws in California and the District of Columbia. The next year, Hawaii, New York, Alaska, and Washington

repealed their abortion laws by legislation or referendum. Hospitals and clinics in New York, the District of Columbia, and California soon provided nearly 90 percent of the nation's legal abortions (Burns, 2005; Garrow, 1994; Joffe, 1995; Lader, 1973; Luker, 1984). In that same year, the AMA appeared to back away from its earlier opposition to 'abortion on request' (Halfmann, forthcoming).

The repeal movement's final victory came in January 1973, when the Supreme Court handed down the *Roe v. Wade* (410 US 113 (1973)) and *Doe v. Bolton* (410 US 179 (1973)) decisions. By a vote of seven to two, the Court struck down Texas's 19th-century statute and Georgia's ALI-style one, and with them the statutes of every state. In *Roe*, the Court found that during the first trimester of pregnancy the abortion decision was between the pregnant woman and her doctor. In the period between the end of the first trimester and viability, the State could regulate abortion to protect maternal health. After viability, the State could regulate, and even prohibit, abortion to protect 'the potentiality of human life' but such regulation must make an exception for the life or health of the pregnant woman (*Roe v. Wade*: 164–165). The Court also struck down Georgia's requirements that abortions be provided only in hospitals and that they be approved by a hospital abortion committee, enabling abortion provision in freestanding clinics.

The Supreme Court's abortion rulings both increased and decreased medicalization and did so through discourses, practices, and identities, and at multiple levels of analysis (see Table 3).

**Table 3.** Abortion medicalization and demedicalization, 1960–1973

	Macro	Meso	Micro
<i>Medicalization</i>			
<i>Discourses</i>	<p><i>Medicalization.</i> Supreme Court utilizes medical discourses: medical autonomy, the doctor–patient relationship, and the mental health consequences of unwanted pregnancies. Court rests abortion decision making with both the woman and her doctor and envisions continued medical gatekeeping. Court retains 'therapeutic exception' for late abortions. Court uses 'mortality risk' to justify prohibition on state regulation during first trimester</p> <p><i>Demedicalization.</i> Court reduces medical gatekeeping for early abortions – abortions available 'on request' without requirement of medical necessity and without approval of multiple doctors or hospital committees. 'Medical-humanitarian' discourse replaced by 'women's rights' and 'fetal rights' discourses</p>	<p><i>Demedicalization.</i> Feminist abortion clinics utilize demedicalization discourse</p>	<p><i>Demedicalization.</i> Abortion providers no longer require women to provide reasons for early abortions</p>

**Table 3.** (Continued)

	Macro	Meso	Micro
<i>Practices</i>	<i>Medicalization.</i> Abortion incidence increases	<i>Demedicalization.</i> Feminist abortion clinics run by non-medical personnel and promote client empowerment	<i>Demedicalization.</i> Feminist abortion providers and counselors challenge hierarchical norms of medical interaction. Vacuum aspiration and local anesthesia allow outpatient abortions in clinics
<i>Identities (and actors)</i>	<i>Demedicalization.</i> Court allows abortions in freestanding clinics. 'Abortion providers' stigmatized as low-skill 'profiteers'	<i>Medicalization.</i> Number of hospitals providing abortions and number of abortions in hospitals increases  <i>Demedicalization.</i> Freestanding clinics, divorced from mainstream medicine, provide most abortions	<i>Medicalization.</i> Provision by doctors replaces most provision by non-medical providers  <i>Demedicalization.</i> 'Abortion counselors' serve 'clients' and 'partners' rather than 'patients'

### Discourses

The Court's rulings increased the medicalization of abortion in several ways. The Court justified access to abortion in terms of privacy rights but also in terms of various medical discourses: the clinical autonomy of doctors, the sanctity of the doctor–patient relationship, and the 'psychological harm' suffered by women who gave birth to and cared for an unwanted child (Halfmann, forthcoming; Lee, 2003: 164). The Court was also equivocal about whether the power of abortion decision making rested mainly with women patients or with doctors. *Roe*'s first reference to abortion decision making located this power with both the pregnant woman and her doctor but all subsequent references, including the final summation of the holding, referred only to the doctor: 'The abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician' (*Roe v. Wade*: 165–166). The opinion also seemed to envision a continued gatekeeping role for physicians. It warned doctors not to abuse 'the privilege of exercising proper medical judgment' and the opinion's author, Justice

