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PERSPECTIVE

Their Body, Our Choice: Organized Medicine's Responsibility to De-medicalize Abortion

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Introduction

Overmedicalization describes the overreliance on medical terminology and frameworks to explain, assess, and address an issue.[1] There is consensus among some scholars that reproductive health care and, in particular, abortion have been overmedicalized, resulting in a devaluation of pregnant persons' autonomy and increasing health disparities in access to reproductive health care.[2] These scholars have also advocated for de-medicalizing abortion to protect reproductive health rights, including expanded access to self-managed abortion, by emphasizing bodily autonomy and emancipation.[3]

One likely contributing factor to this overmedicalization is organized medicine's improper overemphasis on the patient-physician relationship rather than patient autonomy as the focal point of its advocacy to preserve and expand reproductive health care rights. Consequently, organized medicine can play a central role in de-medicalizing abortion by focusing instead on the pregnant person's autonomy. We consider organized medicine to broadly encompass large physician organizations that advocate for physicians and patients, while observing that organized medicine is not solely to blame for this phenomenon.[4]

In this essay, we review the overmedicalization of abortion from a historical perspective. We outline how organized medicine has contributed to this phenomenon and why continued overmedicalization devalues legal rights, questions pregnant persons' autonomy, and hinders efforts to expand access to reproductive health care. Finally, we call on organized medicine to adopt policies to de-medicalize abortion and, ultimately, to recognize individuals' right to autonomy and personal decision-making independent of the medical establishment.

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Discussion

A fundamental pillar of contemporary bioethics is respecting autonomy, which is defined as the duty to protect and foster a person's free and uncoerced choices.[5] Autonomy emphasizes the person's individual right to make decisions. Consequently, any attempt to subvert or dilute the right of the individual to make decisions is in direct conflict with the right to autonomy. As seen in reproductive health care, especially with the provision of abortion, one such dilution of individual rights occurs by *requiring* a clinician's input in what is ultimately supposed to be the pregnant person's decision.

From a historical perspective, the overreliance on the clinician for decision-making in the abortion context can be considered a relatively novel development. Before the 1820s, under common law in the United States, abortion was generally legal up until "quickening," a relative point in pregnancy during which the pregnant person feels fetal movement.[6] Although similar to current gestational limits on abortion, quickening was a different type of legal limit, the pregnant person was the sole decision-maker of whether that threshold had passed, in contrast to today, where the medical establishment makes that determination.

An egregious example of overreliance on the clinician's judgment over a pregnant person's autonomy can even be found in the *Roe v. Wade* decision. In *Roe*, Justice Blackmun wrote, "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."[7] *Roe* charged the "attending physician" with the role of the decision-maker and, at most, recognized the pregnant person as an advisor in the process.

As a society, we have progressed in how we frame a pregnant person's autonomy since *Roe*. Minnesota's Protect Reproductive Options Act—which was enacted as part of new sweeping legal protections for reproductive rights in response to the 2022 *Dobbs v. Jackson Women's Health Organization* decision that eliminated the right to abortion as a fundamental constitutional right—is one example.[8] The act states that "every *individual* has a fundamental right to make *autonomous* decisions about the individual's own reproductive health, including the fundamental right to use or refuse reproductive health care" and "every *individual* who becomes pregnant has a fundamental right to continue the pregnancy and give birth, or obtain an abortion, and to make *autonomous* decisions about how to exercise this fundamental right."[9] Another example is California's Proposition 1, which was overwhelmingly approved by voters in 2022 and amended the California Constitution to establish a right to reproductive freedom.[10] The amendment states, "The state shall not deny or interfere with an *individual's* reproductive freedom in their most intimate decisions, which includes their fundamental right to choose to have an abortion and their fundamental right to choose or refuse contraceptives."[11] The focus on the individual and their autonomy in both examples is to identify the rights holder as the individual (i.e., the pregnant person), notably without any reference to clinicians or the medical establishment.

