

# Historical Priorities and the Responses of Doctors' Associations to Abortion Reform Proposals in Britain and the United States, 1960–1973

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*In the 1960s and early 1970s, policy-makers in Britain and the United States considered proposals to make abortions more readily available. The main doctors' associations in each country responded differently to these proposals. Doctors' associations in both countries initially sought to preserve clinical autonomy by ensuring that doctors could continue to "diagnose" the "medical necessity" of abortions. However, the American Medical Association (AMA) eventually changed its position to allow abortion on request. The study explains this difference by way of an "historical priorities" approach to analyzing the construction of collective political demands. It argues that "policy legacies" provide contexts in which collective actors prioritize among their policy desires. The study finds that because of differing health care policy legacies British doctors' associations viewed abortion clinical autonomy as a higher priority than did the AMA. Moreover, British doctors' associations were most concerned about patient infringements on clinical autonomy, while the AMA was equally concerned about state infringements on autonomy.*

In the 1960s and early 1970s, policy-makers in Britain and the United States considered, and eventually enacted, abortion reform proposals that sought to make abortions more readily available. The responses of major doctors' associations to these proposals differed markedly.<sup>1</sup> Both the British Medical Association (BMA) and the American Medical Association (AMA) initially sought to preserve their power to "diagnose" the "medical necessity" of abortions and, as a result, opposed both abortion on request and abortion for grounds of economic hardship. However, in 1970, the AMA appeared to abruptly reverse its position. In this study, I attempt to explain this difference. I ask: why, after doctors' associations in both countries had opposed abortion on request and for economic hardship, did the AMA eventually support such a policy?

I do not attempt to explain differences in the abortion *reforms* themselves, but instead differences in the *responses of doctors' associations to reform proposals*. These differing responses are important because they were key determinants of the abortion reforms that were eventually enacted, and because they contributed to differing abortion rights discourses—a discourse on

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1. In the interest of readability, I use the word "doctors" throughout the article. By this I mean doctors of medicine.

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the right to health in Britain and a discourse on the right to control one's body in the United States (Hindell and Simms 1971; O'Connor, Orloff, and Shaver 1999b; Rubin 1987).

To answer the question posed above, I develop what I call an "historical priorities" approach in which policy legacies provide contexts for collective actors to prioritize among their policy desires. The approach contributes to literatures on "policy legacies" (Esping-Andersen 1990; Hall 1986; Pierson 1994; Skocpol 1992; Weir 1992) and "demand formation" (Immergut 1992a; Skocpol 1992; Steinmo 1993) in political sociology and political science.

The study begins with an outline of policy legacy and institutionalist demand formation arguments and then describes ways in which the historical priorities approach improves upon them. It proceeds with a description of the data and methods. It then describes the ways in which abortion reforms threatened doctors' clinical autonomy, and outlines the abortion reforms that were enacted in each country. Finally, an account of relevant events and actors shows the utility of the historical priorities approach for explaining the differing demands of doctors' associations on the abortion issue.

## **Policy Legacies, Demand Formation, and Historical Priorities**

### ***Policy Legacies***

Policy legacy arguments suggest that earlier policies have legacies that importantly affect later ones (see Amenta 1998; Bonastia 2000; Esping-Andersen 1990; Hacker 1998; Hall 1986, 1989; Hecló 1974; Hicks and Misra 1993; Huber, Ragin, and Stephens 1993; Kaufman 1998; Pedriana and Stryker 1997; Pierson 1992, 1994; Skocpol 1992; Steinmo, Thelen, and Longstreth 1992; Weir 1992). For example, Theda Skocpol (1992) argues that corrupt administration of Civil War pensions caused Progressive-era reformers to shy away from a general system of old-age pensions because they didn't think that the state was capable of administering them honestly. Policy legacies can affect actors' resources, incentives, cognitions, emotions, or access to information (Goodwin, Jasper, and Polleta 2000; Pierson 1994; Walsh 1981). They can also affect actors' normative beliefs about the legitimacy of practices, forms of organization, and organizations themselves (Skocpol 1992; Skrentny 1998).

### ***Demand Formation***

Institutionalist demand formation arguments rightly criticize interest-based and rational choice theories of policy-making because such theories assume *a priori* the "interests" and policy desires of political actors. Instead, institutionalists contend that policy desires and perceived interests are historically constructed, dynamic, and strongly influenced by institutions (Dobbin 1994; Dowding and King 1995; Gusfield 1981; Hall 1986; Hathaway 1998; Immergut 1992b; March and Olsen 1984; Skocpol 1992; Steinmo 1993; Wildavsky 1987). (For reviews see Clemens 1997; Hall and Taylor 1996; Immergut 1998; March and Olsen 1989; Myles and Quadagno 2002; Steinmo, Thelen, and Longstreth 1992.) For example, Sven Steinmo (1989) argues that the fragmented, open American political system allowed interest groups to seek narrow, particularistic tax exemptions, while Britain's centralized political system required interest groups to form coalitions pursuing broader, generalized tax reforms.

### ***Historical Priorities***

The historical priorities approach builds on both policy legacy and demand formation theories. It contributes to the policy legacy literature by identifying an additional mechanism by which policy legacies affect collective actors. Policy legacies not only affect the resources,

incentives, cognitions, and legitimacy norms of collective actors, but also create multi-issue spaces and affect the priorities that collective actors construct within those spaces. The historical priorities approach contributes to demand formation theories because it examines actors' policy desires on more than one issue and because it focuses on the ways in which institutions (including policy legacies) affect actors' *priorities* among those policy desires.<sup>2</sup> In a typical institutionalist demand formation argument, the differing institutions of two countries cause interest groups to construct different desires on a particular policy. In the historical priorities approach, by contrast, interest groups in the two countries may have the same desires on a particular policy, but differing institutions cause the groups to prioritize differently among those desires.

To put it another way, most work on demand formation asks: Did this group desire this policy? The historical priorities approach asks: *How much* did this group desire this policy in comparison with other possible policies in a multi-issue space? And what is the nature of that space? Thus, the historical priorities approach attends to multiple issues and distinguishes between policy desires, priorities, and demands. Policy desires are the outcomes that actors would pursue if there were no opportunity costs. Policy priorities are a ranking of multiple policy desires given the existence of such costs. Policy demands are articulated claims that are a function of policy desires and policy priorities. (For a similar argument on the relationship between policy demands and attention, see Jones 1994.)

## Data and Methods

The study relies on a combination of primary and secondary data sources. Primary sources date from 1960 to 1973. The main primary sources include internal debates and policy statements of the AMA, the BMA, and the Royal College of Obstetricians and Gynaecologists (RCOG), as well as confidential telephone interviews that I conducted in 2002 with five of the few living key decision-makers from the 1960s AMA. The study also utilizes articles from medical journals and the medical press—the *British Medical Journal*, *Lancet*, the *Journal of the American Medical Association*, the *New England Journal of Medicine*, *American Medical News*, *Medical World News*, and *Modern Medicine*.<sup>3</sup> Finally, the study relies on newspaper and magazine articles, the records and reports of social movement and governmental organizations, and first-hand accounts by prominent abortion activists such as Lawrence Lader (1973) and Dr. Bernard Nathanson (1979) of the National Association for the Repeal of Abortion Laws (NARAL), Dr. Alan Guttmacher (1972) of the Planned Parenthood Federation (U.S.), Lucinda Cisler (1970) of the National Organization for Women, Keith Hindell and Madeline Simms (1971), and Dr. Peter Diggory (Potts, Diggory, and Peel 1977), leaders of Britain's Abortion Law Reform Association (ALRA).

The study also utilizes secondary evidence—several of the many excellent historical works on American and British abortion politics and policy. Here, the study's contribution is to re-interpret the findings of these studies, many of which examine single nations, in light of cross-national patterns (for exemplars of this approach, see Orloff and Skocpol 1984; Skocpol 1979). In order to test the validity of secondary sources, I checked them against each other and against primary sources.

