SILENT NO MORE: PHYSICIANS' LEGAL AND ETHICAL OBLIGATIONS TO PATIENTS SEEKING ABORTIONS

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PROLOGUE: SOME TRUE STORIES

Guadalupe Negron

The autopsy report says Guadalupe Negron bled to death, but she may have died from lack of information.

> Ten days ago the 33-year-old Bronx woman paid $800 for an abortion at what a health worker called a filthy, underequipped clinic, in Corona, Queens, even though she could have had a less expensive, safer operation performed at one of the hospitals and licensed clinics throughout New York City. . . . Each year thousands of women in the city, many of them poor or recent immigrants, have abortions in unlicensed clinics . . . [M]any do not know there are less expensive, and safer options. . . .[1]

The newspaper article did not state whether Ms. Negron spoke with a health care provider who might have given her better advice.

Sonia Jaffe Robbins

Sonia, who was in a long-term marriage and already had a daughter in college, became pregnant at age fifty. Having been a pro-choice activist since the 1970s, she assumed that her gynecologist was also pro-choice. When she requested advice regarding an abortion from her gynecologist's secretary, she was surprised when she was told, "Well, I really don't know what to tell you." When she found a new doctor, she was informed that he would only perform the abortion at a clinic because "it's dirty to do it in the office. . . . [A] doctor who has obstetrical patients shouldn't have them sitting in the waiting room next to women having terminations."[2]

Mary

> In 1992 a young Black woman named Mary received the results of her pregnancy test at a federally-funded family planning clinic in her neighborhood: she was pregnant. Mary was scared and confused, but she knew that she did not want to have the baby. She wasn't sure if it was too late to have an abortion or where she could obtain one. She had heard about another woman in her neighborhood who had been rushed to the hospital bleeding from

1. Emily M. Bernstein, *A Lesson in One Woman's Decision: Knowledge is Key in Choosing Clinics for Abortions*, N.Y. TIMES, July 19, 1993, at B1. Since 1980, hospital and medical licensing authorities had been aware that Ms. Negron's physician provided seriously deficient care. Lisa Belkin, *Hospital Says it Barred Doctor in Abortion Death*, N.Y. TIMES, July 16, 1993, at B1. The doctor, who has since disappeared, lost his license. *Doctor Loses License in Negligence Case*, N.Y. TIMES, Aug. 4, 1993, at B2.

2. Sonia Jaffe Robbins, *I Say Legal, They Say Dirty*, N.Y. NEWSDAY, June 17, 1991, at 32.

a perforated uterus after getting an abortion at a storefront doctor's office. She wasn't sure if her diabetes would make it more dangerous to go through the procedure.

Mary was grateful to be able to turn to the clinic for help because she had no health insurance and could not afford to visit a private gynecologist. When she addressed her concerns to the counselor, the counselor refused to give her any information about abortion. She would not even tell Mary where she could find a safe and inexpensive clinic that performed abortions. Instead, the counselor gave her a selective list of clinics and hospitals providing prenatal care. She told Mary that some of these facilities might also perform abortions, but she could not identify them. When Mary insisted that she had made up her mind to terminate the pregnancy, the counselor responded: "this project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortion." Mary left the clinic even more bewildered, wondering where to turn next.[3]

Sylvia A. Law

As a young woman, I sought a pregnancy test in a state where abortion was legal and readily available. The nurse told me, beaming, "Honey, you're going to have a baby." I replied, "No, honey, I am going to have an abortion." A few years later, when I again sought results of a pregnancy test, a nurse, obviously dejected, said, "It's bad news. You're pregnant." Thrilled with the confirmation of a desired pregnancy, I replied, "Whoopee!"[4]

INTRODUCTION

More than half of the pregnancies among American women are unintended, and half of these are terminated by abortions; in 1988, 1.6 million abortions were performed in the United States.[5] Often, a woman is informed by a physician or other health care provider that she is pregnant.[6] This Article explores the ethical and medical principles that should guide

3. Dorothy E. Roberts, Rust v. Sullivan *and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587, 588-89 (1993).

4. There is no reason to believe that nurses are less sensitive than physicians in these communications. All medical professionals are influenced by the ethical standards of their professions and their education. Because doctors occupy the top of the medical care hierarchy, nurses, physician assistants, and other employees are likely to adopt the communication policies encouraged by the physicians for whom they work. For this reason, this article focuses on the practices, ethical norms, and education of physicians.