Despite societal and legal advances in how autonomy is viewed, organized medicine continues to lag in its response. Organized medicine has been rightfully active in sounding the alarm over the consequences of *Dobbs* on reproductive health rights. However, for many decades, organized medicine has inappropriately advocated for the incorporation of clinicians' perspectives as a part of the calculus of an autonomous right of the pregnant person, contributing to the overmedicalization of abortion. It did so even in the framing of its *Dobbs* refutations, where organized medicine anchored its advocacy on the practice of medicine rather than the pregnant person's autonomous choice.[12] For illustration, Table 1 includes public statements issued in response to the *Dobbs* decision by three of the largest medical organizations in the United States, collectively with over 500,000 members.[13] The table also includes our analysis of these statements and our recommended modifications to reframe the right to an abortion as an autonomous

choice rather than continuing to dilute this right by unnecessarily incorporating the medical establishment and contributing to overmedicalization.

Beyond public statements made immediately after the release of the *Dobbs* decision, the well-intended permanent policy changes in response to this decision also continue to perpetuate overmedicalization. For instance, post-*Dobbs*, the American Medical Association amended its Ethics Opinion 4.2.7 on abortion to read, "Like all health care decisions, a decision to terminate a pregnancy should be made *privately within the relationship of trust between patient and physician* in keeping with the patient's unique values and needs and the physician's best professional judgment"—again, demanding the incorporation of a physician's judgment into what should really be the pregnant person's decision.[14]

By toeing the line of placating advocates on both sides and morphing "women's choice" into a decision made under the watchful eye of a clinician, organized medicine may hope that abortion access will be viewed as a well-overseen, irrefutably ethical practice. However, this approach has diluted pregnant persons' autonomy by aggrandizing the role of clinicians in the decision-making process. Consequently, over the years, the clinician's role has transformed into an arbiter of legal rights and a required party to the decision-making process, in direct conflict with the bioethical view of autonomy and reproductive rights.

Previous successes

Organized medicine's focus on the practice of medicine and clinicians' rights rather than pregnant persons' autonomy may, in part, be due to its previous legal successes in protecting access to abortion. For instance, in *Stuart v. Camnitz*, state restrictions on abortion were successfully challenged by claiming violation of physicians' rights and corruption of medical practice.[15] However, the precedent it sets is "a legal ruling focused on only one person in the doctor-patient dyad, and it was not the pregnant woman."[16] Despite such limited physician-centric abortion protection wins, the more significant national abortion protections that ought to find a basis in autonomy are upended, as evidenced by the *Dobbs* decision. Organized medicine's current approach may have won some battles but lost the war.

By assuming that medicalizing abortion will force legislators to stay out of the exam room, not only has organized medicine fumbled the strategic importance of emphasizing autonomy for the long-term protection of all, but it has also effectively and paternalistically extolled the roles of clinicians in the process. Even prior to the *Dobbs* decision, schol-

TABLE 1. Analysis of statements released by three of the largest medical organizations in response to the Dobbs decision, along with recommended modifications to emphasize autonomy rather than contribute to overmedicalization

Organization	Original public statement*	Analysis	Recommended statement
American Medical Association	"[A]n egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients' rights to evidence-based reproductive health services."	The statement emphasizes the medical profession and the clinician's role three times, rather than focusing on pregnant persons' autonomy.	"An egregious allowance of government intrusion into private and intimate decisions of individuals."
American Academy of Family Physicians	"[N]egatively impacts our practices and our patients by undermining the patient-physician relationship and potentially criminalizing evidence-based medical care."	The statement focuses on the patient-physician relationship and provision of medical care rather than pregnant persons' autonomy.	"Negatively impacts the ability of individuals to make private and intimate decisions."
American College of Physicians	"A patient's decision about whether to continue a pregnancy should be a private decision made in consultation with a physician or other health care professional, without interference from the government."	The statement appears to require a consultation with a "physician or other health care professional" for a pregnant person to make a decision about continuing their pregnancy.	"A pregnant person's decision about whether to continue a pregnancy should be private, without interference from the government."