The study utilizes the logic of what Skocpol and Somers (1980) call "macro-causal analysis," in which "the analyst selects a small number of cases (often nation states) for investigation and

2. I utilize Hall's (1996) definition of institutions: "the formal or informal procedures, routines, norms and conventions embedded in the organizational structure of the polity or political economy. These can range from the rules of a constitutional order or standard operating procedures of a bureaucracy to the conventions governing trade union behavior or bank-firm relations" (p. 938). By this definition, policies are institutions.

3. For the first four of these journals, I identified and read all articles on abortion from 1960 to the time of each nation's reform, using the search terms "legal abortion" and "therapeutic abortion" of the *Index Medicus*.

moves back and forth between theory and history in an effort to identify the causes of a clearly defined outcome" (Mahoney 1999:1155). Within that logic, it uses methods of nominal comparison and narrative analysis (Mahoney 1999). It seeks to both explain differences in the cases and to build theory. It also seeks to interpret the *meaning* of medical associations' abortion positions within the contexts in which they were developed (Ferree et al. 2002; Geertz 1973; Quadagno and Knapp 1992). Case selection is based on a "most similar-systems design" aimed at holding certain sources of variation constant (Przeworski and Teune 1970). The countries chosen are both English-speaking, western, industrialized democracies with common law legal systems, "liberal" welfare states, and a shared cultural heritage (Esping-Andersen 1990; Hacker 1998; Jacobs 1993; O'Connor, Orloff, and Shaver 1999a; Ruggie 1996).

## Professional Dominance, Clinical Autonomy, and Abortion

### *Medical Professional Dominance*

In a highly influential analysis, Eliot Freidson (1970a, 1970b) argued that in the 1960s, the medical profession in Britain and the United States held the dominant position in the health care division of labor and thus gained clinical autonomy—control over the substance of its work, autonomy from supervision, and control over other workers. Clinical autonomy also entailed control over patients (Haug 1976). Doctors maintained their special status by claiming to be trustworthy, knowledgeable, and ethical, and also sought to institutionalize their authority through licensure and control over services and facilities, such as prescription drugs and hospitals (Hafferty and Light 1995; Light 1993). Clinical autonomy was a source of considerable power. Doctors could argue from expertise based on knowledge of the special characteristics of their work, and could thus only be contradicted by other doctors (Freidson 1970a, 1970b).

This professional dominance perspective is often framed as universal and the demands of medical professional organizations are assumed *a priori*. Thus, the perspective suggests that doctors' associations in all countries will fight hard to defend clinical autonomy whenever it is threatened, including when it is threatened by abortion reforms. By contrast, the historical priorities approach suggests that doctors' associations will prioritize among their policy desires, clinical autonomy being only one of these, and that given differing policy legacies, doctors' associations will construct different priorities.

### *Abortion Reforms as Threats to Clinical Autonomy*

Doctors' associations in Britain and the United States were indeed threatened by abortion reform proposals. Before the 1960s, the two countries had similar abortion policies that had been enacted at the behest of doctors' associations in the late nineteenth century. The policies criminalized abortion, but permitted a doctor to provide a "therapeutic" abortion when it would preserve the life, and in some cases, the health of a pregnant woman. The meanings of "life" and "health" were poorly defined and variably interpreted and enforced—providing doctors with wide discretion (Francome 1984; Hindell and Simms 1971; Luker 1984; Mohr 1978). As I detail below, when policy-makers in both countries considered reform proposals in the 1960s, doctors' associations in both countries expressed concern about the implications of these reforms for clinical autonomy. They argued that legal regulation of abortion provision had the potential to intrude on doctor-patient relationships by specifying when abortions could be provided. It could also allow patients to request abortions for "non-medical" reasons, such as rape or economic hardship. This would create categories of patients who were eligible by law for abortions, thus removing the necessity of doctors' diagnoses and

**Table 1 • Abortion Positions of the British Medical Association (BMA), the Royal College of Obstetricians and Gynaecologists (RCOG), and the American Medical Association (AMA)**

	RCOG-BMA 1966	AMA 1967	AMA 1970
Indications <sup>a</sup>			
Health	✓	✓	
Fetal abnormality	✓	✓	
Economic hardship			
Rape or incest		✓	
Mental disability			
Pregnancy below age of consent			
Abortion on request			✓ ( <i>de facto</i> ) <sup>b</sup>
Restrictions			
Approval by multiple doctors	✓	✓	✓
Approval by specialist	✓		
Facilities restriction <sup>c</sup>	✓	✓	✓
Text	Doctors “must retain their freedom of action and never be put in a position of being coerced . . . into terminating a pregnancy . . . unless they themselves are convinced that it is in the best interests of a particular woman and her potential child” (RCOG 1966, p. 852).	A doctor may be “permitted to prescribe and administer treatment for his patient commensurate with sound medical judgment and currently established scientific knowledge” (AMA 1967, pp. 40–51, 201–03).	Doctors should not provide abortions in “mere acquiescence to the patient’s demand” (AMA 1970, p. 388).

<sup>a</sup> A checkmark indicates that the medical association supported the listed indication.

<sup>b</sup> The AMA resolution said that abortions should not be provided “merely” at a patient’s request, but it did not specify indications for abortions thus allowing *de facto* abortion on request.

<sup>c</sup> In Britain, NHS facilities or facilities approved by the Minister of Health. In the United States, accredited hospitals.

turning doctors into “mere technicians.” Doctors’ associations worried that “abortion on demand” would have a similar effect.<sup>4</sup> The associations also sought to guard their profession against abortion “profiteers” by requiring approval of abortions by multiple doctors or specialists and by restricting abortion provision to certain types of facilities. Such requirements reduced the autonomy of individual doctors from their colleagues, but helped maintain doctors’ collective autonomy by preserving their reputation for ethicality and trustworthiness.

Although doctors’ associations in both countries expressed similar desires to preserve clinical autonomy on abortion, they had differing priorities and demands. Table 1 lists the abortion positions of the medical associations. A checkmark indicates that the medical association sup-

4. Throughout the study, I use the phrase “abortion on demand” only in quotation marks. The phrase was common in doctors’ statements about abortion, but was technically incorrect as individual doctors in both countries maintained the right to refuse to perform abortions.

ported the listed indication. As the table shows, British medical associations opposed abortion on request and for specific grounds of economic hardship, rape, mental disability, and pregnancy below the age of consent. The AMA first avoided the abortion issue, then opposed abortion on request and for grounds of economic hardship, and finally allowed *de facto* abortion on request.

## The Abortion Reforms

The reforms that were eventually enacted in each country strongly reflected the medical positions, though the demands of doctors' associations were hardly the only factor at work. In Britain, abortions required the approval of two doctors for grounds of physical or mental health, fetal abnormality, or economic hardship (when care of an additional child would harm the health of the pregnant woman's existing children). In the United States, abortions could be performed by a single doctor without statutory grounds (i.e., upon request) in the first trimester of pregnancy.<sup>5</sup> An account of the policy legacies, historical priorities, and demand formation of doctors' associations in each country follows.

