definition of therapeutic abortion to the judgment of the medical profession. During the 1930s, reputable physicians in the United States had supported a broadening of the acceptable indications for therapeutic abortion. Organized medicine could have promoted the liberal interpretation of indications for therapeutic abortion put forward by doctors like Taussig and Bourne. Hospitals and their attorneys could have planned to use the precedent created by the Bourne case if American officials ever prosecuted a physician or hospital for the performance of a therapeutic abortion in a hospital. These strategies, however, were not pursued. The political conservatism of the period made it increasingly unlikely that the medical profession would follow such a bold course.

The proponents of abortion committees wanted more than legal protection; they wanted moral protection for the therapeutic abortions that were performed. When Dr. Hesseltine of Chicago first heard of the committee idea, he noted that “it would give moral support” to those involved in therapeutic abortion.²⁴ When Doctors Harry A. Pearse and Harold A. Ott described the abortion committee at Florence Crittenton Hospital, they observed that the committee would “conduct its deliberations on a high ethical plane, thereby avoiding the imputation of immorality to the procedures it approves. Thus,” they assured their audience, “the attending physician can be certain that any abortion . . . which he may do with the committee’s approval will be legally defensible, medically indicated, and morally acceptable” (emphasis added). Chicago’s Rudolph Holmes applauded the committee plan for insuring the morality of therapeutic abortions. “It would be a great protection to the operator as well as a deterrent to dangerous aspersions by outsiders,” he remarked.²⁵ The committees could make some abortions morally pure and protect medical reputations from attack. Therapeutic abortion committees not only gave their stamp of approval to a select number of abortions, they gave the procedure and the doctor their blessings.

Therapeutic abortion committees provided a way for some members of the obstetrics and gynecology department to impose their views on their colleagues. The new system institutionalized conservative medical views about abortion. When Pearse and Ott explained why Florence Crittenton had created a therapeutic abortion committee in 1940, they pointed to the difficulty of convincing doctors to “curtail[1]” their practice of abortion for preferred patients. Some physicians performed therapeutic abortions in response to the needs of their patients. “Humanitarian impulses cloud professional vision,” Pearse and Ott reported, and
to consider a case which he has not carefully studied, nor about which he does not feel strongly.” Physicians who believed in providing therapeutic abortions on more liberal grounds would be unlikely to submit patients to the committee. As a committee approved and disapproved cases, doctors learned not to submit cases like those vetoed in the past. Dr. Alan F. Guttmacher reported that many requests never reached the abortion committee at Mt. Sinai Hospital in New York because doctors asked committee members in advance how they would react to certain requests. “Many physicians are discouraged by telephone conversation or corridor consultation with a single Committee member,” Guttmacher reported.77

Moreover, abortion committees discouraged women from seeking therapeutic abortions. MacKenzie’s report of his hospital’s abortion committee made this aspect of its work explicit: “No woman will consent to be taken to the hospital for possible examination and interrogation unless she desperately feels the need for help.”78 Consciously built into the review process were procedures that could be expected to embarrass women patients. Women might have to endure both physical examinations and verbal questioning from several doctors before receiving a therapeutic abortion. This policy was justified, in the minds of some, because some women tried to “abuse” the law and obtain therapeutic abortions for nonmedical reasons. Yet it treated all women as suspects and forced all of them to endure repeated examinations. The University of Virginia Hospital’s abortion board reviewed cases with psychiatric indications by having each of the board’s three members interview the woman, compare notes, and then decide her fate.79 Women whose cases might pass muster might prefer to avoid this trying process.

Not only physicians, but hospitals, came under scrutiny for the number of therapeutic abortions performed. Doctors Samuel A. Cosgrove and Patricia A. Carter of the Margaret Hague Maternity Hospital in New Jersey started a competition between hospitals with a 1944 article. The physicians opposed Taussig’s call for a broadening of the indications for therapeutic abortion. The authors called for strictly limiting the practice of therapeutic abortion to the rare cases when “the pregnancy threatens the life of the mother imminently.” Physicians performed so many abortions in the nation’s teaching hospitals, Cosgrove and Carter charged, that they could not teach medical students an “abhorrence of abortion in general.” Their article presented a table showing the incidence of therapeutic abortion compared to the number of deliveries at seven hospitals. The Johns Hopkins University topped the
list with a therapeutic abortion to delivery ratio of 1:35. Margaret Hague proudly came out with the lowest ratio, 1 abortion to 16,750 deliveries.80

The medical monitoring of therapeutic abortions is a manifestation of the rise of both conservative medical attitudes toward therapeutic abortion and McCarthyism within medicine. Although Cosgrove and Carter denied wishing to impose their moral values on others, the article’s red-baiting and inflammatory language said otherwise. They connected Taussig’s call for abortion law reform to Russia and its “amoral and unethical” society. They stigmatized therapeutic abortion—a legal and legitimate procedure—by renaming it “abortion-murder.” Nineteenth-century antiabortion activists used this type of language in their campaign to criminalize abortion; their descendants used it to condemn abortions performed to save a pregnant woman’s life, abortions long approved by the profession.81 The article provided a seemingly objective way to judge a hospital’s ethical standards. Though a few objected to the language of “murder” and to the insinuation that a comparatively high therapeutic abortion rate meant that a hospital condoned immoral and illegal medical practices,82 concern about these rates contributed to the restriction of therapeutic abortion.