Blackmun, planned to issue a statement stressing that the Court had not authorized ‘abortion on demand’ but chose not to, perhaps because Chief Justice Burger had made a similar statement in his concurrence (Garrow, 1994: 587; Greenhouse and Siegel, 2010; Savage, 2005). The Court also maintained the ‘therapeutic exception’ for late abortions and, in *Doe*, broadened the range of ‘illnesses’ for which such abortions were a permissible treatment – an instance of the ‘expansion of medicalized categories’ (see Conrad and Potter, 2000). The Court’s distinction between the regulation of first and second trimester abortions was also justified through medical discourse – states could not regulate first trimester abortions because they had a lower mortality rate than childbirth (Halfmann, forthcoming). But the Court’s discourse also reduced medicalization in several ways. The Court reduced medical gatekeeping for early abortions. Such gatekeeping had three main dimensions: Who authorized abortions – doctors, hospital committees, or patients themselves? Why were they authorized – for physical or mental health, fetal abnormality, rape or incest, or for women’s own reasons? And where were they provided – in hospitals (where doctors could supervise their peers) or in freestanding clinics? The Court reduced medical gatekeeping for early abortions on all of these dimensions, allowing early abortions for women’s own reasons without a requirement of medical necessity, and authorizing abortions outside of hospitals as long as a single doctor agreed to provide them (Halfmann, forthcoming). The Court’s rulings also reduced medicalization because the extension of privacy rights to abortion helped re-define the debate from a medical-humanitarian discourse prominent during the state-level reform campaigns to a discourse focused on the contest between ‘women’s rights’ and ‘fetal rights’ (Burns, 2005). Finally, at the micro level, abortion providers no longer required women to provide statutorily specified medical reasons for their abortions.

### *Practices*

Changes in abortion practice also increased the medicalization of abortion. By broadening the grounds for abortion, the Court increased the incidence of a medical procedure. The number of legal abortions rose from 23,000 in 1969 to 745,000 in 1973 (Centers for Disease Control and Prevention, 1980; Jones et al., 2008). But other changes in abortion practice reduced medicalization. Feminist clinics and their staffs challenged standard medical organizational and interactional practices. The clinics were typically led by non-medical personnel and sometimes explicitly excluded doctors from clinic decision making. They also stressed educating women patients, including them in decision making, and treating them as ‘clients’ or ‘partners’ rather than patients (Joffe et al., 2004; Ruzek and Becker, 1999). In addition, the outpatient abortions provided by the clinics were aided by the development of new abortion techniques, vacuum aspiration, and local anesthesia, that eliminated the need for overnight hospital stays.

### *Identities*

Changes in the collective and individual identities of abortion providers also increased the medicalization of abortion. The number of hospitals providing abortions and the number of abortions in hospitals increased (Rosenberg, 1995). In addition, most states

restricted abortion provision to licensed physicians. As a result, abortion provision by doctors increased markedly while self-induced abortions and abortions by non-medical providers virtually disappeared. But changes in the identities of providers also reduced medicalization. The majority of legal abortions moved from hospitals to free-standing single-purpose clinics segregated from mainstream medicine. Approximately a third of these clinics were non-profit organizations established by feminist and family planning organizations (Goldstein, 1984a, 1984b; Henshaw, 1982; Lindheim, 1979). In 1972, clinics and hospitals each provided approximately half of abortions, but the percentage of clinic abortions increased approximately 5 percent per year, reaching 75 percent in 1978, and currently standing at 95 percent (Jones et al., 2008; Rosenberg, 1991). Many of the feminist clinics explicitly embraced a discourse of demedicalization. The segregation of abortion services from mainstream medicine also created a new identity, the 'abortion provider' who was often portrayed as a low-skilled 'profiteer' and who retained some of the earlier stigma of 'the abortionist' among his or her colleagues (Freedman, 2010; Joffe, 1995, 2009). Finally, feminist clinics introduced another new identity – 'the abortion counselor' – a woman who guided the patient through the process, provided emotional support, and monitored the doctor's performance.