### *The National Health Service (NHS), Clientelist Doctor-State Relations, and the Historical Priorities of the BMA and RCOG*

In the British case, I focus on the actions and positions of the BMA. Other medical organizations were also active on the abortion issue, but none had its clout.<sup>6</sup> I also focus on the RCOG because it strongly influenced the BMA. The BMA included both general practitioners (GPs) and consultants (elite hospital-based specialists), but the majority of its members were GPs. The RCOG represented only consultant obstetricians and gynecologists, and especially the leaders of those specialties (Hindell and Simms 1971; Moran and Wood 1993; Stevens 1966). In both the BMA and RCOG, the executive councils made most decisions on abortion policy while the legislative bodies were only minimally involved (Hindell and Simms 1971). Britain's National Health Service (NHS), established in 1948, was a classic example of a "state hierarchical" health care system, in which care was delivered through a centralized organization that controlled most factors of production. The state owned and ran hospitals, and consultants were state employees. GPs were independent contractors, but almost all of their income came from capitation payments from the state (Hamm 1982; Tuohy 1999). The BMA and the health ministry had a pronounced "clientelist" relationship and British medical leaders were extensively involved in the administration of the NHS. Fourteen Regional Health

5. Ian Mylchreest (1995) contends that the U.S. and British abortion reforms do not differ substantially because they both relied on the doctor-patient relationship to regulate abortion, but this claim ignores the fact that the British reform gave doctors more power over women patients. Doctors in both countries could refuse to provide abortions, but British doctors were also able to make judgments as to whether women seeking abortions met statutory grounds. It can also be argued that the reforms did not differ substantially if their implementations are taken into account. Though the British law was more restrictive than the American one, most British doctors interpreted abortion laws liberally and women could evade obstructive doctors by turning to an extensive private market (Hindell and Simms 1971). Clearly, laws and their implementations are not necessarily identical (see, for example, Heimer 1999), but there are still good reasons to study changes in abortion laws themselves. Orloff (1993) argues that legal requirements of medical approval undermine women's citizenship claims. And doctors' liberal interpretations of abortion law and the growth of a large private market for abortions occurred only *after* enactment of the Abortion Act and were neither intended nor anticipated by Parliament.

6. The Royal Medico-Psychological Association (1966) endorsed a variety of grounds including fetal abnormality, rape, pregnancy below the age of consent, and economic hardship. However, it opposed abortion "for convenience" and warned against defining abortion grounds too exactly because this might introduce an element of "coercion" in which patients would "expect the doctor to acquiesce" and "the role of the surgeon or gynecologist would be reduced to that of a technician carrying out an objectionable task" (pp. 1071–2). In the same year, the Medical Women's Federation (1966) endorsed grounds of physical or mental health only.

Authorities (RHAs) had important policy roles and doctors served in them as appointees and professional staff (Hamm 1982; Stevens 1966).

*The Breadth of the Reform's Impact.* The NHS health care policy legacy affected the historical priorities, and thus the demands, of the BMA and RCOG. To begin, the health care policy legacy shaped the distribution of the reform's impact on the BMA and RCOG membership. By the 1960s, virtually all doctors participated in the NHS—though perhaps half of consultants and a third of GPs also maintained private practices on the side. Doctors and policy-makers expected that the vast majority of abortions would be provided within the NHS.<sup>7</sup> By NHS rules, patients seeking specialist services could only access them with a referral from their GP (Gould 1985; Stevens 1966). Thus, women seeking abortions first needed to see a GP. Moreover, medical ethics required that even patients seeking private abortions obtain a referral from a GP. As such, abortion law reform had everyday implications for a broader segment of the medical profession in Britain than in the United States. It affected approximately 60 percent of doctors—every GP, as well as all gynecological and psychiatric specialists (Stevens 1966:111, 166).

*Clinical Autonomy as a High Priority in a Narrow Issue Space.* The health care policy legacy also shaped the priority that medical associations gave to clinical autonomy and affected the breadth of issues on which medical associations contended. At the founding of the NHS in 1948, individual doctors suffered a reduction in their power over the economics and organization of medical care, but they were compensated for this loss with a guarantee of clinical autonomy. As Carolyn Tuohy (1999) writes:

While the budgetary parameters of the NHS were established in a hierarchical top-down manner, the clinical autonomy of the physicians to determine patterns of care according to professionally determined norms was preserved in what Rudolf Klein refers to as the “implicit bargain” between the medical profession and the state upon which the NHS was founded. (P. 28)

As the result of this bargain, British doctors had great clinical freedom. The British health ministry had no formal control over GPs aside from restricting them to certain geographic areas. And though consultants were salaried employees, they still had substantial clinical autonomy—only needing to work within general NHS policies for resource use. GPs and consultants were not subject to any formal system of peer review or utilization review as in the United States (Bjorkman 1989; Brooks 1995; Dohler 1989; Elston 1991; Fry 1969; Hamm 1982; Harrison and Schulz 1989; Moran and Wood 1993; Starr and Immergut 1994; Stevens 1966).

This policy legacy had two main effects. First, it created a narrow issue space for the medical associations. Large questions of national health insurance and the relationship of doctors to the state were largely settled by the time of the abortion reforms. British doctors contended strongly over fewer core issues than did their American counterparts, and, as a result, they could afford to devote more resources to the abortion issue. The period of the abortion reform was one of tranquility in British health politics.

The high water mark of UK medicine was probably in the late 1960s. In that era of what has often been labeled “consensus politics” the prevailing wisdom was that experts knew best. Hence health care should be left to doctors. There was broad agreement across the main political parties about the existence of the welfare state, including the NHS, and a general belief that steady growth would continue to allow poverty to be reduced and health to be improved. While the costs of the NHS, the

7. After the enactment of the abortion reform, abortion rights activists opened single-purpose abortion clinics in which abortions were available on a self-pay basis and without referral from a GP. These clinics eventually provided approximately half of abortions. However, the extent of this private provision was not anticipated by the BMA or Parliament while the reforms were being considered, and though this private provision lessened GPs' contact with abortion patients, this contact remained substantial (Hindell and Simms 1971; Potts, Diggory, and Peel 1977).

pay of doctors, and the role and status of general practitioners had all at one time been extremely contentious political issues, by 1965 negotiated agreements between the BMA and the government had been reached on each of these three. (Moran and Wood 1993:132)

Second, the “implicit bargain” elevated the priority of clinical autonomy. For British medical associations, clinical autonomy was a core issue, perhaps *the* core issue, and they rebelled against any infringement upon it (Bjorkman 1989; Dohler 1989; Elston 1991; Harrison and Schulz 1989; Moran and Wood 1993; Starr and Immergut 1994).

*Abortion Clinical Autonomy as a High Priority.* Given the breadth of the reforms’ impact and the fact that clinical autonomy was one of a few core issues for British medical associations, they made *abortion* clinical autonomy a high priority. As Table 2 shows, the BMA and RCOG were actively involved in the abortion debate from the first serious proposals to the enactment of an abortion reform. They lobbied and negotiated with bill sponsors and government ministers on numerous occasions, published reports, wrote letters to MPs, and published letters in the press. They even threatened that they would not implement the reform if it were unacceptable to them. In addition, concerns about clinical autonomy were explicitly articulated, more so than in the United States, in BMA and RCOG reports.

The BMA and RCOG took an active interest in the abortion reform from the beginning. “Private member’s” bills to reform abortion laws were introduced in the 1950s and early 1960s. These were bills introduced by individual legislators rather than by the Government. As a procedural matter, such bills were allowed only minimal agenda time and, as a result, didn’t go far. But when a Labour Government took office in 1964, BMA leaders suspected that the Government would soon introduce abortion legislation (British Medical Journal 1965). In July 1965, the BMA Representative Body directed the BMA Council to establish a special committee on abortion and to ask the Government to delay introducing any legislation until the committee completed its report (British Medical Association 1965).

In November 1965, abortion received its first major parliamentary attention when Lord Lewis Silkin of the Labour Party introduced a private member’s bill at the behest of the Abortion Law Reform Association (ALRA). Again the BMA responded. BMA leaders asked Lord Silkin to delay the bill until the BMA committee finished its report. When he refused, the BMA issued an interim report. Silkin’s bill passed the House of Lords, but could not be considered by the more important House of Commons before the parliamentary session ended (Hindell and Simms 1971).

