Life, Liberty and the Pursuit of Happiness: Almost 40 Years of Legal Abortion

Uta Landy, PhD
Cushner Lectureship
September 21, 2012
Reproductive Health 2012
New Orleans, LA
Dr. Irving Cushner, 1924-1986
Cushner’s Accomplishments

• Professor of Ob-Gyn at Johns Hopkins
• Co-Chair of campaign to repeal Maryland’s abortion law before Roe
• First Chair, Board of Directors, Alan Guttmacher Institute
• Deputy Assistant Secretary for Population Affairs (DASPA) during the Carter Administration
• Chair, National Medical Committee of Planned Parenthood Federation of America
• Chair, Population and Family Planning Section, American Public Health Association
• ACOG Health Care Commission
• “Moving Midwifery Ahead” project
Cy Romney, Albert Einstein College of Medicine, Ob-Gyn Department Chair
A statement on abortion by
one hundred professors of obstetrics

Am J Obstet Gynecol, 112:992-998
April 1, 1972
A statement on abortion by one hundred professors of obstetrics

In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we, the undersigned professors and chairmen of obstetric-gynecologic services, believe that it will be helpful to the medical profession at large to enunciate our position with regard to this increasingly liberal course of events. We do so not for the purpose of controlling these events but rather for the purpose of contributing to the solution of an imminent problem of rather staggering proportions.

Many physicians still believe that abortions should be done only for medical reasons and that only they are qualified to determine when these reasons exist. In order to comply with the new laws and court decisions, however, it will be necessary for physicians to realize that abortion has become a predominantly social as well as medical responsibility. For the first time, except perhaps for cosmetic surgery, doctors will be expected to do an operation simply because the patient asks that it be done. Granted, this changes the physician's traditional role, but it will be necessary to make this change if we are to serve the new society in which we live.

There are, of course, patients whose request for abortion should be more carefully scrutinized, but these are rare cases, for example, where the decision was impetuously reached or neurotically motivated. Professional and paraprofessional counseling will play an important role here. There are patients also who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies.

How many abortions will have to be done under universal law repeal? There are no accurate data upon which to base an answer to this question. The best estimate for the first year is one million, which amounts to one for every four births. This one-to-four ratio can also be applied to individual hospitals in calculating the number of abortions they will be expected to do.

Can we handle such a load? Yes, with careful planning, conscientious effort, and modern techniques. If only half of the 20,000 obstetricians in this country do abortions, they can do a million a year—at a rate of two per physician per week. Already we do more than a million other pelvic operations every year. The doctor with conscientious objections must, of course, be excused, but he will be expected to refer his patients elsewhere. A more difficult dilemma will be faced by the doctor who approves of abortions for some reasons but not all, for he may be accused of being unduly arbitrary or capricious.

It is our belief that even this volume of operations can be handled with existing hospital facilities. It will be necessary to do most of the abortions during the first 10 to 12 weeks, by the suction technique, with the use of local anesthesia, and on an ambulatory basis. These practices have been proved safe and effective for years in other countries where abortion is widely available. The public must be educated to seek abortions in the first trimester, when the risks are minimal. Physicians should learn to do early abortions with suction, since it is a simple, safe procedure requiring less time and entailing less blood loss than conventional curettage. Physicians should also become familiar with administering local anesthesia, with or without short-acting analgesics or narcotics, so that the time, expense, personnel, and complications associated with general anesthesia will be reduced. In order
Current and past chairs of academic departments in every state signed on in 1972.

