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Political Institutions and the Comparative Medicalization of Abortion

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Abstract

Comparative-historical research on medicalization is rare and, perhaps for that reason, largely ignores political institutions, which tend to vary more across countries than within them. This article proposes a political-institutional theory of medicalization in which health care policy legacies, political decentralization, and constitutionalism shape the preferences, discourses, strategies, and influence of actors that seek or resist medicalization. The theory helps explain why abortion has been more medicalized in Britain than the United States. The analysis finds that the American medical profession, unlike its British counterpart, focused on defending private medicine rather than protecting its power to "diagnose" the medical necessity of abortions; that American political decentralization aided the establishment of abortion on request by encouraging strategic innovation and learning that shaped social movement strategies, medical issue avoidance, and the growth of nonhospital clinics; and finally, that constitutionalism promoted rights discourses that partially crowded out medical ones.

Keywords

abortion, medicalization, social movements, medical profession, political institutions

Since the late 1960s, more than a thousand studies have examined medicalization (for reviews, see Ballard and Elston 2005; Bell and Figert 2012; Busfield 2017; Conrad 2007), and these have yielded valuable insights about the nature, causes, and consequences of the process. But most of these studies examine only a single country—most commonly the United States or the United Kingdom. Because of this lack of comparative perspective, existing scholarship has paid inadequate attention to political institutions, which typically vary more across countries than within them.[1]

Responding to longstanding calls for comparative-historical research on medicalization (Conrad and Schneider 1980) and health social movements (Epstein 2008) as well as calls to integrate medical sociology and the political sociology of the welfare state (Olafsdottir and Beckfield 2011), this study develops a political-institutional theory of medicalization in which health care policy legacies, political decentralization, and constitutionalism mold the "interests," actions, and influence of social actors that seek or resist medicalization. It assesses the theory through a comparison of abortion medicalization in the United States and Britain between 1967 and 1977—the period in which the two countries experienced major changes in law, service delivery, and physician engagement that shaped the later medicalization of abortion. The article finds that abortion medicalization was stronger in Britain than in the United States and that the political-institutional theory of medicalization helps explain why.

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BACKGROUND

The two most prominent definitions of medicalization define it as a process by which aspects of everyday life come under medical *jurisdiction* (Zola 1983:295) or by which social problems are addressed through medical *discourses and treatments* (Bell and Figert 2012; Conrad 1992:211). To this, Halfmann (2012) adds *medical practices* (not just treatments), *the presence of individual and collective medical actors* (not just their jurisdiction), and *medical identities* (drawing from Clarke et al. 2003). Under this definition, the one used here, medicalization increases when biomedical *discourses, practices*, or *actors/identities* "become more prevalent, powerful, or salient in addressing social problems" (Halfmann 2012:5–6). As such, medicalization should be viewed as a continuum in which conditions are more or less medicalized rather than a binary state—medicalized or not. Moreover, medicalization often increases along one dimension while decreasing along another.

Cross-national research on medicalization (and demedicalization) has identified determinants of this process that can be grouped into four main families: social actors, culture/discourse, state bureaucracies, and political institutions. These families of factors are often explicitly borrowed from the literatures on comparative welfare states and the consequences of social movements (Amenta et al. 2010; Bosi, Giugni, and Uba 2016; Van Kersbergen and Vis 2014). In the comparative-historical literature on medicalization, *social actor* theories typically focus on four types of actors: (1) physicians (including psychiatrists) and their organizations (C. Benoit et al. 2010; L.M. Carpenter 2010; Conrad and Bergey 2014); (2) business organizations, especially those in the pharmaceutical, biotechnology, and insurance industries (Conrad and Bergey 2014; Morrison 2015); (3) nonmedical professionals in fields such as education, psychology, public health, social welfare, alternative medicine, drug control, and law enforcement (E. Benoit 2003; Malacrida 2003; Nathanson 2007); and (4) patients/consumers and social movements (M. Carpenter 2010; Conrad and Bergey 2014; Nathanson 2007). The assumption of most social actor theories is that cross-country or historical variation in the medicalization of a given issue will correspond with the relative power of the social actors active on that issue in terms of their resources, social status, legitimacy, political influence, and capacity for persuasion or disruption.

Social movements and medical actors (defined here as individual physicians, medical professional associations, and physician-led organizations such as hospitals) play a central role in this study. Previous studies show that these types of actors have various and contextual attitudes toward medicalization and demedicalization, and as a result, those studies offer no clear basis for developing hypotheses about such attitudes (Conrad 1992; Epstein 2008). In fact, some scholars have critiqued the tendency of many scholars to assume "medical imperialism"—that physicians always seek medicalization and are its main drivers (Strong 1979; S.J. Williams 2001). Existing theory does, however, suggest hypotheses about the conditions under which social movements and medical actors are most likely to achieve their medicalization (or demedicalization) goals. Social movement resource theory expects that movements with more resources (e.g., members or money) will be more influential in policymaking (McCarthy and Zald 1977), and this may apply to other institutional locations of medicalization as well. And professional dominance theory (Freidson 1970) claims that medical actors are the most powerful participants in the health care sector (especially during the period of this study) and routinely obtain their preferred outcomes.

A second family of theories, *discourse/culture*, emphasizes the ways in which problems, solutions, risks, villains, victims, and ideas about medicalization itself are framed and socially constructed (Nathanson 2007). These theories also point to broader cultural forces (with material structures and consequences) such as national values, patriarchy, racism, religious belief, rationalism, and neo-liberalism (C. Benoit et al. 2010; Clarke et al. 2003; Conrad 2007; Nathanson 2007). A third family, *state bureaucracy*, focuses on the political power, legitimacy, and implementation capacities of state bureaucracies; their support or opposition to medicalization; and their relationship to medical professionals (C. Benoit et al. 2010; E. Benoit 2003; Nathanson 2007).

A Political-Institutional Theory of Medicalization

Only a handful of studies have incorporated *political-institutional* factors in comparative work on medicalization, mainly by examining the effects of welfare state and health policy legacies on the process (E. Benoit 2003; L.M. Carpenter 2010; M. Carpenter 2000; Conrad and Bergey 2014; Nathanson 2007; Olafsdottir 2007). The political-institutional theory of medicalization broadens this

focus by identifying factors and mechanisms that have not before appeared in the medicalization literature. It includes not only health policy legacies but the effects of two other political institutions: political decentralization and constitutionalism. It also identifies two causal mechanisms, borrowed from the welfare state literature, by which health policy legacies affect medicalization: (1) by shaping the "interests" of medical associations and (2) through "failures" of medicalization that shape the later cognitions and claims of social actors and government officials (Halfmann 2011; Tocqueville 1955). Finally, the theory argues that the effects of political institutions on medicalization often occur through social actors because political institutions shape their preferences, strategies, discourses, and efficacy.

Policy legacies. Policy legacies can promote or discourage subsequent medicalization in a variety of ways. They can shape the perceived interests of individual and collective actors (Pierson 1993; Skocpol 1992; Van Kersbergen and Vis 2014). For example, medical actors in public health care systems may attend more closely to medicalization with clinical implications, while those in private systems may be more concerned about medicalization with economic significance (Halfmann 2011). Policies also establish discourses and jurisdictions in a given issue area that provide contexts for later medicalization, both in the initial issue area and in those deemed related or similar (E. Benoit 2003; Nathanson 2007). Failed policies can discredit medicalization, lead to policy learning, and open up new political opportunities. Similarly, the medicalization of a given social problem often legitimizes its continued medicalization (E. Benoit 2003; Carpenter 2010; Van Kersbergen and Vis 2014).