## Discussion

In the section above, I used my typology of medicalization to identify more than a dozen instances of medicalization or demedicalization for each period of abortion policy making along multiple dimensions and levels of analysis. I also showed that medicalization and demedicalization occurred simultaneously. This analysis contrasts with those of other scholars who have examined the medicalization and demedicalization of abortion during these periods. For the 19th century, Burns (2005), Luker (1984) and Thomson (1998) argue that the regulars' anti-abortion campaign and the new state abortion statutes involved medicalization because they made abortion an issue of scientific-medical concern and constructed abortion as a treatment for illness. Riessman (1983: 9) agrees about the regulars' campaign but argues that the new abortion laws *demedicalized* abortion because they criminalized it. Conrad and Schneider (1980a: 1) view the period not as medicalization but as 'medical involvement in deviance definitions' (also see 1980a: 267n). For the 1960s and 1970s, Conrad and Schneider (1980a: 254n) and Riessman (1983: 9) argue that the Supreme Court's abortion decisions involved medicalization but do not explain why this is so. Imber (1986) argues that the broadening of medical indications for abortion constituted medicalization while the provision of abortions for women's own reasons constituted demedicalization. Joffe (1986, 1995; Joffe et al., 2004) argues that the Court's medical justifications for the abortion rulings involved medicalization but that freestanding clinics reduced medicalization by divorcing abortion from mainstream medicine and challenging medical interaction norms. Finally, Burns (2005) sees the period as demedicalization. The state-level abortion reforms of the late 1960s involved a narrow 'medical-humanitarian frame' but with the 1970 state abortion law repeals this frame broke down and was replaced by a struggle between 'women's rights' and 'fetal rights' frames.



The analyses of the medicalization and demedicalization of abortion leave much to be desired. Most conceptualize medicalization as a category rather than a value. Instead of assessing whether particular developments increased or decreased medicalization, they assess whether abortion was 'medicalized' or 'demedicalized' at a particular time. As a result, most argue that a given episode constituted either medicalization or demedicalization but not both. A few recognize that both processes occurred simultaneously but even these identify only one or two instances of medicalization or demedicalization while missing many others. Finally, most of these studies focus mainly on changes in macro discourses, while ignoring changes in practices and identities and changes at the meso and micro levels.

## Conclusion

Over the past three decades, hundreds of studies have identified instances of medicalization and demedicalization and provided rich insights into the causes and consequences of these processes. There will doubtless be hundreds more studies to come. But those studies will be richer, and contribute more to cumulative knowledge and theory building, if they are sensitive to the complexity and dynamism of medicalization and demedicalization and consider these processes in their many dimensions – discourses, practices, and identities – and at multiple levels of analysis.

Identifying increases and decreases in medicalization is important for a few reasons. First, a central goal of the medicalization literature is to identify the causes of medicalization and demedicalization. Scholars have debated such factors as 'medical imperialism', inter and intra-professional rivalry, capitalism, patriarchy, technocracy, secularization, and social control, to name but a few (Clarke et al., 2003; Conrad, 1992, 2005, 2007; De Swaan, 1988; Foucault, 1988, 1991, 1995; Freidson, 1970; Illich, 1977; Lupton, 1997; Rose, 2006; Starr, 1982; Zola, 1972). They have also debated causes of demedicalization, such as social movements (of patients, women, gays and lesbians, people with disabilities, and proponents of alternative medicine) and critiques by social scientists, journalists, and physicians (Conrad, 2007, 2008; Fox, 1977; Hislop and Arber, 2003; Kurz, 1987; Lee, 2003; Lowenberg and Davis, 1994; McLeod et al., 2004; Williams and Calnan, 1996). These debates will no doubt continue, but before scholars can determine the causes of medicalization and demedicalization, they must be able to fully identify those processes. Moreover, it is quite possible that the causal factors driving medicalization and demedicalization vary over different dimensions of medicalization and at different levels of analysis.