In May 1966, the ALRA found a sponsor in the House of Commons—Liberal Party MP David Steel (British Medical Association 1966a; British Medical Journal 1966b, 1966c; Hindell and Simms 1971; Lancet 1966). In response to the Silkin and Steel bills, the BMA and the RCOG published three reports on abortion in 1966, both on their own and jointly (British Medical Association 1966b; BMA-RCOG 1966; RCOG 1966). These reports sought to protect the clinical autonomy and discretion of doctors on abortion and were followed up by extensive contact with bill sponsors and the Government. As Table 1 shows, the BMA and RCOG reports supported statutory indications for physical and mental health and fetal abnormality, but opposed indications in Steel and Silkin’s bills for economic hardship, rape, mental disability of the pregnant woman, and pregnancy below the age of consent. The position of the BMA and RCOG was quite similar to that of the 1967 AMA. But, unlike the AMA, the BMA and RCOG explicitly and repeatedly expressed concerns about clinical autonomy. The associations argued that doctors should make the decisions about the necessity of abortions and should base those decisions solely on medical criteria. They argued that “non-medical” criteria would prevent doctors from assessing each case “on its own merits,” compromise the “freedom of action” of doctors, lead to doctors being “coerced” or “pressured,” and lead patients to believe that abortions would be carried out “automatically” (British Medical Association 1966b:41; BMA-RCOG 1966:1649–50; RCOG 1966:852).



**Table 2 • Actions of the British Medical Association (BMA), the Royal College of Obstetricians and Gynaecologists (RCOG), and the American Medical Association (AMA) on Abortion Reform**

<i>BMA and RCOG</i>	<i>Internal Actions</i>	<i>External Actions</i>
Jul 1965	BMA Representative Body directs BMA Council to prepare report <sup>1</sup>	BMA Representative Body directs BMA Council to ask Government for delay <sup>1</sup>
Nov 1965		BMA leaders ask bill sponsor to delay until release of BMA report <sup>2</sup>
Jan 1966	BMA Council approves interim report <sup>3</sup>	BMA Council sends interim report to bill sponsor <sup>3,4,5</sup>
Apr 1966	RCOG issues report, threatens non-cooperation <sup>6</sup>	RCOG leaders discuss report with bill sponsor <sup>2</sup>
Jul 1966	BMA Council approves final report <sup>7</sup>	
Nov–Dec 1966	BMA and RCOG issue joint report <sup>8</sup>	BMA and RCOG send copies of report to and meet with Minister of Health, Home Secretary and bill sponsors <sup>2,9,10</sup>
Dec 1966		BMA leaders send letter to bill sponsor welcoming amendments <sup>2</sup>
Jan 1967		BMA Council sends copies of BMA-RCOG report to members of House of Commons standing committee <sup>9</sup>
Jan 1967		BMA Council encourages BMA division secretaries to write to local MPs that are members of House of Commons standing committee <sup>9</sup>
May 1967		BMA and RCOG leaders visit bill sponsors seeking amendments <sup>2,11,12</sup>
Jun 1967		BMA and RCOG publish letter in <i>Times</i> opposing bill as written <sup>2,11,12</sup>

*(Continued)*

## Notes

1. British Medical Association. 1965. "Annual Representative Meeting: Abortion." *British Medical Journal Supplement*, July 17, p. 54.
2. Hindell, Keith and Madeline Simms. 1971. *Abortion Law Reformed*. London: Peter Owen.
3. British Medical Association. 1966. "Proceedings of Council: Therapeutic Abortion." *British Medical Journal Supplement*, January 22, pp. 19–20.
4. British Medical Journal. 1966. "Leading Articles: Therapeutic Abortion." *British Medical Journal*, January 29, pp. 248–9.
5. British Medical Journal. 1966. "Leading Articles: Legislation on Abortion." *British Medical Journal*, March 5, pp. 559–60.
6. Royal College of Obstetricians and Gynaecologists. 1966. "Legalized Abortion: Report by the Council of the Royal College of Obstetricians and Gynaecologists." *British Medical Journal* 1:850–2.
7. British Medical Association. 1966. "Proceedings of Council: Therapeutic Abortion." *British Medical Journal Supplement*, July 9, pp. 10–11.
8. British Medical Association and the Royal College of Obstetricians and Gynaecologists. 1966. "Medical Termination of Pregnancy Bill: Views of the British Medical Association and the Royal College of Obstetricians and Gynaecologists." *British Medical Journal*, December 31, pp. 1649–50.
9. British Medical Association. 1967. "Annual Report of Council: Therapeutic Abortion." *British Medical Journal Supplement*, p. 66.
10. British Medical Association. 1966. "Abortion Law Reform." *British Medical Journal Supplement*, November 12, p. 191.
11. British Medical Journal. 1966. "Leading Articles: Abortion Law." *British Medical Journal*, December 31, p. 1607.
12. Potts, Malcolm, Peter Diggory, and John Peel. 1977. *Abortion*. Cambridge: Cambridge University Press.

Table 2 • Continued

AMA	Internal Actions	External Actions
1964	Board of Trustees establishes Committee on Human Reproduction <sup>13</sup>	
1965	Committee on Human Reproduction issues report urging states to enact ALI reforms, House of Delegates rejects <sup>14</sup>	
1967	Committee on Human Reproduction issues report supporting ALI reforms, but not urging state action, House of Delegates approves <sup>15</sup>	
1969	Section on Preventive Medicine offers resolution urging states to repeal abortion laws, House of Delegates rejects <sup>16</sup>	
1970	Board of Trustees offers resolution stating abortion between woman and her doctor, House of Delegates approves substitute compromise measure <sup>17</sup>	
1971	Abortion rights attorneys ask AMA to submit <i>amicus</i> brief in <i>Roe v. Wade</i> , AMA declines <sup>18</sup>	

## Notes

13. Interview #03.

14. American Medical Association. 1965. *House of Delegate Proceedings, Clinical Convention*. Chicago: American Medical Association.

15. American Medical Association. 1967. *House of Delegate Proceedings, Annual Convention*. Chicago: American Medical Association.

16. American Medical Association. 1969. *House of Delegate Proceedings, Clinical Convention*. Chicago: American Medical Association.

17. American Medical Association. 1970. *House of Delegate Proceedings, Annual Convention*. Chicago: American Medical Association.

18. Garrow, David J. 1994. *Liberty and Sexuality: The Right to Privacy and the Making of Roe v. Wade*. New York: Macmillan.

The RCOG summed up the position of the doctors' associations when it stated that it opposed an indication for pregnancies below the age of consent because it might force doctors to provide abortions that they did not believe to be in the best interests of the pregnant woman or the fetus.

Gynaecologists and other doctors concerned must retain their freedom of action and never be put in the position of being coerced by the terms of the Bill and the conditions of their employment into terminating a pregnancy if they have any ethical objections, and unless they themselves are convinced that it is in the best interests of a particular woman and her potential child. (RCOG 1966:852)

Steel promptly accepted many of the BMA and RCOG criticisms. He withdrew the indications for economic hardship, rape, mental disability, and pregnancy below the age of consent. But he also liberalized the physical and mental health indication to include the "well-being" of the pregnant woman and he did not require that abortions be approved by at least one consultant as the BMA and RCOG had asked. Later, he also added an indication for the

well-being of the pregnant woman's children (an implicit economic hardship ground) (BMA-RCOG 1966; Hindell and Simms 1971).

BMA and RCOG leaders continued to push for more. They wanted the "well-being" of the pregnant woman omitted from the health clause because it might lead to abortion "for convenience," and they continued to pursue a "consultant clause." Steel acceded to their first demand, but not their second. Still, they were not satisfied. They published a letter in *The Times* that said they could not support the bill without the deletion of the language about the "well-being" of the pregnant woman's other children and without the addition of a consultant clause. But the measure passed the House of Commons in July 1967 and the House of Lords in October 1967 without these changes (British Medical Journal 1966a; Hindell and Simms 1971; Potts, Diggory, and Peel 1977).<sup>8</sup> Given the breadth of the reforms' impact, the narrow issue space, and the high priority that the BMA and RCOG placed on clinical autonomy in general, they made the abortion bill a top priority—taking numerous internal and external actions on the issue and repeatedly demanding that abortion clinical autonomy be preserved.