Political decentralization. Political decentralization is embodied in such institutions as federalism and the separation of powers (presidentialism, bicameralism, and judicial review). It yields numerous political contexts and often lengthy policymaking, both of which provide numerous opportunities for innovation, learning, alliance formation, and venue switching (Amenta and Young 1999; Baumgartner and Jones 1991; Halfmann 2011; Skocpol 1992). This diversity of contexts, actors, and strategies makes it more likely that some actors will challenge the dominant actor in an issue area (often the medical profession). Finally, actors in federal polities often organize themselves federally so that they can exert constituent pressure in every electoral district (Skocpol 1992). This may make it easier for them to defuse intraorganizational conflict because they can allow subnational units to go their own way, but they may also have difficulty forging and articulating national positions.

Constitutionalism. Constitutionalism is a set of norms and principles in which government power is limited by fundamental rights and in which judicial policymaking and rights discourses are prevalent (Ferree et al. 2002; Glendon 1987; Scheppele 1996). Constitutionalism often moralizes issues, encourages absolutist claims, and increases controversy, all of which may cause elected officials and medical associations to avoid such issues because they fear blame from intense minorities. Rights discourses may also inhibit or displace medical ones (Burns 2005; Glendon 1987; Weaver 1986). Judicial policymaking may also increase the influence of professional elites, such as physicians, because judges view them as colleagues who, like them, have expert knowledge, serve the public good, and are representative of broader elite opinion (Halfmann 2011).

DATA AND METHODS

This study utilizes comparative-historical, case study, and interpretive methods to examine the implications of medicalization theories not only across cases but also at multiple points within them, allowing for a large number of observations that address the alleged small-n problem of comparative-historical analysis. It presents "strategic narratives" purposely structured to assess the degree to which hypothesized causal factors and mechanisms are present in the cases and to identify previously unrecognized factors and mechanisms (George and Bennett 2005).

The study focuses on three institutional locations—law, services, and medical engagement—in which the medicalization of abortion has the strongest implications for *access* to abortion services, as opposed to locations that might influence other aspects of abortion, such as stigma or the *utilization* of services. The selection of national cases and the historical period of the study is based on a "most similar-systems" design that roughly controls for potential causal factors that the countries and time periods have in common, such as cultural and religious traditions, political and legal systems, and social and demographic trends (George and Bennett 2005; Glendon 1987). The Abortion Act of 1967 did not apply to Northern

Ireland and thus is not considered here. The boundaries of the period have been chosen both to capture key events and ensure that the contexts of medicalization in the two countries are as comparable as possible. The period of the study begins in 1961, when abortion reform first reached the policy agenda in the United States (1965 in Britain) and when both countries were in the midst of dramatic social and demographic changes relating to gender, family, and sexuality. It ends in 1977, after both countries had enacted and implemented new laws and before a dramatic change occurred in the American context: the entry of Evangelical Christians into the debate and increasing party polarization over abortion. As such, the period examined here represents a "branching moment of relatively high uncertainty" in which "options open and then close off" (Katznelson 1997:12). Many of the changes of the period were "sticky," establishing precedents and logics that continue to shape the medicalization of abortion. In other words, the study examines a "critical juncture" that launched "path dependent" processes (Capoccia and Kelemen 2007; Katznelson 1997).

Documents, secondary historical monographs, and a small number of interviews are used to reconstruct key events, chronologies, contexts, and meanings, and these sources are triangulated in order to corroborate and contextualize each other. The arguments of single-country studies are also reanalyzed in light of cross-national patterns (Skocpol and Somers 1980). More information about these sources and their selection is in the Supplemental Material, available in the online version of the journal. Because the documentary record is not as complete for the American Medical Association (AMA) as for other actors, the author conducted four supplementary one-hour interviews with senior AMA officials in 2001 and 2002. Informants were chosen because they played central roles in the AMA's deliberations over abortion during the 1960s and 1970s. Three were from the AMA's executive staff, and one was a member of the House of Delegates who had served on the association's reproduction committees.

RESULTS

The Medicalization (and Demedicalization) of Abortion

The enactment and implementation of new abortion laws in the 1960s and 1970s left abortion more strongly medicalized in Britain than in the United States in three institutional locations: law, service delivery, and the participation and positions of medical associations.

Law. In both countries, beginning in the nineteenth century, abortion was a criminal offense, but physicians could perform therapeutic abortions for reasons of medical necessity, defined in terms of threats to the life and more rarely, the physical health of the pregnant woman. In 1938, a British court added a narrow mental health ground (*Rex v. Bourne* 1939). There was no similar ruling in the United States, but over time, many physicians began providing abortions for broader health reasons, including mental health and fetal abnormalities. In 1967, Britain and three American states (California, Colorado, and North Carolina) enacted laws that codified this change, broadening the legal definition of medical necessity to include both physical and mental health and, in all except California, fetal abnormality. In addition, Britain added narrow economic hardship grounds (defined as a risk to health), and the three American states added indications for rape, incest, and underage pregnancy.[2] The new laws required authorization by two doctors in Britain, three in North Carolina, and hospital committees in California and Colorado. Over the next five years, 10 more American states enacted similar reforms (Great Britain Parliament 1967; Roemer 1971). Though these reforms were notable breakthroughs, they merely modified the existing medical-supervision regime and thus had little effect on the medicalization of abortion.

In Britain, legal change ended there, but in the United States, a second period of reform decreased the medicalization of abortion. Between 1969 and 1972, state and federal courts struck down abortion laws in 10 states and the District of Columbia, and in 1970, New York, Washington, Alaska, and Hawaii enacted abortion laws that allowed physicians to provide early abortions on request (Roemer 1971). Finally, in 1973, the American Supreme Court struck down the laws of most states, allowing abortion on request before fetal viability. The ruling decreased medicalization by eliminating requirements of medical necessity and thus the power of physicians to approve abortions. In contrast to Britain, national abortion reform replaced the highly medicalized discourse of therapeutic abortion with a discourse about the constitutional right of privacy. The American reform did not completely eliminate medicalization though: In most states, abortions could only be carried out by physicians, and post-viability abortions required medical necessity (*Doe v. Bolton* 1973; *Roe v. Wade* 1973).

Services. After the reforms, the incidence of legal abortion increased in both countries while self-abortions and abortions by nonphysicians declined, thus increasing medicalization (Cates and Rochat 1976; Centers for Disease Control and Prevention 1980; Great Britain Office for National Statistics 2001). But, the countries differed in the degree to which abortion services were delivered by socially legitimate, mainstream medical actors. In the United States, nonhospital clinics supplied approximately 70% of abortions by 1977, and this grew to 95% by 2000 (Finer and Henshaw 2003; Guttmacher Institute 2003; Henshaw 1982). Clinic abortions were provided by physicians (as required by law in most states), but those physicians and the clinics themselves were stigmatized and marginal to mainstream medicine. This fact, along with the social construction of abortion as an "elective" procedure, contributed to the exclusion of abortion from the category of standard medical care. Mainstream physicians looked down on "abortionists" for their involvement with morally questionable "dirty work," their entrepreneurship ("profiteering"), their provision of abortion at the "demand" of patients, and their performance of a technically simple procedure provided in an "assembly-line" fashion (Goldstein 1984; Joffe 1995). In addition, though most clinics were founded and managed by physician-entrepreneurs, one-third were nonprofit (often with a feminist or social justice orientation), and these involved nonmedical providers in many aspects of care, especially referrals and counseling. Though these clinics were required by law to employ physicians, many clinics, and especially the feminist ones, excluded physicians from leadership roles (Joffe 1995). Private clinics were also prevalent in Britain—in 1977, they supplied approximately half of English and Welsh abortions and 12% of Scottish ones—but this was a lower percentage than in the United States, and the majority of abortions took place in National Health Service (NHS) hospitals (Great Britain Office for National Statistics 2001).