Dr. Karl L. Adams
Professor of Obstetrics and Gynecology and Physiology
Mount Sinai School of Medicine
New York, New York

Dr. William M. Allen, Past Chairman
Department of Obstetrics and Gynecology
Washington University School of Medicine
St. Louis, Missouri

Dr. Nicholas S. Asali
Professor of Obstetrics and Gynecology
and Physiology
University of California
Los Angeles, California

Dr. Allan C. Barnes
Professor Emeritus
Department of Obstetrics and Gynecology
Johns Hopkins Medical School
Baltimore, Maryland

Dr. Fritz E. Beller
Professor of Obstetrics and Gynecology
New York University School of Medicine
New York, New York

Dr. Ralph C. Berman, Chairman
Department of Obstetrics and Gynecology
University of Oregon Medical School
Portland, Oregon

Dr. Jack N. Biehn
Professor and Head
Department of Obstetrics and Gynecology
University of Connecticut School of Medicine
Storrs, Connecticut

Dr. Walter A. Bonney
Professor and Chairman
Department of Obstetrics and Gynecology
School of Medicine
West Virginia University
Morgantown, West Virginia

Dr. Richard L. Burt
Professor and Chairman
Department of Obstetrics and Gynecology
Bowman Gray School of Medicine
Winston-Salem, North Carolina

Dr. Elise R. Carrington, Chairman
Department of Obstetrics and Gynecology
Woman's Medical College of Pennsylvania
Philadelphia, Pennsylvania

Dr. David Charles
Professor and Chairman
Department of Obstetrics and Gynecology
Baylor University Medical School
Houston, Texas

Dr. Ronald A. Chess
Professor of Obstetrics and Gynecology
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Dr. G. D. Christian
Professor and Chairman of Obstetrics and Gynecology
University of Arizona School of Medicine
Tucson, Arizona

Dr. John F. Clark, Chairman
Department of Obstetrics and Gynecology
Howard University College of Medicine
Washington, D.C.

Dr. Arpad I. Caspi
Professor of Obstetrics and Gynecology
Washington University School of Medicine
St. Louis, Missouri

Dr. David Danforth, Chairman
Department of Obstetrics and Gynecology
Northwestern University School of Medicine
Chicago, Illinois

Dr. Clarence D. Davis
Professor of Obstetrics and Gynecology
Yale University School of Medicine
New Haven, Connecticut

Dr. Russell R. de Alvaras
Professor and Chairman
Department of Obstetrics and Gynecology
Temple University Hospital
Philadelphia, Pennsylvania

Dr. Leo J. Dunn
Professor of Obstetrics and Gynecology
Medical College of Virginia
Richmond, Virginia

Dr. Theodore Palkowitz
Professor of Obstetrics and Gynecology
Northwestern University School of Medicine
Chicago, Illinois

Dr. Charles Fields
Clinical Professor
Department of Obstetrics and Gynecology
Mount Sinai Hospital
New York, New York

Dr. T. Terry Hayashi
Professor of Obstetrics and Gynecology
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Dr. Douglas M. Haynes, Dean
Professor of Obstetrics and Gynecology
University of Louisville School of Medicine
Louisville, Kentucky

Dr. Louis H. Hittman
Professor Emeritus
Department of Obstetrics and Gynecology
State University of New York
Downstate Medical Center
Brooklyn, New York

Dr. Charles Hurd, Chairman
Department of Obstetrics and Gynecology
University of North Carolina School of Medicine
Chapel Hill, North Carolina

Dr. Erle Henrikson, Clinical Professor
Obstetrics and Gynecology
University of Southern California
School of Medicine
Los Angeles, California

Dr. Edwin M. Gold
Professor in Residence
University of California School of Public Health
Berkeley, California

Dr. Donald A. Goss
Professor and Chairman of Obstetrics and Gynecology
Vanderbilt University School of Medicine
Nashville, Tennessee

Dr. J. W. Greene, Jr., Chairman
Department of Obstetrics and Gynecology
The University of Kentucky School of Medicine
Lexington, Kentucky

Dr. Frank C. Greus, Jr.
Professor of Obstetrics and Gynecology
Bowman Gray School of Medicine
Winston-Salem, North Carolina

Dr. S. B. Gnass
Professor and Chairman
Obstetrics and Gynecology
Mount Sinai School of Medicine
New York, New York

Dr. Alan S. Quastler
Professor Emeritus
Obstetrics and Gynecology
Mount Sinai Medical School
New York, New York

Dr. T. Terry Hayashi
Professor of Obstetrics and Gynecology
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Dr. Douglas M. Haynes, Dean
Professor of Obstetrics and Gynecology
University of Louisville School of Medicine
Louisville, Kentucky