Political pressure clearly influenced medical policy and practice. Hospital administrators felt pressed by both colleagues and state officials to keep their level of therapeutic abortions down and in line with that of other hospitals. Guttmacher reported forming the abortion board at Mt. Sinai Hospital in 1952 because “it was rumored around New York . . . that Mt. Sinai was an ‘easy’ place in which to have an abortion.” He did not want his obstetrical service’s fame, he said, to derive from “its great leniency toward abortion!” He and the other obstetricians decided, Guttmacher reported, “to substitute a conservative, restrictive policy on therapeutic abortion for the liberal, permissive one then in force.” Others told of one psychiatrist’s experience: the first time he recommended a therapeutic abortion, the district attorney’s office called him and told him that he “better watch his step.” Dr. Theodore Lidsz, of Yale University School of Medicine, noted there was “a tendency on the part of the hospital not to wish to have its rate higher than the rest of the hospitals in the state, because there might be pressure from someone in the state government. Thus there is constant care to keep the rates lower” (emphasis added). And, he thought the rates were “dropping” as a result.83 Doctors at Yale had to be acutely aware of the danger of being associated with abortion or communism given the political situation in Connecticut, where the Catholic Church
nist organizing for women's reproductive rights. The United States had no such movement, feminist or medical, for reform or repeal of the abortion laws until the mid-1950s and 1960s. When a handful of physicians sought arrests as a way of challenging the criminal abortion laws in the late 1960s and early 1970s, they had a larger social movement supporting them, and criminal abortion cases could become test cases.

During the 1940s and 1950s, a nationwide crackdown ended the relative ease of obtaining abortions. The new repression destroyed the old system in which physicians referred patients to abortion specialists who practiced in private clinics and replaced it with new rules and regulations. Hospitals assisted the state by forming therapeutic abortion committees, which further restricted abortion practice. The state's visible interest in stopping the skilled physician-abortionists who had the trust and respect of the medical community magnified the medical community's sense that it needed to be more strict and that those who performed therapeutic abortions needed better legal protection.

Physicians and historians believe that hospitals gained authority over the decisions and practices of physicians only recently, during the 1970s and 1980s, because of new governmental regulation of health care, malpractice suits, and the entrance of corporations into the medical system. Yet therapeutic abortion committees show that hospitals gained control over physicians and medical practice at a much earlier date. Therapeutic abortion committees brought physicians' practices under hospital scrutiny and control over thirty years earlier than generally assumed. These committees were forerunners of the oversight under which nearly all doctors work today. In the forties and fifties, formal committees reviewed and could overrule a physician's medical judgment regarding therapeutic abortion. The committees represented a new intervention in the relationship between physicians and patients and an erosion of physicians' freedom to make medical decisions.

The initial controls on doctors' practices grew out of a politically charged, pro-natalist atmosphere hostile to female autonomy. Hospital review of physicians' decisions began with review of reproductive procedures. Review of obstetrical procedures was designed not only to protect women from unnecessary operations, but also to patrol women's own decision-making over reproduction. During the 1930s, hospital administrators became concerned about the need to regulate obstetrical operations, partly in response to public criticism of high maternal
mortality rates. They were uniquely anxious about abortion, however. A 1935 study alerted hospital administrators of their “duty” to “prevent . . . illegal operations.” By 1940, national hospital standards required physicians to consult with other physicians before performing therapeutic abortions. By 1954, the Joint Commission on Accreditation of Hospitals (JCAH) issued standards that required consultation for only three operations—all of them concerning reproduction. First-time cesarean sections, curettages or any procedure in which a “pregnancy may be interrupted,” and sterilization required consultation. No other operations required review. The JCAH explained, “We are dealing here with not only professional [sic] but also moral and legal considerations.”

Though new hospital policies restricted the practice of most physicians, they protected specialists and created a small domain in which specialists could perform legal abortions in hospitals without fear. The review of physicians’ decisions to perform therapeutic abortions by committees became the mark of a legal abortion. The fact that physicians such as Keener and Timanus performed abortions frequently and outside hospital walls made their practices, in the eyes of the profession and the law, illegal. Hospital policy delegitimated the tradition of private, out-of-hospital practice of therapeutic abortion.

Doctors Timanus and Keener’s attempts to liberalize the law through their own criminal trials were extraordinary, but their trials achieved precisely the opposite of what they had hoped for. Instead of easing the practice of abortion, the cases confirmed and strengthened the repression of the era. Their cases show how law and medicine were intertwined and mutually reinforcing. In the 1940s and 1950s, hospitals created a new apparatus for reducing the number of therapeutic abortions. This newly instituted committee system redefined the law. No state laws required hospitals to review doctors’ decisions to induce abortions. Nonetheless, the creation of restrictive policies governing therapeutic abortion regulated abortion both inside and outside the hospital and delineated what was “legal” and “illegal.” Timanus succinctly expressed medicine’s role in the courtroom when he remarked, “The profession . . . convicted me.”

Women seeking abortions were subjected to more intrusion and scrutiny by both the state and the medical system. They were examined, verbally and physically, by state officials if caught during a raid, or by medical authorities if a therapeutic abortion had been recommended. The state forced women to speak of their pregnancies, sexual
partners, and abortions and to name their abortionists in court. Newspaper coverage of raids and criminal trials further exposed and shamed the women who had abortions and the people who provided them. As hospitals restricted access to therapeutic abortion in order to avoid legal trouble, their rules mirrored the state’s methods of interrogating, exposing, and embarrassing women. The political atmosphere inhibited discussion of abortion and women’s need for it, along with other ideas that challenged the status quo. Silencing, forced speaking, naming names, and public exposure of subversive behavior and beliefs were all characteristic of the McCarthy Era. They aptly describe the period’s repression of abortion as well.