*State and Patient Infringements on Clinical Autonomy.* The NHS health care policy legacy also affected the attitudes of medical associations towards the state and thus had implications for the balance that the associations sought between state and patient infringements on clinical autonomy. Because of the clientelist relationship between doctors and the state, contacts between the BMA, the RCOG, and policy-makers on abortion had more the character of consultation than lobbying. Steel was very responsive to BMA and RCOG suggestions and even visited the BMA House for some meetings. Steel's main co-sponsor, Michael Winstanley, was a BMA local official. According to ALRA Executive Director, Vera Houghton (1967), "It was obvious to us . . . that Mr. Steel [and] Dr. Winstanley . . . were going to feel much happier if the bill had the support of the BMA and that they considered this support would greatly facilitate its passage" (p. 2). The BMA and RCOG also met with the Health and Justice ministers who in turn negotiated with Steel. Though the abortion bill was a private member's bill and Steel was not a member of the Labour party, Steel needed Labour votes for the legislation to pass and also needed the Government to allot extra agenda time for the bill (Hindell and Simms 1971). The relationship between the health ministry and the medical associations was not only one of closeness, but of interdependence. Medical labor was the key input for the NHS. This allowed the RCOG to make the not-so-veiled threat that Parliament should assure that doctors would cooperate with the new law before changing it (RCOG 1966).

The relationship of the medical associations to the state affected the nature of the BMA and RCOG's concerns about clinical autonomy. The doctors' associations were more concerned about patient infringements on clinical autonomy than they were about state ones. The statutory specification of indications for abortion inherently involved a threat to doctors' clinical autonomy by the state since such specification dictated the circumstances under which doctors could provide abortions. And the specification of *non-medical* indications involved a threat to clinical autonomy from women patients who could "demand" abortions. In their various reports, the BMA and RCOG expressed far more concern about the second issue than the first.

On the first issue, the joint BMA-RCOG report argued that the law should not restrict doctors' discretion unduly by defining abortion indications too narrowly. Thus, the associations opposed clauses in Steel's bill that required that risks to health be "serious" or "grave" (BMA-RCOG 1966:1649). But these concerns about state infringements took a clear back

8. The House of Lords added an amendment stating that an abortion would only be legal if the risk to health posed by continuing the pregnancy was greater than the risk to health of abortion. Proponents of the amendment considered it anti-abortion, but this response was predicated on the false, but widespread, belief that abortions were usually more dangerous than pregnancy. Later, it would become clear that early abortions were almost always safer than pregnancy and some would argue that the clause made it impossible to prosecute doctors for providing early abortions (Hindell and Simms 1971).

seat to concerns about infringements by women patients. Repeatedly, the medical associations expressed misgivings about “demands” from women patients. The British medical associations opposed specific indications for rape. By contrast, the AMA supported such indications. The BMA argued that the legislation should not contain “non-medical” indications such as economic hardship, rape, or pregnancy below the age of consent because such circumstances would be adequately covered under the health and mental health indications. It argued that an indication specifically for pregnancies below the age of consent “might lead to pressure being placed on the girl herself, or on the doctors in charge of the case, to terminate pregnancy in cases where the attending doctors believe in all the circumstances that there are insufficient grounds for terminating pregnancy” (British Medical Association 1966b:41).

Likewise, the BMA-RCOG joint report argued that the so-called social clauses would lead women to believe that they were entitled to an “automatic” abortion.

These [clauses] are objectionable in specifying indications which are not medical. They will, in our opinion, give rise to serious difficulties in practice. They might well lead to an excessive demand for terminations on social grounds, and this would be unacceptable to medical professionals. Each case has to be assessed on its own merits, and express reference to [these indications], though only permissive, would inevitably lead the public to believe that termination would automatically be carried out in the instances mentioned. (BMA-RCOG 1966:1649–50)

In light of their clientelist relationship with the state, British medical associations were more concerned that abortion reforms would lead to infringements on clinical autonomy by women patients than by the state. And given the breadth of the abortion reform’s impact, a narrow issue space, and the high priority they gave to preserving clinical autonomy in general, the BMA and RCOG treated abortion clinical autonomy as a high priority. They expended considerable effort opposing “non-medical” grounds for abortion. As the section below will demonstrate, the British medical associations and the AMA shared similar policy desires. What differed were their priorities—and the demands that flowed from them.

### **Private, Fee-For-Service Health Care, Conflictual Doctor-State Relations, and the Historical Priorities of the AMA**

In the American case, I focus on the AMA, again because no other medical organization had its clout.<sup>9</sup> The AMA included both family practitioners and specialists, but was disproportionately composed of older, conservative, solo family practitioners from rural areas (Freidson 1970a; Tatalovich 1971). In contrast to Britain, the AMA’s legislature, the House of Delegates, was more heavily involved in abortion politics. But it was an undemocratic body which filled its seats through non-programmatic elections and was dominated by the Board of Trustees (Freidson 1970a; Tatalovich 1971).

In the 1960s, the United States had a mainly private, fee-for-service health care system. Most working people had private insurance provided by their employer. The Medicare and Medicaid programs, established in 1965, provided insurance for the elderly and some of the poor, but a substantial number of people remained uninsured. Doctors billed patients or insurers directly at “prevailing rates” for each service provided. Public health care provision was minimal (O’Connor et al. 1999a; Tuohy 1999). The AMA leadership had a historical

9. In the United States, the liberal American Public Health Association and the American Medical Women’s Association were out in front of the AMA, calling for the repeal of all abortion restrictions in 1968 (Fraser 1968; Tatalovich 1971). The American College of Obstetricians and Gynecologists (ACOG) was ahead of the AMA on economic hardship grounds, but lagged behind on abortion on request. In 1968, the ACOG endorsed grounds for economic hardship if that hardship might affect health (New York Times 1968). In 1971, the ACOG approved abortion “to safeguard the patient’s health or improve her family life situation” (Davis 1985:58, 69), and in 1972, it called for abortion on request (Lader 1973).

mistrust of the state. During the first half of the twentieth-century the AMA opposed, usually successfully and often in the language of anti-communism, any government involvement in the economics or organization of health care. It opposed attempts to establish national health insurance in the Progressive era, the New Deal and the Truman presidency. Until the 1960s, it opposed federal funding of medical schools. During the 1960s, it opposed Medicaid and Medicare, but was bitterly defeated (Moran and Wood 1993; Starr 1982).

### ***Breadth of the Reform's Impact***

As in Britain, the health care policy legacy affected the historical priorities, and thus the demands, of the AMA. To start, the policy legacy shaped the breadth of abortion reform's impact on the AMA membership. In the private, fee-for-service system, patients could access specialists directly without a referral from a family doctor. Thus, under a liberalized abortion law, family doctors could completely avoid abortion if they so chose. In addition, in 1970, New York and the District of Columbia legalized abortion on request. In both places, single-purpose abortion clinics were established. These demonstrated to obstetrician-gynecologists that the increased demand for abortions resulting from abortion on request could be accommodated by abortion specialists providing outpatient abortions in private offices or clinics (Medical World News 1970d; Nathanson 1979). Thus, obstetrician-gynecologists could avoid providing abortions if they chose. In addition, with limited public provision, American doctors would not face workplace pressure from the state to provide abortions, as would their counterparts in Britain. As such, abortion reform would affect only a small number of AMA members. The main effect of reform would be on obstetrician-gynecologists and then only on those who chose to perform abortions. Both family doctors and obstetrician-gynecologists would have ample opportunity to "exit" the abortion issue, and would eventually do so in large numbers. By 1980, 75 percent of abortions were provided in single-purpose clinics (Tietze 1983).

### ***Clinical Autonomy as a Low Priority in a Broad Issue Space***

The health care policy legacy also affected the orientations of AMA leaders to clinical autonomy and the number of core issues on which they contended. Numerous analysts have suggested that the American medical profession has, consciously or unconsciously, traded aspects of its clinical autonomy for power over the economics and organization of health care (Harrison and Schulz 1989:205; Klein 1981; Moran and Wood 1993; Reinhardt 1987; Starr and Immergut 1994; Tuohy 1999; Weiner 1997). Many of the most burdensome controls on clinical autonomy occurred only after the AMA's 1970 change of position on abortion, but even before then, the AMA accepted systems of peer review and utilization review that would be unthinkable in Britain (e.g., the Joint Commission on Accreditation of Hospitals and utilization review under Medicare) (Brooks 1995; Ermann 1988; Fry 1969). This does not mean that AMA leaders did not care about clinical autonomy. In fact, they often argued that economic and organizational power were necessary for its preservation (Starr 1982). The argument, instead, is that clinical issues had lower priority among the AMA's policy desires than did economic and organizational ones. This lower priority was in part the result of the broad range of issues on which the AMA contended. In contrast to Britain, battles over national health insurance and the relationship of doctors to the state were alive and well in the United States. Without settlement on these issues, the AMA faced a broad menu of potential issues and had to make decisions about how best to allocate its resources. Often, issues of clinical autonomy got short shrift.