The two countries also differed in terms of abortion funding, an indicator of the degree to which abortion was considered part of standard medical care. In the United States, most patients paid out-of-pocket while approximately one-quarter received public funding through Medicaid, the health insurance program for some of the poor. But in 1977, Congress eliminated federal funding for Medicaid abortions (though approximately a dozen states continued funding abortions with their own money; Guttmacher Institute 2003). In Britain, all hospital abortions were publicly funded, and after 1981, an increasing number of private clinic abortions were as well (Great Britain Office for National Statistics 2001).

The engagement of the medical profession. The preferences and participation of medical associations in the abortion debate can be considered elements of medicalization because of the profession's power to determine which services are medically necessary and thus part of standard medical care. In Britain, the medical associations most affected by abortion policy, the British Medical Association (BMA) and the Royal College of Obstaetricians and Gynaecologists (RCOG), immersed themselves in abortion policymaking and services and actively pursued a medical-necessity reform. In the United States, *individual* doctors played a crucial role in the campaign to reform abortion laws, but the AMA and American College of Obstetricians and Gynecologists (ACOG) were hesitant to deal with the issue. In the interest of space, this article focuses on the AMA, the most influential of the two organizations, but the ACOG took similar positions to the AMA.[3] Initially, the AMA preferred medical-necessity reforms like its British counterparts, but it eventually accepted abortion on request. And after *Roe*, the AMA only weakly defended abortion services (Imber 1986; Jaffe, Lindheim, and Lee 1981).

Contemporary abortion policy and practice. A detailed discussion of contemporary abortion policy and practice is beyond the scope of this article, but many of the patterns established in the late 1960s and early 1970s continue today. Abortion remains more medicalized in Britain than in the United States. British abortions still require medical necessity, though interpretations have broadened considerably. More abortions are provided in mainstream settings than in the United States, and even private clinics are well integrated into the NHS, which pays for most abortions, including those in private clinics. The medical profession remains highly engaged in abortion policy and provision (British Pregnancy Advisory Service 2013; Great Britain Department of Health 2017). In the United States, by contrast, abortion services remain strongly segregated from mainstream medicine. Most physicians and hospitals do not provide abortions, and most women pay for them out-of-pocket. Protest, harassment, violence, and anti-abortion legislation have made mainstream providers even more reluctant to provide abortions (Freedman 2010; Joffe 2003). Various anti-abortion laws also substitute legislative

judgment for medical judgment, preventing physicians from providing timely and accessible care, choosing appropriate procedures and safety measures, and providing accurate information. Medical associations mainly sidestepped the abortion debate until the 1990s and are still not as engaged as the British profession (Freedman 2010; Imber 1986; Jaffe et al. 1981; Joffe 1995).

Explaining Abortion Medicalization in the United States and Britain

How to explain these differences? It should first be noted that abortion reforms in the United States and Britain and in rich democracies more generally were driven by a number of shared factors: secularization, changing women's roles, increased participation of women in higher education and the labor force, the sexual and contraceptive revolutions, declining fertility and marriage, and epidemics of fetal abnormalities. There were other similarities in the abortion politics of the two countries as well. In both countries, the public was supportive of some reform but took little notice until the laws had already been changed, and the Catholic Church was fiercely opposed while Protestant denominations, including many Evangelical ones, were supportive or neutral (Halfmann 2011; Luker 1984).

But the two countries also differed in several ways that drove differences in the medicalization of abortion. Pattern matching across cases and across time offers some support for social movement, medical dominance, and cultural theories. The American abortion movement was much larger than the British movement, and this is consistent with the more expansive reform in the United States. But the American anti-abortion movement was also much larger than its British counterpart, and this likely cancelled out some of the American abortion movement's resource advantage. In terms of the timing of the reforms, the British Abortion Act was enacted in 1967 when the abortion movement lagged its opponent in numbers but held the advantage in elite connections. After 1967, however, the abortion movement successfully repelled attacks on the Act, both when it was smaller than its opponent and after 1975, when it gained a numerical advantage through alliance with the labor movement (Halfmann 2011; Hindell and Simms 1971; Hoggart 2003; Lovenduski 1986). In the United States, the two opposing movements achieved a similar number of victories in the states (i.e., on legislation, referenda, and court rulings) both when the abortion movement had a significant resource advantage between 1962 and 1970 and when the two sides were more evenly matched in 1971 and 1972. The antiabortion movement did, however, win significant victories after *Roe* when its resources and numbers dwarfed those of its opponent (Halfmann 2011; Karrer 2011; Staggenborg 1991; D.K. Williams 2015; see the Supplemental Material in the online version of the journal for more detail on the resources of the movements and their policy victories and losses).

Medical associations in both countries were quite powerful and preferred medical-necessity reforms, but contrary to medical dominance theory, only the British associations achieved this preference. And contrary to religious culture theories, the country with the highest percentage of Catholics, the United States, ended up with the most liberal policy. The prevalence of rights discourse in the United States is consistent with the stronger role of classical liberalism in that country (Ferree et al. 2002; Glendon 1987) but is inconsistent with how similar the discourses and reforms in the two countries were between 1960 and 1969. In addition, cultural values that date back to the founding of the United States cannot account for the abrupt change from medical necessity to early abortion on request in the late 1960s. State bureaucracies were not key drivers of reform in either country.

This is not to say that discourses, social movements, and the medical profession were unimportant to the medicalization of abortion. Instead, political-institutional theory helps us trace the roots of social actors' preferences, strategies, resources, and discourses. Policy legacies, political decentralization, and constitutionalism help us explain why British medical associations pursued and obtained medical-necessity reforms while their American counterparts did not, why the American abortion movement became larger and made more radical claims than the British movement, why nonhospital clinics became so central to American abortion provision, and why the narrow therapeutic discourse in the United States was eventually displaced by broader discourses related to rights.

Health care policy legacies and medical interests in Britain. The stronger British medicalization of abortion was shaped by health care policy legacies, especially the ways in which they influenced the perceived interests of the medical associations. British physicians had fought the creation of the NHS in 1948 because it stripped them of much of their economic and organizational independence. As compensation for that loss, they received high

incomes, a key role in NHS management, and clinical freedom that surpassed that in the United States. As a result, medical associations developed close relationships with the state and viewed clinical autonomy as a fundamental value (Elston 1991).

This legacy shaped the heavy involvement of the British medical associations in reform politics. The associations published reports, shared them with members of parliament (MPs), debated the bill in the newspapers, and urged members to write letters to their MPs (BMA 1965, 1966a, 1966b, 1967; BMA and RCOG 1966; Gullick 1967; Hindell and Simms 1971; MacLennan 1965; Potts, Diggory, and Peel 1977). Most importantly, they participated extensively in the drafting of the bill: consulting with the bill's sponsor, Liberal MP David Steel, the government's health and justice ministers, and the main social movement organization, the Abortion Law Reform Association (ALRA; Hindell and Simms 1971; Houghton 1967).