* Source: M. K. Wynia, "Professional Civil Disobedience: Medical-Society Responsibilities after Dobbs," *New England Journal of Medicine* 387/11 (2022).

ars such as Lois Shepherd and Hilary Turner noted that "constitutional law vests the government and sometimes the medical profession with the power to protect women's health, not women themselves," and organized medicine is partially to blame.[17]

Practical implications

Beyond the bioethical implications of the overmedicalization of abortion, overmedicalization has real-life consequences for pregnant persons, especially as stakeholders seek to find legal pathways to rectify the negative impact of *Dobbs* on access to reproductive health care. It can hinder these efforts if personal decisions around pregnancy continue to be framed around the patient-clinician relationship rather than the pregnant person's individual autonomous choice. This is especially concerning for its potential to negatively impact self-managed abortions, defined as any action that is taken to end a pregnancy outside of the formal health care system.[18] For instance, in light of data clearly demonstrating that the use of mifepristone and misoprostol requires little to no intervention by clinicians at least until the 10th week of gestation, the Food and Drug Administration has been urged to approve over-the-counter (OTC) sale of these medications to enable safer and more effective access to self-managed abortions, especially in abortion-restrictive jurisdictions.[19] Moreover, the Food and Drug Administration approved the first daily oral contraception pill for use without a prescription in the summer of 2023.[20] However, the current framework for autonomy in reproductive health care adopted by organized medicine requiring clinician involvement is in direct conflict with OTC access to contraceptives and abortion pills despite ample evidence supporting their safety and effectiveness.[21] This is especially troubling since the pregnant persons who would benefit the most from OTC access are from marginalized communities, thereby resulting in adverse health equity implications.[22]

Additionally, restrictive states have used the overmedicalization of abortion to pass laws intending to restrict abortion access under the guise of regulating medicine, requiring medical evaluations when data clearly indicate that such evaluations may not be medically necessary. By contrast, if the focus remained on autonomy, such laws would be less likely to be introduced in the first place. Instead of providing accessible care, overmedicalizing this process has increased barriers to care.[23]

Conclusion

Perhaps organized medicine simply needs to be made aware that its attempts to interject the medical profession into conversations about pregnant persons' autonomy can be detrimental to the very ends it hopes to achieve. Maybe the medical community intentionally incorporates the clinician's role into their advocacy to "stay in their lane," even though autonomy is the cornerstone of bioethics, and safeguarding autonomy thus sits squarely in the realm of organized medicine. Or, possibly, previous one-off successes in outcomes of individual cases while employing a physician-centric approach have blinded organized medicine to the bigger battle over autonomy. None of these possibilities justify ignoring the importance of centering the efforts on individuals' autonomy.

Attempts to include clinicians as a necessary part of the decision-making process detract from the moral authority of the decision-maker herself. Predicating personal decision-making on decisional expertise does not protect our vulnerable patients—it infantilizes them. It justifies questioning and stripping away an individual's autonomy, which may hinder efforts to expand access to those who most need it. This is not to say that clinicians cannot or should not play a role in their patients' important medical decisions, nor is it intended to eliminate the clinician's agency. Rather, it is to shift the debate to recognize the autonomous choices of the individual. This recognition is crucial to establishing the individual as the central authority of decision-making in the clinical setting and the rights holder in the legal domain. Finally, this is not a call to adopt new bioethical policies but a call to adopt positions that are in line with current bioethical principles and understandings of autonomy.

Therefore, it is imperative that organized medi-

cine reevaluate its approach to autonomy, especially in reproductive health care. Both in court and in public, organized medicine must adopt stances in line with the bioethical principle of respecting autonomy that focus on the individual's autonomy rather than the patient-clinician relationship or the provision of medical care alone.

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