Second, when analysts examine only a few dimensions of the medicalization of a social problem, they often mistake the part for the whole and thus disagree about whether the social problem as a whole is 'medicalized' or 'demedicalized'. As I showed above, this error characterized analyses of the abortion issue – scholars examined the same events but could not agree whether they constituted medicalization or demedicalization. Some readers might object that the approach offered here makes it impossible to aggregate the multiple dimensions of medicalization and demedicalization in order to determine whether the medicalization of a social problem as a whole has increased or decreased. One way to address this issue would be for analysts to

weight different instances of medicalization and demedicalization according to the analyst's main theoretical concerns, for example, the balance of power between doctors and patients, or women and men, or the differing ways that welfare states address social problems. Different theoretical concerns will result in different assessments of which aspects of medicalization or demedicalization are most consequential. This may appear to resemble the approach that I criticize here in which the analyst attends only to some dimensions and levels of medicalization while ignoring others. There is an important difference though. The analysts that I criticize focus on certain instances of medicalization because these are all that they see. The typology, by contrast, helps the analyst to identify all or most instances of medicalization and then make intentional theoretical *choices* about which of these to emphasize.

Third, existing conceptualizations of medicalization dramatically understate the prevalence of *demedicalization*. Medicalization probably does outweigh demedicalization but the extant literature gives the impression that demedicalization is virtually nonexistent. The literature gives lip service to the possibility of demedicalization while ignoring it in practice. The abortion case suggests that medicalization is often accompanied by demedicalization. Such incomplete medicalization may provide opportunities for resistance or, alternatively, disguise the degree of medicalization by making it appear that both processes are occurring in equal measure. Finally, the existing literature on medicalization focuses too much on macro-level discourses. As this article has shown, practices and identities are also important carriers of medicalization and medicalization also occurs at the meso and micro levels.

Finally, scholars of medicalization and demedicalization have typically sought to assess the normative implications of these processes. But such assessments are only possible when these processes are viewed in their full complexity. The medicalization of abortion sometimes resulted in higher quality and more available abortion services, legitimated claims to abortion, and reduced legal sanctions and stigma. At the same time, it gave (often male) doctors power over women seeking abortions. For much of the 19th and 20th century, abortions had to be approved by doctors for reasons of medical necessity. This denied women the power to have abortions for their own reasons – an affront to their rights of bodily self-determination and their ability to participate in the polity as ‘independent individuals’ (i.e. citizens) (Orloff, 1993). Beginning in the 1970s, women could obtain early abortions on request, without a requirement of medical necessity, but doctors still had the power to refuse abortion provision and most did so. The construction of abortion as a medical issue also tended to individualize abortion and obscure its social context. Issues such as the prevention of unwanted pregnancies, the availability of sex education and contraception, and unequal responsibilities for childrearing were left unaddressed (Sheldon, 1997). The demedicalization of abortion also had mixed results. It promoted less hierarchical provider–client interactions but also increased providers' susceptibility to protest and harassment because they were isolated from legitimating biomedical institutions. Abortion rights supporters were often ambivalent about both medicalization and demedicalization. They saw benefits and costs to both but these were difficult to assess and changed over time and across different contexts (see Joffe et al., 2004).

Future researchers might apply the typology offered here to other cases of medicalization and demedicalization in order to determine if these cases are equally multi-faceted,

if medicalization occurs simultaneously with demedicalization, and if different causal factors drive medicalization along its different dimensions and levels of analysis. Some promising sites for such research include other aspects of abortion policy such as federal insurance funding of poor women's abortions, biomedical discourses on fetal pain and post-abortion syndrome, the rise of 'crisis pregnancy centers' modeled after medical organizations, the rise in pharmaceutical abortions, the relationship between amniocentesis and abortion, and the use of ultrasound images in antiabortion activism. Some other promising sites include social problems where scholars cannot agree whether medicalization is increasing or decreasing or both. Some examples include sexuality, menopause, childbirth, sleep, disability, homosexuality, drug use, obesity, eating disorders, self-injury, gambling, and healthism (Adler and Adler, 2007; Conrad, 2007; Lowenberg and Davis, 1994; Sobal, 1995).