Given their desire to preserve clinical freedom, the medical associations repeatedly demanded, to a greater degree than their American colleagues, that all abortion indications fit into a medical-necessity framework that would allow doctors to exercise clinical discretion. Abortion reform involved dual threats to clinical freedom—from the state, which would specify the conditions under which physicians could provide abortions, and from women patients, who might "demand" abortions. Given their now friendly relations with the state, the BMA and RCOG were much more worried about the latter. They argued that doctors should "diagnose" the necessity of abortion using solely medical criteria and assess each case "on its own merits" with "freedom of action" and without being "coerced" or "pressured" by the state or by patients (BMA and RCOG 1966:1649–50). The associations worried that "social" (nonmedical) grounds might lead women to believe that abortions would be authorized "automatically" (RCOG 1966:852). As a result, the associations opposed specific indications for economic hardship, rape, and underage pregnancy, instead demanding that they be covered under a broader mental health ground. They also opposed language allowing doctors to consider the patient's "well-being" as a health criterion because it might lead to abortion "for convenience." Over the objections of the ALRA, Steel acceded to these demands (BMA 1966a, 1966b; BMA and RCOG 1966; Hindell and Simms 1971; RCOG 1966).

In terms of service delivery, the medical associations, and especially the RCOG, worried that some physicians might offer broad interpretations of the law in exchange for large fees, jeopardizing the profession's reputation. To this end, they demanded that all abortions be approved by at least one NHS consultant (senior specialist), but because this measure would have dramatically restricted abortion access, Steel and the ALRA successfully resisted it. The medical associations did, however, obtain a conscientious objection clause (BMA 1966a, 1966b; BMA and RCOG 1966; Hindell and Simms 1971; Houghton 1967; Keown 1988).

Health care policy legacies and medical interests in the United States. In the United States, most hospitals were private and most physicians were self-employed and received fee-for-service reimbursement from private and (after 1965) public insurers, neither of which did much to control costs. As a result, American physicians had strong economic autonomy and very high incomes (Starr 1982). The AMA wanted to keep it that way. It opposed most government involvement in the economics or organization of health care and went mainly undefeated before the enactment of Medicare in 1965 (Quadagno 2004; Starr 1982). Health policy scholars note that the profession cared more about economic than clinical autonomy—though it considered them related (Klein 1981; Starr 1982; Interview 2).

Two other features of the American medical system also influenced the medicalization of abortion. Unlike in Britain, patients could access specialists without referrals, and as a result, primary care physicians would play only a limited role in abortion provision. And because physicians were self-employed, they were free to deny requests for care without explicitly invoking a conscientious objection (Imber 1986; Potts et al. 1977). Initially, some American ob/gyns feared that demands for abortion on request would force them to devote most of their time to abortion rather than childbirth. However, the establishment of single-purpose abortion clinics in the District of Columbia, California, and New York in 1969 and 1970 reassured them that they could decide how many abortions to do since clinics would pick up the slack. Most mainstream ob/gyns and hospitals decided not to do any (Guttmacher 1972; *Medical World News* 1970; Pakter and Nelson 1971; Tietze and Lewit 1972).

Like the BMA and RCOG, the AMA initially supported medical-necessity requirements, but given its greater interest in economic issues than clinical ones and the fact that physicians and hospitals could easily organize abortion out of their practices, it mainly tried to avoid the abortion issue and then partially yielded to demands for abortion on

request. In 1965, some members called on the AMA House of Delegates to adopt a resolution in support of state medical-necessity reform bills. The House of Delegates declined after one of its committees worried that AMA involvement with the issue might threaten the legitimacy of the AMA-controlled state medical boards that licensed and regulated physicians and thus controlled their supply. In 1967, the AMA Delegates approved a resolution declaring that therapeutic abortions were ethical, but they declined to advocate abortion reform, arguing that it was the responsibility of state legislatures. In 1969, the Delegates overwhelmingly defeated a resolution proposed by physicians in academic medicine and public health that called for states to allow abortion on request. Finally, in 1970, the Delegates approved a compromise resolution facilitated by the AMA board. It did not specify criteria for approving abortions and thus allowed them on request, but it also retained the logic of medical-necessity by recommending that abortions be approved by three doctors and only when they were in a patient's best interests, rather than in "mere acquiescence" to her demands (AMA 1965, 1967, 1969, 1970; Interviews 1 and 4). A year later, the AMA continued to avoid the issue, declining requests to sign amicus briefs in *Roe* and *Doe* (Garrow 1994).

Not only did the AMA have a general suspicion of the state and a primary concern for economic issues, but these concerns were especially salient at the time of the abortion reforms. Though the AMA had failed to prevent Medicare in 1965, it gained significant concessions on cost control. Soon after, critics accused it of molding the program to its own interests and abusing its reimbursement system. Congress and the president looked likely to enact a national health insurance plan (Starr 1982). Moreover, after the Medicare defeat, a new leadership team affiliated with the AMA's political action committee had taken control of the association and was eager to polish the image of the profession (Campion 1984; Interviews 1, 2, 3, and 4). Given this crowded and threatening agenda, the AMA had to prioritize, and abortion was not a top priority (Interviews 2, 3, 4). "It was not even in the top 10," said an AMA staff member of the time, "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 2). Rather than fighting to maintain medical necessity, the AMA partially liberalized its abortion stance. This allowed it to appease some of its critics but on a matter with few economic consequences (Howard 1970). Though the new AMA position, with its failure to specify grounds for abortion authorization, reduced physicians' autonomy in relation to their patients (who might now "demand" abortions), many physicians saw it (or reframed it) as an increase in their autonomy from both the state and patients because physicians alone would decide whether they wanted to do abortions and they could easily organize them out of their practices (Interview 1 and 2).

Political decentralization. Political decentralization also decreased abortion medicalization in the United States by facilitating new movement strategies and claims, reducing the AMA's willingness to take a public position on abortion and contributing to the growth of nonhospital clinics. The American abortion movement of the early and mid-1960s was composed of professionals, mainly physicians and lawyers, who focused on maternal deaths and fetal abnormalities and sought to reform abortion laws along medical lines similar to those in Britain (Garrow 1994). But in late 1968 and early 1969, these activists, along with a large number of new ones from the feminist, environmental population control, and civil liberties movements, increasingly utilized new discourses demanding the partial demedicalization of abortion. They argued that existing laws should be "repealed" and that doctors should do abortions "on demand" or "on request." Many made these arguments in the language of human and constitutional rights (Burns 2005; Hart and Lowry 1968; Luker 1984; Staggenborg 1991).

Political decentralization helps to explain changes in the claims of the American movement. In the American federal system, abortion reform process was lengthier, later, and more decentralized than in Britain. American policymaking (from the first state bill to national reform) lasted approximately 12 years and ended in 1973, while British policymaking took two years and ended in 1967. In the United States, abortion was debated in the legislatures and/or courts of every state (author's data set) as well as in the Supreme Court and Congress, while in Britain, it was considered only in the national parliament. The slow, decentralized American policymaking process helped activists learn about the most effective policies and political strategies, both from other venues and from historical experience, and this led to new discourses, tactics, and alliances.

From the beginning, American activists knew that medical-necessity reforms were unlikely to significantly reduce the number of illegal abortions

because they would rely on physician interpretations of health that were likely to be narrow (Overstreet 1971). As a result, most activists privately supported abortion on request but believed that the public was not ready for such a change (Kimmey 1971). But the medical-necessity reforms of 1967 helped lay the groundwork for abortion on request by drawing attention to the weaknesses of those reforms (Hart and Lowry 1968; Hall 1968). As a result, "failed" policies in Colorado and North Carolina, which only minimally increased abortion access, led to more radical demands. They also led to a liberalization in public opinion, especially elite opinion, as well as increased movement mobilization as clergy and feminist organizations established referral services for illegal abortions (Hall 1968; Kaplan 1997; Roemer 1971). The long and dispersed policymaking process allowed initial reformers to develop new claims and ally with other movements of the 1960s protest wave, such as the student, anti-war, women's liberation, and population control movements that were then challenging a wide variety of authorities, including medical ones. This dramatically increased the size and disruptive potential of the movement (Staggenborg 1991).