Dr. Louis H. Hittman
Professor Emeritus
Department of Obstetrics and Gynecology
State University of New York
Downstate Medical Center
Brooklyn, New York

Dr. Charles Hurd, Chairman
Department of Obstetrics and Gynecology
University of North Carolina School of Medicine
Chapel Hill, North Carolina

Dr. Erle Henrikson, Clinical Professor
Obstetrics and Gynecology
University of Southern California
School of Medicine
Los Angeles, California
Dr. Walter L. Herrmann, Chairman
Department of Obstetrics and Gynecology
University of Washington School of Medicine
Seattle, Washington

Dr. Lawrence L. Hester, Jr.
Professor and Chairman
Obstetrics and Gynecology
Medical College of South Carolina
Charleston, South Carolina

Dr. Roy G. Holly
Professor of Obstetrics and Gynecology
Jefferson Medical College
Philadelphia, Pennsylvania

Dr. Carl P. Huber
Professor of Obstetrics and Gynecology
Indiana University School of Medicine
Indianapolis, Indiana

Dr. Charles A. Hunter, Jr.
Professor and Chairman
Obstetrics and Gynecology
Indiana University School of Medicine
Indianapolis, Indiana

Dr. Donald L. Hutchinson
Chairman, Department of Obstetrics and Gynecology
University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Dr. S. Leon Israel
Professor of Obstetrics and Gynecology
University of Pennsylvania School of Medicine
Philadelphia, Pennsylvania

Dr. W. F. Bernet James
Chairman
Department of Obstetrics and Gynecology
Mohrman Medical College School of Medicine
Nashville, Tennessee

Dr. Wayne L. Johnson
Professor of Obstetrics and Gynecology
Indiana University School of Medicine
Indianapolis, Indiana

Dr. Irwin H. Kaiser
Professor of Obstetrics and Gynecology
Albert Einstein College of Medicine
New York, New York

Dr. Harold J. Kaminetzky, Chairman
Department of Obstetrics and Gynecology
New Jersey College of Medicine and Dentistry
Jersey City, New Jersey

Dr. Nathan Kane
Professor and Chairman
Department of Obstetrics and Gynecology
Yale University School of Medicine
New Haven, Connecticut

Dr. William G. Keettel
Chairman
Department of Obstetrics and Gynecology
University of Iowa College of Medicine
Iowa City, Iowa

Dr. Theodore M. King, Chairman
Department of Obstetrics and Gynecology
Albany Medical College
Albany, New York

Dr. Kermit E. Krantz
Professor and Chairman
Department of Obstetrics and Gynecology
University of Kansas Medical Center
Kansas City, Kansas

Dr. Norman Kretschmer
Professor and Chairman
Department of Obstetrics and Gynecology
Stanford University School of Medicine
Stanford, California

Dr. Mortimer Levitt, Professor of Research in Obstetrics and Gynecology
New York University Medical Center
New York, New York

Dr. James H. McChesney
Professor and Chairman
Department of Obstetrics and Gynecology
University of Texas Medical Branch
Galveston, Texas

Dr. William J. McGanity
Professor and Chairman
Department of Obstetrics and Gynecology
University of Texas Medical Branch
Galveston, Texas

Dr. Charles E. McLennan, Chairman
Department of Obstetrics and Gynecology
Stanford University School of Medicine
Stanford, California

Dr. John R. Marshall
Professor of Obstetrics and Gynecology
U.C.L.A. School of Medicine
Los Angeles, California

Dr. James A. Merrill
Professor and Head of Obstetrics and Gynecology
University of Oklahoma School of Medicine
Oklahoma City, Oklahoma

Dr. George W. Mitchell
Professor and Chairman
Department of Obstetrics and Gynecology
Tulane University School of Medicine
New Orleans, Louisiana

Dr. J. George Moore
Professor and Chairman
Department of Obstetrics and Gynecology
School of Medicine
University of California
Los Angeles, California

Dr. John A. Morris
Professor of Obstetrics and Gynecology
University of Kansas School of Medicine
Kansas City, Kansas