### ***Abortion Clinical Autonomy as a Low Priority***

Given the narrow impact of the reform on AMA members, the AMA's broad issue space, and the comparatively low priority that it gave to clinical autonomy in general, *abortion*

clinical autonomy was not a high priority for the AMA. As Table 2 shows, the AMA was only minimally involved in abortion reforms. The AMA passed several internal resolutions on abortion, but these were statements of medical ethics rather than external calls for government action, and the association explicitly rejected making such calls. At no time did AMA representatives contact policy-makers about abortion. When the AMA was asked by abortion rights attorneys to file an *amicus* brief in *Roe v. Wade*, it declined. Though the AMA's positions on abortion indications sometimes matched those of their counterparts in Britain, the AMA only rarely made explicit references to concerns about clinical autonomy in its resolutions.

The AMA first tried to avoid the abortion issue. It then implicitly asserted clinical autonomy from women patients seeking "abortion on demand" and finally ceded some of that autonomy in 1970. Abortion reform first landed on the governmental agenda largely through the auspices of the American Law Institute (ALI), a legal modernization organization that included an abortion statute in its 1959 Model Penal Code. The statute expanded the legal grounds for abortion to include not only physical and mental health, but also rape, statutory rape, incest, and fetal abnormality. From 1961 to 1966, ALI abortion reforms were rejected in six states, and from 1967 to 1973, reforms were enacted in fourteen states and rejected in fourteen others (American Law Institute 1959, 1980, 1985; Burns 1998; Wechsler 1968).

Individual doctors were in the forefront of the ALI-based reform movement, but the AMA was not involved at all, and its state-level affiliates were minimally involved (Guttmacher 1972; Lader 1973). Many state-level abortion reforms took place without state medical associations taking positions, let alone leadership. By the end of 1967, 30 states had considered abortion bills, but only 17 state medical societies had adopted abortion resolutions (Medical World News 1967). Of the ten ALI statutes enacted between 1967 and 1969, state medical societies took an active role in only five (Ingram 1969; Jain and Gooch 1972; Jain and Hughes 1968; Jain and Sinding 1972; Tatalovich 1971).

The AMA leadership initially avoided the abortion issue. In 1964, the AMA Board of Trustees established a Committee on Human Reproduction. A year later, the Committee submitted a report to the Board of Trustees that recommended that the AMA House of Delegates urge the states to enact ALI-style abortion legislation (Interview #03). The Board did not approve the Committee's report, but instead sent it without comment to the House of Delegates. The House of Delegates reference committee opposed AMA involvement in the issue, arguing that it was the responsibility of state legislatures.<sup>10</sup> The reference committee also suggested that a more liberal AMA abortion stance would jeopardize the legitimacy of state medical examining boards (American Medical Association 1965:92). These boards had the power to grant and revoke licenses for medical practice and were usually controlled by AMA state affiliates. This gave the AMA control over the supply of doctors—a central economic and organizational issue for the association (Stone 1980). Here, the reference committee suggested that there was a necessary tradeoff between the AMA's power over the economics and organization of medical care and the clinical autonomy of doctors on abortion. It felt that the AMA should preserve the former and the House of Delegates agreed (American Medical Association 1965:88–93; Medical Tribune 1965; Medical World News 1965; Tatalovich 1997).

Two years later, the AMA finally took a position on abortion reform, but only after Colorado and North Carolina had become the first states to institute ALI reforms. The Board and the House of Delegates approved a new report by the Committee on Human Reproduction (American Medical Association 1967:40–51, 201–03). This time, the reference committee noted that they found the new report more satisfactory because it merely altered the AMA's internal position, but did not go so far as to urge the states to take any action. The resolution was quite similar to the position of the BMA. It allowed abortions for grounds of physical and mental health, fetal abnormality, and rape or incest, but implicitly asserted doctors' clinical

10. All resolutions before the AMA House of Delegates are first sent to a reference committee that hears testimony and makes recommendations.

autonomy because it did not allow for grounds of economic hardship or abortion on request. But although British and American doctors' associations had similar policy desires on abortion, they had different policy priorities. The BMA and RCOG reports made explicit statements about the threat to clinical autonomy posed by abortion reform and contacted policy-makers to reiterate their concerns. By contrast, AMA representatives did not bother to make such statements and did not contact policy-makers or disseminate the new resolution to them (American Medical Association 1967; Kirschten 1967).

In the late 1960s, a growing number of reformers began to complain that doctors were implementing new state-level abortion reforms too conservatively. Many reformers began to advocate the complete *repeal* of abortion laws, allowing abortion on request (Fung 1993; Lamm 1970; Lyons 1969; O'Connor et al. 1999a). The growing feminist movement was also mobilizing more heavily around abortion. Several feminist groups ran abortion referral services and some activists began a litigation campaign that presented test cases of both nineteenth century and ALI model statutes to state and federal courts (Cisler 1970; Hole and Levine 1973; Lader 1973; Lyons 1969; Nathanson 1979; Staggenborg 1991).

In December 1969, the AMA's Section on Preventive Medicine, composed of liberal-minded mostly publicly-employed doctors, proposed a House of Delegates resolution urging states to repeal abortion laws. The AMA was opposed. The House of Delegates reference committee labeled the proposal "extreme" and reported that testimony had run 12-1 against it (American Medical Association 1969:312). It also noted that opinion polls of doctors showed that "an overwhelming majority" opposed "abortion on demand" (p. 312). The House of Delegates rejected the proposal despite picketing by NOW and other feminist groups (American Medical Association 1969:241, 312; Cisler 1970).

### *Abortion Clinical Autonomy Becomes an Even Lower Priority*

But a mere six months later, the AMA changed its position and allowed abortion on request. It is unlikely that the association's policy desires changed in such a short time, and below I present evidence that the opinions of AMA members did not, in fact, change. Instead, abortion, already a low priority issue for the AMA, became an even lower one. In 1970, the AMA faced several crises that threatened its power over the economics and organization of medical care. Most importantly, enactment of national health insurance appeared imminent as the AMA battled a temporary coalition of government, business, the insurance industry, traditional liberal reformers and consumers' movements. The coalition included Richard Nixon and the National Governor's Association.<sup>11</sup> The AMA was also losing members to new medical specialty organizations and confronting critiques from young and left-wing doctors (Blakeslee 1969; Champion 1984; Medical World News 1970c; Nature 1970b; New York Times 1969; Nordheimer 1969; Starr 1982).

In this broad issue space, in which numerous core issues were at stake, the AMA had to prioritize. Abortion had previously been a low priority issue for the AMA, but given these threats to the economic and organizational power of doctors, it was now an even lower one. To explore the AMA's priorities, I interviewed several key figures from the period. When asked if abortion was a high priority at the time, an AMA board member replied, "Not at all. There are so many other things. Frankly, most doctors don't want anything to do with abortion" (Interview #03). A staff member in the AMA's Washington office agreed: "Abortion was not a top priority, in fact, it was not even in the top ten" (Interview #02). According to him, higher priority issues included Health Maintenance Organizations (HMOs), national health insurance, appropriations bills for the Department of Health, Education, and Welfare, and

11. In the end, no national health insurance plan was enacted, but this was mostly a matter of bad timing. In 1973, the OPEC oil shock, recession, and inflation pushed proposals for national health insurance off the agenda (Starr 1982).

grants from the National Institutes of Health. “We had so many other things nationally that the AMA was interested in. We just couldn’t afford to spend that much time on the abortion issue” (Interview #02). According to another AMA staff member, “When you talk about the 1970 annual meeting of the AMA House of Delegates, abortion certainly wasn’t the most controversial issue before the House” (Interview #04). According to this staffer, higher priority issues included “socialized medicine,” Medicare, the establishment of new specialty organizations, and malpractice insurance.