Political fragmentation also affected the willingness of the AMA to engage with the issue. Like many organizations in federal polities, the AMA was organized to match it—with county, state, and national affiliates that allowed it to exert constituent pressure in every electoral district (Campion 1984). But state medical societies held varying positions on abortion, and this caused problems for the national AMA leadership. An analysis of newspaper and medical journal articles (see Supplemental Material in the online version of the journal) shows that state medical societies endorsed medical-necessity bills (officially or unofficially) in at least 23 states, including all 13 that enacted such reforms between 1967 and 1972. And, they endorsed abortion-on-request bills in approximately 70% of the 26 states in which such bills were introduced. But some state medical societies, most notably those in states with large Catholic populations, opposed abortion on request. There were also differences among specialties: Abortion on request had stronger support among physicians from universities, public health, and psychiatry than among ob/gyns and primary care physicians, and the latter were better represented in the AMA (*Modern Medicine* 1969; Interview 1). This dissension encouraged the AMA's national leaders to avoid the abortion debate. It also helped them to do so. Because state medical societies could declare their own views on state legislation, there was less pressure on national AMA leaders to take a position. They argued that abortion law was the appropriate domain of state affiliates. And when the AMA's national leadership finally proposed a new resolution in 1970, it brokered a vague compromise. "It was a good politician's solution to a problem—keep everybody happy," said one AMA executive (Interviews 1 and 4).

Decentralization and the lengthy policymaking that accompanied it also affected abortion services. In the late 1960s and early 1970s, many women's liberation organizations, frustrated with the slow pace of reform and hoping to serve needy women while putting pressure on the existing system, provided abortion referrals, counseling, aftercare, and in some cases, illegal procedures. This experience, along with a growing critique of patriarchal medicine, convinced many activists that nonprofit feminist clinics could provide better and more sensitive services than hospitals because they were less expensive, less likely to employ anti-abortion staff, and more likely to offer counseling and emotional support (Cisler 1970; Kaplan 1997; Reagan 1997). The unwillingness of ob/gyns to provide abortions also contributed to the growth of clinics. Some physicians claimed that "abortion on demand" (as they called it) reduced medical power and discretion, while others feared being labeled "abortionists" working in "abortion mills." The attitudes of physicians largely determined the policies of their hospitals (Jaffe et al. 1981; Joffe 1995; Joffe, Weitz, and Stacey 2004). Clinics also developed because physician-entrepreneurs in the market-based American health system saw them as business opportunities. The very legality of clinics was also facilitated by political decentralization because the positive safety records of the pre-*Roe* clinics in New York, California, and the District of Columbia convinced the Supreme Court that the hospital requirements contained in most state laws were unnecessary (*Doe v. Bolton* 1973; Pakter and Nelson 1971; Tietze and Lewit 1972).

In Britain's unitary polity, the situation was much different. Like their counterparts in the early American reform movement, the early British activists were social elites—mainly middle- and upper-class women, including many professionals—and many had strong personal ties to Parliament and the state bureaucracy. Like the early American movement, the association focused on maternal deaths, pursued a medical-necessity reform, and did not call for abortion on request or frame abortion as a

matter of women's rights. In the context of a unitary polity, a quick and early national-level reform incorporated those narrow, medicalized demands (Hindell and Simms 1971; Houghton 1967). It would be eight more years before abortion activists called for "abortion on demand" (Hoggart 2003).

Constitutionalism. Constitutionalism decreased abortion medicalization in the United States by promoting rights discourses and providing litigation opportunities as well as increasing medical avoidance of the abortion issue. The British and American polities both contain elements of constitutionalism, but it is unusually strong in the United States with its written constitution and bill of rights, strong powers of judicial review, and long history of resolving policy disputes in constitutional courts. This makes rights discourses especially influential in the United States and not just in the courts (Glendon 1987; Scheppele 1996). This was also the time of the "rights revolution," in which federal courts strongly expanded individual rights, and activists imitated the legal strategies of the civil rights movement and, in the case of abortion activists, the birth control movement (Epp 1998). Political fragmentation and venue shopping also encouraged constitutional strategies. The emergence of the second-wave feminist and anti-abortion movements, along with their embrace of rights discourses, which framed abortion in moral terms, increased controversy, and as a result, lawmakers began to avoid the abortion issue (Burns 2005). This prompted activists to consider alternatives to legislation such as referenda, educational campaigns, protest, civil disobedience, and constitutional challenges (Hart and Lowry 1968; Kimmey 1971). Moreover, as legal challenges increased, many lawmakers refused to legislate until they saw what the courts might do, and this prompted advocates to mount still more court challenges (Garrow 1994). Litigation was also appealing because the anti-abortion movement, though gaining ground in legislatures, was still relatively weak in the courts (Staggenborg 1991). The first legal challenges were initiated by the California Committee on Therapeutic Abortion and Association for the Study of Abortion (ASA) in 1966 and 1968, respectively (Garrow 1994). But after the California Supreme Court struck down that state's pre-reform law in September 1969 (*People v. Belous* 1969), a wide variety of groups joined in. By the fall of 1970, there were 20 cases in three-judge federal courts and five in the Supreme Court (Roemer 1971). And in December 1971, the Supreme Court heard oral arguments in the cases that would eventually bring down abortion laws nationwide (Garrow 1994; Rubin 1987). By contrast, the British abortion movement, located in a system with an unwritten constitution and minimal judicial review, never had similar options to its American counterparts. It could only pursue legislation through the national parliament using medical discourses approved by the medical profession.

Through constitutional litigation, American activists developed and disseminated rights discourses that challenged and partially supplanted earlier medicalized ones related to threats to pregnant women's physical and mental health, deaths from illegal abortions, and fetal abnormalities (Burns 2005; Ferree et al. 2002; Luker 1984; Munson 2018; Reiterman 1971; Ziegler 2009). Most litigators pursued a strategy first developed by legal scholar and ASA consultant Roy Lucas, which argued that "life" and "health" were so vague that physicians could not perform abortions without risking prosecution, that the First Amendment's "freedom of association" protected physician-patient relationships, and that a fundamental right to control one's reproduction was part of the marital privacy right established in the 1965 *Griswold v. Connecticut* contraception case (Garrow 1994; Lader 1973; Lucas 1967). More feminist lawyers put forth those and other, broader, arguments, contending that abortion laws violated women's right to equal protection of the laws and that forced childbirth was a form of involuntary servitude as well as a cruel and unusual punishment for having sex (Siegel 2010). Medical associations also embraced constitutional discourses. Arguments about clinical discretion and medical necessity were joined by constitutional defenses of the physician-patient relationship and a claim that *Griswold* had established a constitutional right for physicians to exercise medical judgement (Interviews 2 and 4; Garrow 1994).

Rights discourses, both from the abortion movement and its opponents, increased controversy (Burns 2005; Glendon 1987), and this discouraged AMA involvement because it increased internal conflict, hindered compromise, and made it impossible to address the issue through "objective" scientific knowledge (Interview 4). The British reform, by contrast, removed abortion from public debate and left it to medical experts who made decisions for ostensibly neutral and scientific reasons.

Though the turn to the courts reduced the involvement of medical professionals in the American debate, it did not reduce their influence because the courts were especially responsive to the opinions of fellow professional experts. For

this reason, litigators almost always enlisted medical professionals as plaintiffs and amici (Hart and Lowry 1968; Lucas et al. 1971). And the views of the medical profession, and especially of the AMA, were critical for Supreme Court Justice Harry Blackmun, the swing voter and author of *Roe.* In his *Roe* opinion, the former counsel for the Mayo Clinic lauded doctors, quoted the AMA's 1970 resolution, and mirrored its compromise (Hunter 2006). Like the AMA resolution, the opinion did not articulate specific grounds for physician gatekeeping but implied that such gatekeeping would continue. It declared that abortion "is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician" and warned doctors not to abuse "the privilege of exercising proper medical judgment." In a press statement, Blackmun insisted that "the Court does not today hold that the Constitution compels abortion on demand" (quoted in Garrow 1994:587). Given Blackmun's esteem for the medical profession, it seems likely that *Roe* would have read differently if the AMA had continued to specify explicit criteria for judging medical necessity.