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### Notes

- 1 At the time, it was believed that quickening (when the pregnant woman first feels fetal movement) was the first moment of fetal movement but with the development of ultrasound, doctors discovered that fetuses move as early as seven weeks gestation though the pregnant woman does not feel movement until 16–21 weeks gestation.
- 2 In the 19th century, medicalization or demedicalization occurred in every cell except for meso practices and identities. This was because, both before and after the enactment of the new laws, abortions were typically provided in homes or physicians' offices. With little change at the meso level, there was little medicalization or demedicalization at that level.

### References

- Adler PA and Adler P (2007) The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography* 36(5): 537–570.
- Beisel N and Kay T (2004) Abortion, race, and gender in nineteenth-century America. *American Sociological Review* 69(4): 498–518.
- Burns G (2005) *The Moral Veto: Framing Contraception, Abortion, and Cultural Pluralism in the United States*. Cambridge, England & New York: Cambridge University Press.
- Centers for Disease Control and Prevention (1980) *Abortion Surveillance Report, 1978*. Atlanta, GA: US Department of Health and Human Services.
- Clarke AE, Mamo L, Fishman JR, Shim JK and Fosket JR (2003) Biomedicalization: Technoscientific transformations of health, illness and biomedicine. *American Sociological Review* 68(2): 161–194.

- Conrad P (1975) The discovery of hyperkinesia: Notes on the medicalization of deviance. *Social Problems* 23(1): 12–21.
- Conrad P (1992) Medicalization and social control. *Annual Review of Sociology* 18: 209–232.
- Conrad P (2005) The shifting engines of medicalization. *Journal of Health and Social Behavior* 46(1): 3–14.
- Conrad P (2007) *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press.
- Conrad P (2008) Contestation and medicalization. In: Teghtsoonian K, Moss P (eds) *Contesting Illness: Processes and Practices*. Toronto: University of Toronto Press, 323–336.
- Conrad P and Potter D (2000) From hyperactive children to ADHD adults: Observations on the expansion on medical categories. *Social Problems* 47(4): 559–582.
- Conrad P and Schneider JW (1980a) *Deviance and Medicalization: From Badness to Sickness*. St Louis, MO: Mosby.
- Conrad P and Schneider JW (1980b) Looking at levels of medicalization: A comment on Strong's critique of medical imperialism. *Social Science & Medicine* 14(1): 75–79.
- Davis JE (2006) How medicalization lost its way. *Society* 43(6): 51–56.
- Davis JE (2009) Medicalization, social control and the relief of suffering. In: Cockerham WC (ed.) *The New Blackwell Companion to Medical Sociology*. Malden, MA: Blackwell Publishers, 211–241.
- De Swaan A (1988) *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era*. Oxford: Polity Press.
- Engel GL (1977) The need for a new medical model: A challenge for biomedicine. *Science* 196(4286): 129–136.
- Foucault M (1973) *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Pantheon Books.
- Foucault M (1988) *Care of the Self: The History of Sexuality, Volume III*. New York: Vintage Books.
- Foucault M (1991) Governmentality. In Burchell G, Gordon C and Miller P (eds) *The Foucault Effect: Studies in Governmentality*. London: Harvester Wheatsheaf, 87–104.
- Foucault M (1995) *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.
- Fox R (1977) The medicalization and demedicalization of American society. *Daedalus* 106(1): 9–22.
- Freedman L (2010) *Willing and Unable: Doctors' Constraints in Abortion Care*. Philadelphia, PA: Temple University Press.
- Freidson E (1970) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. New York: Dodd, Mead & Company.
- Gaines AD and Davis-Floyd R (2004) On biomedicine. In: Ember C, Ember M (eds) *Encyclopedia of Medical Anthropology*. New Haven, CT: Yale University Press, 95–109.
- Garrow DJ (1994) *Liberty and Sexuality: The Right to Privacy and the Making of Roe v. Wade*. New York: Macmillan.
- Gavigan SAM (1986) On 'bringing on the menses': The criminal liability of women and the therapeutic exception in Canadian abortion law. *Canadian Journal of Women and the Law* 1(2): 279–312.
- Goldstein MS (1984a) Abortion as a medical career choice: Entrepreneurs, community physicians, and others. *Journal of Health and Social Behavior* 25(2): 211–229.
- Goldstein MS (1984b) Creating and controlling a medical market: Abortion in Los Angeles after liberalization. *Social Problems* 31(5): 514–529.
- Good MJDV (1998) *American Medicine: The Quest for Competence*. Berkeley, CA: University of California Press.