Dr. Robert A. Munroe
Professor and Chairman
Department of Obstetrics and Gynecology
University of New Mexico School of Medicine
Albuquerque, New Mexico

Dr. James Nelson
Professor and Chairman
Department of Obstetrics and Gynecology
State University of New York
Downstate Medical Center
Brooklyn, New York

Dr. Robert E. Malek
Professor and Chairman
Department of Obstetrics and Gynecology
State University of New York
Upstate Medical Center
Syracuse, New York

Dr. John E. Nettles
Professor of Obstetrics and Gynecology
University of Oklahoma School of Medicine
Oklahoma City, Oklahoma

Dr. Edmund W. Overstreet
Professor of Obstetrics and Gynecology
University of California
School of Medicine
San Francisco, California

Dr. Ernest W. Pagel
Professor and Chairman
Department of Obstetrics and Gynecology
University of California School of Medicine
San Francisco, California

Dr. Roy T. Parker
Professor and Chairman
Department of Obstetrics and Gynecology
Duke University School of Medicine
Durham, North Carolina

Dr. Warren H. Pease
Professor and Chairman
Department of Obstetrics and Gynecology
University of Nebraska School of Medicine
Omaha, Nebraska

Dr. Ben M. Pecham, Chairman
Department of Obstetrics and Gynecology
University of Wisconsin Medical School
Madison, Wisconsin

Dr. Jack A. Pritchard
Gillette Professor of Obstetrics and Gynecology
Southwestern Medical School
Dallas, Texas

Dr. Edward Quilligan, Chairman
Department of Obstetrics and Gynecology
University of Southern California
School of Medicine
Los Angeles, California

Dr. Clyde L. Randall
Professor and Chairman
Department of Obstetrics and Gynecology
State University of New York
Buffalo School of Medicine
Buffalo, New York

Dr. John W. Roddick, Jr.
Professor of Obstetrics and Gynecology
University of Kentucky School of Medicine
Lexington, Kentucky

Dr. Seymour L. Romney
Professor and Chairman
Department of Obstetrics and Gynecology
Albert Einstein College of Medicine
New York, New York

Dr. Keith P. Russell
Professor of Obstetrics and Gynecology
University of Southern California School of Medicine
Los Angeles, California

Dr. Kenneth J. Ryan
Professor and Chairman of Obstetrics and Gynecology
University of California School of Medicine
La Jolla, California
100 professors signed. None were women.

12 are still living.
“A Statement on Abortion by One Hundred Professors of Obstetrics”

• “Physicians should learn to do early abortions with suction...on an outpatient basis...using less time and entailing less blood loss than conventional curettage.”

• “Physicians should also become familiar with administering local anesthesia ...so that time, expense, personnel and complications... will be reduced.”

• “Those with conscientious objections must be excused, but are expected to refer patients.”

• “Abortion should be made equally available to the rich and the poor.”
Decline of Hospital Abortions

No. of providers
ACGME Mandate

- The new standard (Section V, A, 2, e), adopted on July 31, 1995 for implementation beginning January 1, 1996, reads:

"No program or resident with a religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, access to experience with induced abortion must be part of residency education. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction that prohibits the residents from providing abortions within the institution, the program must ensure that the residents receive satisfactory education and experience in managing the complications of abortion. Furthermore, such residency programs (1) must not impede residents in the programs who do not have religious or moral objections from receiving education and experience in providing abortions at another institution and (2) must publicize such policy to all applicants to those residency programs."
“Hospitals that refuse to follow the revised guidelines can be put under review by the ACGME. In a worst case scenario, the council may strip the hospitals of their accreditation.”

- John C. Gienapp, Executive Director of the Accreditation Council for Graduate Medical Education
ACOG, 1996

“We believe that abortion training needed to get back to the mainstream of medical training.”
...to the Rescue!
1999: Kenneth J. Ryan Residency Training Program in Abortion and Family Planning
Fellowship in Family Planning

24 Ob/Gyn Programs and 1 Family Medicine Program
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65 programs in 30 states, 2 Canadian provinces and Puerto Rico
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