DISCUSSION

This article represents an attempt to put comparative-historical inquiry and political-institutional theory at the center of research on the determinants of medicalization and demedicalization. As the findings suggest, political institutions can strongly shape previously hypothesized drivers of those processes, and comparative research offers a useful method for identifying such effects. As such, political-institutional theory challenges theories in which cross-national and historical differences in medicalization are determined by the preexisting power and preferences of the actors involved and the dominance of particular cultural discourses. Instead, political institutions help determine these.

The theory suggests that three particular institutions, which have received little attention in the existing literature on medicalization, can strongly shape the preferences, discourses, strategies, and efficacy of actors pursuing or resisting medicalization. Counter to assumptions of "medical imperialism," the policy legacies of public or private medical systems can tilt medical "interests" toward the preservation of clinical autonomy or away from it, with implications for the types of medicalization they might pursue and the intensity with which they do so. Political decentralization can increase opportunities for innovation and learning by social movements, medical associations, and courts. It also gives activists opportunities to form groups, build coalitions, expand the scope of conflict, and move contention to more favorable venues. Constitutionalism aids rights discourses that supplement and sometimes supersede medical ones.

Methodologically, the utility of comparative-historical research for building political-institutional theory suggests that such research is essential for developing and appraising theories of medicalization. It can help researchers identify causal factors and mechanisms that are missing from previous accounts. It can also reveal the importance of historical legacies and path dependence (Carpenter 2010; Shostak, Conrad, and Horwitz 2008). Finally, it can aid researchers in refining the concept of medicalization and measuring it (Halfmann 2012).

Future research should determine the utility of political-institutional theory in contexts other than those examined here. These include other countries (and especially those outside the West; Bell and Figert 2012) as well as other times, institutional locations, and types of social problems—especially those other than deviance, the current focus of most comparative-historical research on medicalization (but see C. Benoit et al. 2010 on childbirth; Carpenter 2010 on male circumcision). Political institutions are likely important in many of these contexts, but the particular institutions and mechanisms examined here will only apply to some. They are most likely to be relevant in cases that relate to the clinical autonomy of physicians, involve interactions between medical actors and social movements, and can plausibly be framed in terms of rights—for example, challenges to medical authority from the feminist, disability rights, self-help, environmental health, alternative medicine, right-to-die, and anti-vaccine movements (Halpern 2004). In this study, political institutions mainly affected the actions and efficacy of social movements and physicians, but they are likely to shape the effects of many other drivers of medicalization as well. Research is also needed on when, how, and why particular types of actors pursue or resist medicalization. Finally, it would be useful to examine the comparative and historical medicalization of abortion within institutional locations other than law, service delivery, and medical engagement.

SUPPLEMENTAL MATERIAL

Supplemental material is available in the online version of the journal.

NOTES

1. An analysis of articles on medicalization that were (1) published in the last 10 years in prominent general sociology and medical sociology journals or (2) cited 40 times or more (at any time) according to the Social Science Citation Index found only four comparative-historical articles among the 155 unique articles in the analysis (see Appendix in the online version of the journal).
2. The Act also allowed doctors to consider "the pregnant woman's actual or reasonably foreseeable environment" and said that abortions could only be provided if their risk was lower than birth—a provision written by anti-abortion legislators who mistakenly believed that abortion was more dangerous than childbirth (Hindell and Simms 1971).
3. ACOG did not approve its first abortion policy until almost a year after the AMA, and it was more restrictive. It required that threats to health be "serious," folded rape and incest into a health indication, included hospital and spousal consent requirements, and required approval by three doctors. It also opposed abortions to address "unwanted pregnancy" or "population control" but allowed doctors to take account of the patient's "total environment." In 1970, the ACOG Board broadened therapeutic grounds to include "social indications," and in February 1971, seven months after the AMA's similar resolution, the membership approved abortion on request. In June of that year, the Board agreed to sign an amicus brief in *Doe v. Bolton* (Aries 2003).

REFERENCES

Amenta, Edwin, Neal Caren, Elizabeth Chiarello, and Yang Su. 2010. "The Political Consequences of Social Movements." *Annual Review of Sociology* 36(1):287–307.

Amenta, Edwin, and Michael P. Young. 1999. "Democratic States and Social Movements: Theoretical Arguments and Hypotheses." *Social Problems* 46(2):153–68.

American Medical Association. 1965. *House of Delegate Proceedings*. Chicago: American Medical Association.

American Medical Association. 1967. *House of Delegate Proceedings*. Chicago: American Medical Association.

American Medical Association. 1969. *House of Delegate Proceedings*. Chicago: American Medical Association.

American Medical Association. 1970. *House of Delegate Proceedings*. Chicago: American Medical Association.

Aries, Nancy. 2003. "The American College of Obstetricians and Gynecologists and the Evolution of Abortion Policy, 1951–1973: The Politics of Science." *American Journal of Public Health* 93(11):1810–19.

Ballard, Karen, and Mary Ann Elston. 2005. "Medicalisation: A Multi-dimensional Concept." *Social Theory and Health* 3(3):228–41.

Baumgartner, Frank R., and Bryan D. Jones. 1991. "Agenda Dynamics and Policy Subsystems." *The Journal of Politics* 53(4):1044–74.

Bell, Susan E., and Anne E. Figert. 2012. "Medicalization and Pharmaceuticalization at the Intersections: Looking Backward, Sideways and Forward." *Social Science & Medicine* 75(5):775–83.

Benoit, Cecilia, Maria Zadoroznyj, Helga Hallgrimsdottir, Adrienne Treloar, and Kara Taylor. 2010. "Medical Dominance and Neoliberalisation in Maternal Care Provision: The Evidence from Canada and Australia." *Social Science & Medicine* 71(3):475–81.

Benoit, Ellen. 2003. "Not Just a Matter of Criminal Justice: States, Institutions, and North American Drug Policy." *Sociological Forum* 18(2):269–94.

Bosi, Lorenzo, Marco Giugni, and Katrin Uba. 2016. *The Consequences of Social Movements* New York: Cambridge University Press.

British Medical Association. 1965. "Annual Representative Meeting: Abortion." *British Medical Journal* July 17 (Supplement):54.

British Medical Association. 1966a. "Proceedings of Council: Therapeutic Abortion." *British Medical Journal* July 9 (Supplement):19–20.

British Medical Association. 1966b. "Therapeutic Abortion: Report by B.M.A. Special Committee." *British Medical Journal* July 2:40–44.

British Medical Association. 1967. "Annual Report of Council: Therapeutic Abortion." *British Medical Journal* May 6 (Supplement):66.

British Medical Association, and 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* 2(December 31):1649–50.

British Pregancy Advisory Service. 2013. *Britain's Abortion Law: What It Says and Why*. London: British Pregnancy Advisory Service.

Burns, Gene. 2005. *The Moral Veto: Framing Contraception, Abortion, and Cultural Pluralism in the United States*. New York: Cambridge University Press.

Busfield, Joan. 2017. "The Concept of Medicalisation Reassessed." *Sociology of Health & Illness* 39(5):759–74.

Campion, Frank D. 1984. *The AMA and U.S. Health Policy since 1940*. Chicago: Chicago Review Press.