Not only was the AMA facing crises, but it was also under new pragmatic leadership that was especially willing to prioritize among AMA policy desires in order to focus on core issues related to the economics and organization of medical care. After the AMA’s failure to prevent Medicare in 1965, members associated with the association’s political action committee had gained control of the Board, fired the executive director, and devoted more resources to public affairs. The old leadership had dug in its heels to fight almost all government initiatives, but the new leadership was pragmatic and eager to polish the AMA’s image. In response to the crises, the AMA leadership made concessions—expressing new concern about a range of issues including infant mortality, the poor, and doctor shortages (Campion 1984; Medical World News 1970b; Starr 1982). In a 1970 speech, executive vice president Ernest B. Howard added abortion liberalization to this list (Campion 1984:301).

In early 1970, New York and Hawaii repealed their abortion laws (without the support of state AMA affiliates). In mid-May, the Board of Trustees proposed a House of Delegates resolution that stated that abortion should be between a woman and her doctor (American Medical Association 1970; American Medical News 1970a, 1970b; Kihss 1969; Steinhoff 1977). In June, the House of Delegates reference committee substituted its own slightly less liberal resolution and this was approved by the House of Delegates (American Medical Association 1970:337–9; American Medical News 1970b). The new resolution allowed *de facto* abortion on request (in states that had repealed their abortion laws) because, for the first time, it did not spell out specific grounds for abortions. They could be provided for any reason (see Table 1) (American Medical Association 1970:338–9). A year later, abortion rights attorneys asked the AMA to prepare an *amicus* brief in *Roe*, but it declined. The AMA’s resolution still had substantial impact, however, because it influenced the thinking of the *Roe* decision’s author, Justice Harry Blackmun (Garrow 1994).

Despite sharing the BMA’s desire to preserve clinical autonomy by opposing abortion on request, abortion was never a high priority issue for the AMA. In the face of a vigorous attack on its power over the economics and organization of medical care, abortion became an even lower priority and a pragmatic new AMA leadership changed the association’s earlier position.

### *State and Patient Infringements on Clinical Autonomy*

The way in which AMA leaders understood the 1970 abortion resolution was also affected by the American health care policy legacy. The AMA’s historical mistrust of the state and its desire to preserve private medicine affected the balance that it sought between state and patient infringements on clinical autonomy. The AMA’s 1967 resolution implicitly asserted clinical autonomy from women patients by opposing abortion on request and for economic hardship. When the AMA yielded on these issues in 1970, it appeared to abandon its concern about clinical autonomy. In fact, however, AMA leaders believed that the new resolution still preserved clinical autonomy because it only yielded *some* autonomy to women patients and because it increased doctors’ autonomy from the state.

The AMA’s 1967 abortion resolution did not allow abortion on request or for grounds of economic hardship, but it also did not articulate an explicit defense of doctors’ autonomy from the demands of women patients, as did the BMA and RCOG reports. The 1967 resolution also allowed abortion for indications of rape or incest. It did not claim, as had the BMA



and RCOG reports, that such indications would cause women to “demand” abortions or to seek “automatic” abortions that would infringe on doctors’ clinical autonomy.

Still, most doctors were opposed to abortion on request. As the repeal movement picked up steam in 1969, most doctors opposed it (Modern Medicine 1967, 1969). Many expressed discomfort with the way that repeal would diminish doctors’ clinical autonomy in relation to women patients (Joffe 1995). Even abortion reform activist Dr. Alan Guttmacher had reservations about yielding his role as a medical advisor and simply acting as a “rubber stamp” (qtd. in Hall 1970:108). Dr. Robert Hall, another abortion reform activist, noted that, “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” (Hall 1970:108). An AMA House of Delegates member complained that “legal abortion makes the patient truly the physician: she makes the diagnosis and establishes the therapy” (Hospital Practice 1970:19). The opposition of doctors to abortion on request was also reflected in the AMA House of Delegates’ rejection of the 1969 proposed resolution to repeal abortion laws. But that proposal identified another threat to clinical autonomy—the state. It argued that existing abortion laws “interfere with a physician’s fundamental right to render what he believes is the best medical care for his patient” (American Medical Association 1969:241). This argument did not prevail on that day, but it reappeared, with different results, six months later.

The 1970 resolution, by eliminating specific indications for abortion, allowed abortion on request (American Medical Association 1970:338–9). Most media coverage portrayed the resolution as a liberalization (Lyons 1970a, 1970b; Nature 1970a)—though not all did (Medical World News 1970a). However, accounts that saw the new resolution solely as a liberalization missed the twin facts that it ceded only *some* clinical autonomy to women patients and that AMA leaders believed it increased clinical autonomy from the state. To be sure, doctors lost some autonomy in relation to women patients because they no longer had specific AMA policy grounds for selectively “diagnosing” the “necessity” of abortions, but the resolution also stressed that doctors should not provide abortions in “mere acquiescence to the patient’s demand” (American Medical Association 1970:388). And as a matter of policy and practice, doctors retained the power to refuse abortions, and later used that power extensively.

Moreover, AMA leaders believed that the resolution increased the clinical autonomy of doctors from the state. According to a top AMA executive at the time, the resolution preserved clinical autonomy, both in relation to patients and state authorities, through its lack of specificity:

... if you simply say it’s between the patient and the physician, then the physician has a lot of latitude and those who don’t want to do abortions have absolutely no need to. And those that do want to do them don’t have to explain, to authorities and such, why they do them. So this goes along a lot with, the doctor should decide, the doctor is the authority figure. (Interview #01)

When asked if the liberalization constituted “abortion on request,” the executive replied:

No, because you’re looking at it from the point of view of the woman and the AMA is looking at it from the point of view of the doctor. I would hope, given they were being reasonable, they considered both, but your principle job if you run the AMA is to protect your membership—the doctors. So how do you protect them from this tangle? Well you say that the whole business is up to the doctor—then he or she is protected—from the patient either way, or from the other people in the community. If the doctor’s Catholic, they don’t have to go along with *Roe v. Wade*. And if they do believe in abortion, then they can do it for other indications than those listed previously. (Interview #01)

### **Alternative Explanations for the Differing Demands of Doctors’ Associations and for the AMA’s 1970 Change of Position**

I have argued here that the demands of the medical associations in the two countries differed because abortion clinical autonomy was a high priority in a narrow issue space for the

BMA and RCOG and a low priority in a broad issue space for the AMA. I've also argued that the BMA and RCOG were more concerned about clinical autonomy from women patients than from the state while the AMA was at least equally concerned about clinical autonomy from the state. It is worth discussing two alternative explanations for the differing demands of the doctors' associations and for the AMA's change of position—feminist demands and changes in medical opinion.

### *Feminist Demands*

Feminist demands for abortion on request were part of the American reform debate, but not the British one. This might explain why the AMA eventually supported abortion on request while the BMA did not. Such demands probably had some impact on the positions of doctors' associations, but they cannot, on their own, explain them. In Britain, feminist demands for abortion on request were absent largely because the abortion reform occurred before second-wave feminism had gained much ground. After the reform, feminists began to demand abortion on request, but BMA and RCOG leaders did not change their position (Francome 1986; Hindell and Simms 1971). In the United States, demands for abortion on request were more widespread, but they were not particularly influential within the AMA. A few voices within the AMA favored abortion on request, but they represented marginal groups such as the Section on Preventive Medicine. And only one woman sat among the approximately 250 members of the 1970 AMA House of Delegates (American Medical Association 1970). In addition, the AMA was a strongly undemocratic organization in which insurgent movements had difficulty making progress. The AMA experienced some external pressure on abortion from feminist groups, which protested at the 1969 and 1970 AMA annual meetings, but these protests were smaller and less disruptive than those of protest groups focusing on health care for the poor (Blakeslee 1969; Campion 1984; Medical World News 1970c; Nature 1970b; New York Times 1969; Nordheimer 1969; Starr 1982). Feminist mobilization played a key role in the passage of abortion law repeal in New York and in legal challenges to abortion laws—helping to legitimate abortion on request (Garrow 1994; Lader 1973). Still, it is doubtful that feminist demands would have been enough to move the AMA leadership if abortion were not already a low priority for the association. On numerous other issues, AMA leaders faced stronger movement pressure, but did not yield.