5. THE ALAN GUTTMACHER INSTITUTE, FACTS IN BRIEF: ABORTION IN THE UNITED STATES 1 (1993).

6. Although some women learn at home that they are pregnant by a commercial test kit, and make decisions to continue or end the pregnancy before consulting a physician, medical personnel commonly inform women they are pregnant.

physicians and other health care providers in conversations that follow the confirmation of pregnancy. It argues that physicians should not automatically assume that a pregnant woman wants to continue or end the pregnancy. Rather, the doctor should ask the woman what her reaction is to the news that she is pregnant, and provide medical information informing the patient of her choices. The physician should then refer her to those appropriate medical services that he or she does not personally provide.

General principles of medical malpractice and medical ethics require responsible physicians to provide the medical information that is relevant to patient choice and to make referrals for medical services that the treating physician is unable or unwilling to provide. Part I demonstrates four sets of common law and medical ethical principles that support this claim: the informed consent doctrine, the obligation to make referrals for services that a treating doctor is unable or unwilling to provide, the prohibition against physician abandonment of a patient in medical need, and cases recognizing a cause of action for wrongful birth. Constitutional principles protecting patient choice also lend support to this claim.

Despite this legal and ethical commitment to patient choice and the duty of physicians to refer, Part II demonstrates that contemporary patterns of medical practice, including medical ethics standards, licensing and accreditation standards, and patterns of medical education, are systemically anti-choice and anti-abortion. While this Article focuses on transactions between individual pregnant women and physicians, the problem exists on a much broader scale. Many factors influence individual physicians: medical education, ethical standards, economics, accreditation and licensing requirements for medical education and health care facilities, the law, the press, and the larger cultural environment. Abortion, one of the most common surgical procedures in the United States,[7] has become a particularly controversial practice. In the 1980s, availability of abortion services became increasingly concentrated in specialized clinics as general physicians and hospitals declined to provide the service.[8] These clinics, their medical personnel, and their patients have been—and continue to be—subject to

7. FREDERICK S. JAFFE, ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY 7 (1981).

8. Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1991 and 1992*, 26 FAM. PLAN. PERSP. 100, 100 (1994):

> The number of hospitals, clinics and physicians' offices that provide abortions—2,380 in 1992—has been declining at a rate of about 65 a year. Most of the decline has occurred among hospitals; the number providing abortions decreased by 18 percent between 1988 and 1992. Most U.S. counties (84 percent) have no known abortion provider, and in non-metropolitan areas, 94 percent of counties have no provider. Among metropolitan areas, 33 percent have no abortion provider or none that serves at least 50 women per year.

See also Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1987 and 1988*, 22 FAM. PLAN. PERSP. 102 (1990) (reporting that 93 percent of nonmetropolitan counties were without a provider of abortion services in 1988).

harassment and violence.[9] Medical training institutions, after initially creating programs to train physicians to perform abortions, began abandoning this training in the 1980s.[10] The segregation and devaluation of abortion

9. *See* Jacqueline D. Forrest & Stanley K. Henshaw, *The Harassment of U.S. Abortion Providers*, 19 FAM. PLAN. PERSP. 9 (1987); Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 FAM. PLAN. PERSP. 246, 250 (1991); Felicity Barringer, *Abortion Clinics Preparing for More Violence*, N.Y. TIMES, Mar. 12, 1993, at A1; Lisa Belkin, *Kill for Life?*, N.Y. TIMES, Oct. 30, 1994, at § 6, p. 47; Susan Gilbert, *Clinic Violence Sets Off Push for Wider Abortion Training*, N.Y. TIMES, Jan. 11, 1995, at C11; Larry Rohter, *Doctor is Slain During Protest Over Abortions*, N.Y. TIMES, Mar. 11, 1993, at A1. *See also* Pro-Choice Network v. Project Rescue, 799 F. Supp. 1417 (W.D.N.Y. 1992) (providing a vivid summary of incidents of clinic violence).