Capoccia, Giovanni, and R. Daniel Kelemen. 2007. "The Study of Critical Junctures: Theory, Narrative, and Counterfactuals in Historical Institutionalism." *World Politics* 59(3):341–69.

Carpenter, Laura M. 2010. "On Remedicalisation: Male Circumcision in the United States and Great Britain." *Sociology of Health & Illness* 32(4):613–30.

Carpenter, Mick. 2000. "'It's a Small World': Mental Health Policy under Welfare Capitalism since 1945." *Sociology of Health & Illness* 22(5):602–20.

Cates, Willard, and Roger Rochat. 1976. "Illegal Abortions in the United States: 1972–1974." *Family Planning Perspectives* 8(2):86–92.

Centers for Disease Control and Prevention. 1980. *Abortion Surveillance Report, 1978*. Atlanta, GA: U.S. Department of Health and Human Services.

Cisler, Lucinda. 1970. "Unfinished Business: Birth Control and Women's Liberation." Pp. 245–89 in *Sisterhood Is Powerful: An Anthology of Writings from the Women's Liberation Movement*, edited by R. Morgan. New York: Random House.

Clarke, Adele E., Laura Mamo, Jennifer R. Fishman, Janet K. Shim, and Jennifer Ruth Fosket. 2003. "Biomedicalization: Technoscientific Tranformations of Health, Illness and Biomedicine." *American Sociological Review* 68(2):161–94.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18(1):209–32.

Conrad, Peter. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.

Conrad, Peter, and Meredith Bergey. 2014. "The Impending Globalization of ADHD: Notes on the Expansion and Growth of a Medicalized Disorder." *Social Science & Medicine* 122(December):31–43.

Conrad, Peter, and Joseph W. Schneider. 1980. *Deviance and Medicalization: From Badness to Sickness*. St. Louis: Mosby.

Doe v. Bolton 410, U.S. 179, 1973.

Elston, Mary Ann. 1991. "The Politics of Professional Power: Medicine in a Changing Health Service." Pp. 58–88 in *The Sociology of the Health Service*, edited by J. Gabe, M. Calnan, and M. Bury. London: Routledge.

Epp, Charles R. 1998. *The Rights Revolutions: Lawyers, Activists and Supreme Courts in Comparative Perspective*. Chicago: University of Chicago Press.

Epstein, Steven. 2008. "Patient Groups and Health Movements." Pp. 499–539 in *The Handbook of Science and Technology Studies*. Vol. 3, edited by E. J. Hackett, O. Amsterdamska, M. Lynch, and J. Wajcman. Cambridge, MA: MIT Press.

Ferree, Myra Marx, William A. Gamson, Jurgen Gerhards, and Dieter Rucht. 2002. *Shaping Abortion Discourse: Democracy and the Public Sphere in Germany and the United States*. Cambridge: Cambridge University Press.

Finer, Lawrence B., and Stanley K. Henshaw. 2003. "Abortion Incidence and Services in the United States in 2000." *Perspectives on Sexual and Reproductive Health* 35(1):6–15.

Freedman, Lori. 2010. *Willing and Unable: Doctors' Constraints in Abortion Care*. Philadelphia: Temple University Press.

Freidson, Eliot. 1970. *Professional Dominance: The Social Structure of Medical Care*. Chicago: Aldine.

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

George, Alexander L., and Andrew Bennett. 2005. *Case Studies and Theory Development in the Social Sciences*. Cambridge, MA: MIT Press.

Glendon, Mary Ann. 1987. *Abortion and Divorce in Western Law*. Cambridge, MA: Harvard University Press.

Goldstein, Michael S. 1984. "Abortion as a Medical Career Choice: Entrepreneurs, Community Physicians, and Others." *Journal of Health and Social Behavior* 25(2):211–29.

Great Britain Department of Health. 2017. *Abortion Statistics, England and Wales: 2016*. London: Great Britain Department of Health.

Great Britain Office for National Statistics. 2001. *Abortion Statistics: Legal Abortions Carried out under the 1967 Abortion Act in England and Wales*. Vol. 28. London: The Stationery Office.

Great Britain Parliament. 1967. *Abortion Act, 1967*. London: Her Majesty's Stationery Office.

Gullick, David. 1967. "Letter from David Gullick, under Secretary, BMA, to Sir John Peel, President, RCOG: Medical Termination of Pregnancy Bill, Meeting at House of Commons 4th May, 1967." London: Archives of the Royal College of Obstetricians and Gynaecologists, A16/4.

Guttmacher, Alan F. 1972. "The Genesis of Liberalized Abortion in New York: A Personal Insight." *Case Western Reserve Law Review* 23(4):756–78.

Guttmacher Institute. 2003. *Trends in Abortion in the United States, 1973–2003*. New York: Alan Guttmacher Institute.

Halfmann, Drew. 2011. *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain and Canada*. Chicago: University of Chicago Press.

Halfmann, Drew. 2012. "Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities." *Health (London)* 16(2):186–207.

Hall, Robert E. 1968. "Abortion Laws: A Call for Reform." *DePaul Law Review* 18(2–3):584–92.

Halpern, Sydney A. 2004. "Medical Authority and the Culture of Rights." *Journal of Health Politics, Policy & Law* 29(4):835–52.

Hart, Thomas M., and Thomas P. Lowry. 1968. *Abortion Law Reform: A Report on the California Conference on Abortion*. Ross, CA: Association for Repeal of Abortion Laws.

Henshaw, Stanley K. 1982. "Freestanding Abortion Clinics—Services, Structure, Fees." *Family Planning Perspectives* 14(5):248–56.

Hindell, Keith, and Madeline Simms. 1971. *Abortion Law Reformed*. London: Peter Owen.

Hoggart, Lesley. 2003. *Feminist Campaigns for Birth Control and Abortion Rights in Britain*. Lewiston, NY: Edwin Mellen Press.

Houghton, Vera. 1967. "Memo to Executive Committee of Abortion Law Reform Association on Amendments to Medical Termination of Pregnancy Bill." London: Wellcome Institute for the History of Medicine, Contemporary Medical Archives Centre, SA/ALR/A6/9/38.

Howard, Ernest B. 1970. "Organized Medicine: The AMA." *Scope: A Publication of the Boston University Medical Center* 3(November-December):4–11.

Hunter, Nan. 2006. "Justice Blackmun, Abortion, and the Myth of Medical Independence." *Brooklyn Law Review* 72(2)147–98.

Imber, Jonathan B. 1986. *Abortion and the Private Practice of Medicine*. New Haven, CT: Yale University Press.

Jaffe, Frederick S., Barbara L. Lindheim, and Philip R. Lee. 1981. *Abortion Politics: Private Morality and Public Policy*. New York: McGraw-Hill.

Joffe, Carole E. 1995. *Doctors of Conscience: The Struggle to Provide Abortion: Before and after* Roe v. Wade. Boston: Beacon Press.

Joffe, Carole E. 2003. "*Roe v. Wade* at 30: What Are the Prospects for Abortion Provision." *Perspectives on Sexual and Reproductive Health* 35(1):29–33.

Joffe, Carole E., Tracy A. Weitz, and Clare L. Stacey. 2004. "Uneasy Allies: Pro-choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights." *Sociology of Health and Illness* 26(6):775–96.

Kaplan, Laura. 1997. *The Story of Jane: The Legendary Underground Feminist Abortion Service*. Chicago: University of Chicago Press.

Karrer, Robert N. 2011. "The National Right to Life Committee: Its Founding, Its History, and the Emergence of the Pro-life Movement Prior to *Roe v. Wade*." *The Catholic Historical Review* 97(3):527–57.