- Gordon D (1988) Tenacious assumptions in western medicine. In: Lock M, Gordon D (eds) *Biomedicine Examined*. Dordrecht: Kluwer Academic Publishers, 19–56.
- Greenhouse L and Siegel R (eds) (2010) *Before Roe v. Wade: Voices that Shaped the Abortion Debate Before the Supreme Court's Ruling*. New York: Kaplan Publishing.
- Hafferty FW (1988) Cadaver stories and the emotional socialization of medical students. *Journal of Health and Social Behavior* 29(4): 344–356.
- Hahn RA (1996) *Sickness and Healing: An Anthropological Perspective*. New Haven, CT: Yale University Press.
- Halfmann D (2003) Historical priorities and the responses of doctors' associations to abortion reform proposals in Britain and the United States, 1960–1973. *Social Problems* 50(4): 567–591.
- Halfmann D (Forthcoming) *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain and Canada*. Chicago, IL: University of Chicago Press.
- Henshaw SK (1982) Freestanding abortion clinics: Services, structure, fees. *Family Planning Perspectives* 14(5): 248–256.
- Hislop J and Arber S (2003) Understanding women's sleep management: Beyond medicalization-healthification? *Sociology of Health and Illness* 25(7): 815–837.
- Illich I (1977) *Limits to Medicine: Medical Nemesis: The Expropriation of Health*. Harmondsworth & New York: Penguin.
- Imber JB (1986) *Abortion and the Private Practice of Medicine*. New Haven, CT: Yale University Press.
- Joffe CE (1986) *The Regulation of Sexuality: Experiences of Family Planning Workers*. Philadelphia, PA: Temple University Press.
- Joffe CE (1995) *Doctors of Conscience: The Struggle to Provide Abortion: Before and After Roe v. Wade*. Boston, MA: Beacon Press.
- Joffe CE (2009) *Dispatches from the Abortion Wars: The Costs of Fanaticism to Doctors, Patients and the Rest of Us*. Boston, MA: Beacon Press.
- Joffe CE, Weitz TA and Stacey CL (2004) Uneasy allies: Pro-choice physicians, feminist health activists and the struggle for abortion rights. *Sociology of Health and Illness* 26(6): 775–796.
- Jones RK, Zolna MR, Henshaw SK and Finer LB (2008) Abortion in the United States: Incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health* 40(1): 6–16.
- Kurz D (1987) Emergency department responses to battered women: Resistance to medicalization. *Social Problems* 34(1): 69–81.
- Lader L (1973) *Abortion II: Making the Revolution*. Boston, MA: Beacon Press.
- Lee E (2003) *Abortion, Motherhood, and Mental Health: Medicalizing Reproduction in the United States and Great Britain*. New York: Aldine de Gruyter.
- Lief HI and Fox RC (1963) Training for 'detached concern' in medical students. In: Lief HI, Lief NR (eds) *The Psychological Basis of Medical Practice*. New York: Harper & Row, 12–35.
- Light D (1979) Uncertainty and control in professional training. *Journal of Health and Social Behavior* 20(4): 310–322.
- Lindheim BL (1979) Services, policies and costs in U.S. abortion facilities. *Family Planning Perspectives* 11(5): 283–289.
- Lowenberg JS and Davis F (1994) Beyond medicalisation–demedicalisation: The case of holistic health. *Sociology of Health and Illness* 16(5): 579–599.
- Luker K (1984) *Abortion and the Politics of Motherhood*. Berkeley, CA: University of California Press.
- Lupton D (1997) Foucault and the medicalisation critique. In: Petersen A, Bunton R (eds) *Foucault, Health and Medicine*. London: Routledge, 94–110.
- Lutfey K (2005) On practices of 'good doctoring': Reconsidering the relationship between provider roles and patient adherence. *Sociology of Health and Illness* 27(4): 421–447.