### *Changes in Medical Opinion*

An alternative explanation for the AMA's 1970 change of position is that its members were swept up in broader societal change in abortion attitudes. Polls of medical opinion provide some support for this. An unscientific 1967 survey by *Modern Medicine* (1967) found that only 27 percent of doctors supported abortions for socioeconomic reasons, and 14 percent supported abortion on request. But by 1969, another *Modern Medicine* (1969) survey found that 51 percent of doctors supported abortion on request. However, this varied strongly by specialty, with the main constituencies of the AMA continuing to oppose abortion on request. Only 39 percent of general practitioners and 41 percent of obstetrician-gynecologists supported abortion on request, while 72 percent of psychiatrists (who were generally not AMA members) did so. More importantly, because the AMA's leadership selection processes were so undemocratic, medical opinion and AMA policy were only loosely coupled.

### **Conclusion**

In this study, I developed an historical priorities approach and used it to explain differences in the demands of doctors' associations on abortion reform proposals. I showed that the

BMA, RCOG, and AMA shared policy desires on abortion, but because of differing health care policy legacies—a national health service with clientelist state-medical relations in Britain and private, fee-for service medicine with conflictual state-medical relations in the United States—the preservation of abortion clinical autonomy was a higher priority for the BMA and RCOG than for the AMA. The abortion reforms had a broader impact on the BMA and RCOG membership than on the AMA membership. The BMA and RCOG valued their clinical autonomy, in relation to economic and organizational power, more highly than did the AMA. And the BMA could make clinical autonomy a higher priority because it faced a narrower issue space than the AMA. Moreover, the BMA and RCOG were most concerned about patient infringements on clinical autonomy while the AMA was at least equally concerned about state infringements. The result of these differing priorities was that the BMA and RCOG steadfastly opposed abortion on request and for economic hardship, while the AMA eventually gave up its opposition.

My findings shed new light on the historical development of abortion policy and politics in Britain and the United States. Too often, analysts of abortion politics and policy take the current substance of abortion debates as given, jumping immediately to the main moral, feminist, medical, or other issues without considering the historical construction of interest group demands and mobilization (or lack of them) and the ways in which these shaped discourses and policy outcomes. By contrast, this study explains the demands and mobilization of a key interest group—doctors' associations. For several reasons, these demands and mobilization are crucial to understanding abortion politics and policy, both past and present, in Britain and the United States. First, the positions of the medical associations affected the abortion reforms that were actually enacted. The U.S. reform (though not necessarily its implementation) was more liberal than the British one, at least in part because of the differing demands of the doctors' associations.<sup>12</sup> The effects of the medical associations in Britain are obvious given the responsiveness of the abortion bill's sponsor to BMA and RCOG concerns. He removed sections of the bill that allowed abortions for indications of economic hardship, rape, mental disability, and pregnancy below the age of consent. The effects are less obvious in the American case. The main effect was on Justice Harry Blackmun, who was the Supreme Court's swing voter in *Roe* and authored the Court's opinion. Blackmun had previously served as general counsel for the Mayo Clinic and was deeply respectful of medical opinion. His *Roe* opinion quoted the AMA's 1970 abortion position, praised doctors with purple prose, and stated that its main aim was to uphold the rights of doctors to practice medicine (Garrow 1994). It is likely that Blackmun's opinion would not have been as wide-ranging had the AMA continued to oppose abortion on request and for economic hardship.

Second, the involvement of British mainstream medicine in abortion policy has served to protect abortion rights from post-reform threats by anti-abortion forces. The BMA has opposed most anti-abortion amendments to the abortion law. And abortion discourse has focused on abortion rights as a right to health—a particularly powerful framing. In the United States, the minimal involvement of mainstream medicine in abortion politics and practice has made abortion rights more vulnerable to attack. The AMA has not played an active role in defending abortion rights. And its absence has contributed to the dominance in abortion rights discourse of a less resonant claim about the right to control one's body (Brodie 1994; Francome 1986; Hindell and Simms 1971; Joffe 1995; O'Connor et al. 1999b).

Finally, the minimal involvement of American mainstream medicine in abortion practice has reduced access to abortions by concentrating abortion provision in single-purpose clinics, which are typically located in large cities. By contrast, NHS abortion access is better distributed geographically (Francome 1986; Imber 1986; Joffe, Anderson, and Steinauer 1997).

12. After the reforms, British doctors interpreted the abortion law liberally and abortions were widely available both in the NHS and in the private market. In the United States, mainstream medicine largely exited abortion provision and it was confined to large single-purpose clinics concentrated in cities. In addition, Congress quickly banned federal funding of abortions for poor women.

The study also offers a new interpretation of the AMA's 1970 abortion resolution. While most accounts have seen the resolution merely as a straightforward liberalization of AMA policy that was wholly supportive of abortion on request, I have argued that in the view of AMA leaders, the resolution was only somewhat supportive of abortion on request and it increased doctors' clinical autonomy from the state.

The study also illuminates the medical professional dominance perspective by putting it in historical and comparative perspective (for similar arguments, see Hafferty and Light 1995; Hafferty and McKinlay 1993; Heidenheimer 1989; Immergut 1992b; Stone 1980; Wilsford 1991). It shows that the "interests" of doctors cannot be assumed *a priori*, but are instead historically constructed. In addition, it is likely that the patterns of demand formation identified here, in which British medical associations are more oriented to preserving clinical autonomy while their American counterparts are more oriented toward maintaining power over the economics and organization of medical care, are evident in other issue areas as well. To my knowledge, no other comparative study of patient challenges to doctors' clinical autonomy exists. There have been several such studies in the American context on movements for mental illness rights, AIDS research and treatment, alternative health care, disability rights, and women's health (Brown 1984; Epstein 1996; Goldstein 1999; Ruzek 1978, 1980; Ruzek, Olesen, and Clarke 1997; Shapiro 1993). At least one of these studies notes a dynamic similar to that detailed here in which doctors offer concessions on issues which they perceive as less threatening to their core interests, and especially their material interests (Ruzek 1980). While it is beyond the scope of this study to examine other issue areas, such research holds promise. In addition to the issues mentioned above, scholars should examine controversies over informed consent, euthanasia, living wills, and patient access to medical information. Scholars should also undertake comparative studies of challenges to clinical autonomy by state and corporate managers on such issues as utilization review, clinical protocols, and the use of doctor-managers.

Finally, the historical priorities approach is useful for the study of collective demand formation more generally. It contends that the policy demands of collective actors are constructed in the context of policy legacies that create multi-issue spaces for collective actors and affect the historical construction of their priorities among policy desires. The approach should be applicable to a wide variety of demand formation processes, but especially so in instances where interest group resources (such as time, money, or political capital) are unusually strained, either because collective actors are currently facing challenges on a variety of issues or because they have suffered some decline in resources. The approach should also have particular value in studies of multi-issue groups, since such groups have greater opportunity and necessity to prioritize among policy desires on different issues. It should also be valuable in corporatist settings where interest groups and the state have opportunities to negotiate explicit tradeoffs among policy desires. Finally, the approach should be useful for understanding interest group logrolling—when a group allies with another group on a low-priority issue, in exchange for the support of that group on a higher priority one. The historical priorities approach should help to identify the issues on which groups will be most willing to make such trades.

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