Katznelson, Ira. 1997. "Reflections on History, Method, and Political Science." *Political Methodologist* 8(Fall):11–14.

Keown, John. 1988. *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982*. Cambridge, UK: Cambridge University Press.

Kimmey, Jimye. 1971. "Abortion Law Reform in the United States." Pp. 7–14 in *Abortion and the Unwanted Child: Papers from the 1969 California Conference on Abortion*, edited by C. Reiterman. New York: Springer.

Klein, Rudolf. 1981. "Reflections on the American Health Care Condition." *Journal of Health Care, Politics and Law* 6(2):188–204.

Lader, Lawrence. 1973. *Abortion II: Making the Revolution*. Boston: Beacon Press.

Lovenduski, Joni. 1986. "Parliament, Pressure Groups, Networks and the Women's Movement: The Politics of Abortion Law Reform in Britain (1967–1983)." Pp. 49–66 in *The New Politics of Abortion*, edited by J. Lovenduski and J. Outshoorn. London: Sage.

Lucas, Roy. 1967. "Federal Constitutional Limitations on the Enforcement and Administration of State Abortion Statutes." *North Carolina Law Review* 46(4):730–77.

Lucas, Roy, Richard D. Lamm, Lorraine Beebe, Cecil Poole, and Dexter L. Handley. 1971. "Abortion: Litigative and Legislative Processes." *Human Rights* 1(2):23–53.

Luker, Kristin. 1984. *Abortion and the Politics of Motherhood*. Berkeley: University of California Press.

MacLennan, Hector. 1965. "Draft of President's Letter to the *Times* for Comment by Members of the Finance and Executive Committee, Royal College of Obstetricians and Gynaecologists." London: Archives of the Royal College of Obstetricians and Gynaecologists, A16/1.

Malacrida, Claudia. 2003. *Cold Comfort: Mothers, Professionals, and Attention Deficit Disorder*. Toronto: University of Toronto Press.

McCarthy, John D., and Mayer N. Zald. 1977. "Resource Mobilization and Social Movements: A Partial Theory." *American Journal of Sociology* 82(6):1212–39.

Medical World News. 1970. "The Widening Horizon of Legal Abortion." *Medical World News*, June 12, pp. 15–16.

Modern Medicine. 1969. "*Modern Medicine* Poll on Socio economic Issues: Abortion—Homosexual Practices—Marihuana." *Modern Medicine* 37(November 3):18–30.

Morrison, Michael. 2015. "Growth Hormone, Enhancement and the Pharmaceuticalisation of Short Stature." *Social Science & Medicine* 131:305–12.

Munson, Ziad. 2018. *Abortion Politics*. Medford, MA: Polity Press.

Nathanson, Constance A. 2007. *Disease Prevention as Social Change: The State, Society, and Public Health in the United States, France, Great Britain, and Canada*. New York: Russell Sage Foundation.

Olafsdottir, Sigrun. 2007. "Medicalizing Mental Health: A Comparative View of the Public, Private, and Professional Construction of Mental Illness." PhD dissertation, Department of Sociology, Indiana University.

Olafsdottir, Sigrun, and Jason Beckfield. 2011. "Health and the Social Rights of Citizenship: Integrating Welfare-State Theory and Medical Sociology." Pp. 101–15 in *Handbook of the Sociology of Health, Illness, and Healing*, edited by B. Pescosolido, Martin J., McLeod, and A. Rogers. New York: Springer.

Overstreet, Edmund. 1971. "California's Abortion Law—a Second Look." Pp. 15–26 in *Abortion and the Unwanted Child: Papers from the 1969 California Conference on Abortion*, edited by C. Reiterman. New York: Springer.

Pakter, Jean, and Frieda Nelson. 1971. "Abortion in New York City: The First Nine Months." *Family Planning Perspectives* 3(3):5–12.

Pierson, Paul. 1993. "When Effect Becomes Cause: Policy Feedback and Political Change." *World Politics* 45(4):595–628.

Potts, Malcolm, Peter Diggory, and John Peel. 1977. *Abortion*. Cambridge, UK: Cambridge University Press.

Quadagno, Jill. 2004. "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945–1996." *Journal of Health and Social Behavior* 45(Extra Issue):25–44.

Reagan, Leslie J. 1997. *When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867–1973*. Berkeley: University of California Press.

Reiterman, Carl. 1971. "Unwanted Children." Pp. 115–22 in *Abortion and the Unwanted Child: Papers from the 1969 California Conference on Abortion*, edited by C. Reiterman. New York: Springer.

Rex v. Bourne 1 K.B. 687, 1939.

Roe v. Wade 410, US 113, 1973.

Roemer, Ruth. 1971. "Abortion Law Reform and Repeal: Legislative and Judicial Developments." Pp. 39–58 in *Abortion and the Unwanted Child: Papers from the 1969 California Conference on Abortion*, edited by C. Reiterman. New York: Springer.

Royal College of Obstetricians and Gynaecologists. 1966. "Legalized Abortion: Report by the Council of the Royal College of Obstetricians and Gynaecologists." *British Medical Journal* 1:850–52.

Rubin, Eva R. 1987. *Abortion Politics and the Courts*. New York: Greenwood Press.

Scheppele, Kim Lane. 1996. "Constitutionalizing Abortion." Pp. 29–49 in *Abortion Politics: Public Policy in Cross-Cultural Perspective*, edited by M. Githens and D. M. Stetson. New York: Routledge.

Shostak, Sara, Peter Conrad, and Allan V. Horwitz. 2008. "Sequencing and Its Consequences: Path Dependence and the Relationships between Genetics and Medicalization." *American Journal of Sociology* 114(S1):S287–316.

Siegel, Reva B. 2010. "*Roe*'s Roots: The Women's Rights Claims That Engendered *Roe*." *Boston University Law Review* 90(4):1875.

Skocpol, Theda. 1992. *Protecting Soldiers and Mothers*. Cambridge, MA: Harvard University Press.

Skocpol, Theda, and Margaret Somers. 1980. "The Uses of Comparative History in Macro-Social Research." *Comparative Studies in Society and History* 22(2):174–97.

Staggenborg, Suzanne. 1991. *The Pro-Choice Movement: Organization and Activism in the Abortion Conflict*. New York: Oxford University Press.

Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.

Strong, P. M. 1979. "Sociological Imperialism and the Profession of Medicine: A Critical Examination of the Thesis of Medical Imperialism." *Social Science & Medicine* 13A:199–215.

Tietze, Christopher, and S. Lewit. 1972. "Joint Program for the Study of Abortion (JPSA): Early Medical Complications of Legal Abortion." *Studies in Family Planning* 3(6):97–119.

Tocqueville, Alexis de. 1955. *The Old Regime and the French Revolution*. New York: Doubleday Anchor Books.

Van Kersbergen, Kees, and Barbara Vis. 2014. *Comparative Welfare State Politics*. New York:Cambridge University Press.

Weaver, R. Kent. 1986. "The Politics of Blame Avoidance." *Journal of Public Policy* 6(4):371–98.

Williams, Daniel K. 2015. *Defenders of the Unborn: The Pro-Life Movement before* Roe v. Wade. New York:Oxford University Press.

Williams, Simon J. 2001. "Sociological Imperialism and the Profesession of Medicine Revisited: Where Are We Now?" *Sociology of Health and Illness* 23(2):135–58.

Ziegler, Mary. 2009. "The Framing of a Right to Choose: *Roe v. Wade* and the Changing Debate on Abortion Law." *Law and History Review* 27(2):281–330.

Zola, Irving Kenneth. 1983. *Socio-Medical Inquiries: Recollections, Reflections, and Reconsiderations*. Philadelphia: Temple University Press.

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