- McClellan S (2003) Doctoring the spirit: Exploring the use and meaning of mimicry and parody at a healing centre in the North of England. *health*: 7(4): 483–500.
- McLeod JD, Pescosolido BA, Takeuchi DT and White TF (2004) Public attitudes toward the use of psychiatric medications for children. *Journal of Health and Social Behavior* 45(1): 53–67.
- Mishler EG (1985) *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, NJ: Ablex Pub.
- Mohr JC (1978) *Abortion in America: The Origins and Evolution of National Policy*. New York: Oxford University Press.
- Morgan KP (1998) Contested bodies, contested knowledges: Women, health, and the politics of medicalization. In: Sherwin S (ed.) *The Politics of Women's Health: Exploring Agency and Autonomy*. Philadelphia, PA: Temple University Press, 83–122.
- Orloff AS (1993) Gender and the social rights of citizenship: The comparative analysis of gender relations and welfare states. *American Sociological Review* 58(3): 303–328.
- Parsons T (1951) *The Social System*. Glencoe, IL: Free Press.
- Pinto S (2004) Development without institutions: Ersatz medicine and the politics of everyday life in rural north India. *Cultural Anthropology* 19(3): 337–364.
- Reagan LJ (1997) *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867–1973*. Berkeley, CA: University of California Press.
- Riessman CK (1983) Women and medicalization: A new perspective. *Social Policy* 14(1): 3–18.
- Rose NS (2006) *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.
- Rose NS (2007) Beyond medicalisation. *The Lancet* 369(9562): 700–702.
- Rosenberg GN (1991) *The Hollow Hope: Can Courts Bring about Social Change?* Chicago, IL & London: University of Chicago Press.
- Rosenberg GN (1995) The real world of constitutional rights: The supreme court and the implementation of the abortion decisions. In: Epstein L (ed.) *Contemplating Courts*. Washington, DC: Congressional Quarterly Press, 390–419.
- Ruef M (2000) The emergence of organizational forms: A community ecology approach. *American Journal of Sociology* 106(3): 658–714.
- Ruzek SB and Becker J (1999) The women's health movement in the United States: From grassroots activism to professional agendas. *Journal of the American Medical Women's Association* 54(1): 4–9.
- Savage DG (2005) Roe Ruling: More Than Its Author Intended. *Los Angeles Times*, 14 September: A1.
- Scambler G and Britten N (2001) System, lifeworld and doctor–patient interaction. In: Scambler G (ed.) *Habermas, Critical Theory and Health*. London: Routledge, 45–67.
- Sheldon S (1997) *Beyond Control: Medical Power and Abortion Law*. London: Pluto Press.
- Sobal J (1995) The medicalization and demedicalization of obesity. In Maurer D, Sobal J (eds) *Eating Agendas: Food and Nutrition as Social Problems*. Hawthorne: Aldine de Gruyter, 67–90.
- Starr P (1982) *The Social Transformation of American Medicine*. New York: Basic Books.
- Stevens AA (1903) *Modern Materia Medica and Therapeutics*. Philadelphia, PA: WB Saunders.
- Strong PM (1979) Sociological imperialism and the profession of medicine: A critical examination of the thesis of medical imperialism. *Social Science & Medicine* 13A(2): 199–213.
- Thomson M (1998) *The Doctor, the Profession, His Patient and Her Abortion. Reproducing Narrative: Gender, Reproduction and Law*. Hants, England: Ashgate.
- US Public Health Service (1970) *Family Planning Evaluation. Abortion Surveillance Report – Legal Abortions, United States, Annual Summary, 1970*. Atlanta, GA: US Public Health Service, Center for Disease Control, Department of Health, Education and Welfare.

- Waitzkin H (1989) A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior* 30(2): 220–239.
- Waitzkin H (1993) *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*. New Haven, CT: Yale University Press.
- Williams SJ and Calnan M (1996) The ‘limits of medicalization?’: Modern medicine and the lay populace in ‘late modernity’. *Social Science & Medicine* 42(12): 1609–1620.
- Zola IK (1972) Medicine as an institution of social control. *Sociological Review* 20(4): 487–504.

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