Madsen v. Women's Health Center Inc., 114 S. Ct. 2516 (1994), upheld a state court injunction imposing a 36-foot buffer zone and noise restrictions around an abortion clinic. Five Justices agreed with Chief Justice Rehnquist that the injunction was not content- or viewpoint-based because it was directed at the protesters' conduct, not their speech. The majority found that noise "control is particularly important around hospitals and medical facilities during surgery and recovery periods. . . ." *Id.* at 2528.

The Court reversed a provision of the injunction that prohibited the display of images observable within the clinic within 300 feet of the facility. "[I]t is much easier for the clinic to pull its curtains than for a patient to stop up her ears, and no more is required to avoid seeing placards through the windows of the clinic." *Id.* at 2529. The Court also reversed a provision of the injunction that prohibited people from physically approaching any person seeking services of the clinic within 300 feet of the clinic, "unless such person indicates a desire to communicate." *Id.* Justice Stevens dissented from this holding. The provision "does not purport to prohibit speech; it prohibits a species of conduct." *Id.* at 2532. Specifically, it prohibits petitioners "from physically approaching any person seeking the services of the Clinic unless such person indicates a desire to communicate by approaching or by inquiring" of petitioners. . . . Absent such consent, the petitioners "shall not accompany such person, encircle, surround, harass, threaten or physically or verbally abuse those individuals who choose not to communicate with them." *Id.* Justices Scalia, Kennedy, and Thomas dissented, arguing that all of the petitioners' activity is protected by the First Amendment. *Id.* at 2535.

The federal Freedom of Access to Clinic Entrances Act, adopted on May 26, 1994, provides criminal penalties and civil remedies against "who[m]ever — by force or threat of force or by physical obstruction, intentionally injures, intimidates or interferes with" any person who is or has been "obtaining or providing reproductive health services." 18 U.S.C. § 248 (1994). Abortion opponents have challenged the federal law as beyond Congressional authority under the Commerce Clause and as unconstitutional under the First Amendment. Initial decisions have uniformly rejected these challenges. *American Life League v. Reno*, 855 F. Supp. 137 (E.D. Va. 1994); *U.S. v. Brock*, 863 F. Supp. 851 (E.D. Wis. 1994).

10. *See* Carolyn Westhoff, *Abortion Training in Residency Programs*, 49 J. AM. MED. WOMEN'S ASS'N 150, 151 (1994) (Abortion training is not offered at all in 30 percent of obstetrics-gynecology residency programs. About half of all OB/GYN chief residents, completing a four year post-graduate education program, report that they had no experience with induced abortion. Only 19 percent had performed ten or more abortions, while more than 90 percent had performed more than ten tubal ligations.); Philip D. Darney, Uta Landy, Sara MacPherson & Richard L. Sweet, *Abortion Training in United States Obstetrics and Gynecology Residency Programs*, 19 FAM. PLAN. PERSP. 158, 160 (1987) (discussing the development of residency training programs in abortion between 1973 and 1985); David A. Grimes, *Clinicians Who Provide Abortions: The Thinning Ranks*, 80 OBSTETRICS & GYNECOLOGY 719, 720 (1992) (stating that the proportion of residency programs routinely offering abortion training declined from 1985 to 1991); Debra E. Blum, *Fewer Programs Found to Teach Future Doctors How to Perform Abortions*, CHRONICLE OF HIGHER EDUC., May 6, 1992, at A39-40. In 1992, 47 percent of residents specializing in obstetrics and gynecology

services has not been confined to states in which anti-choice views are politically dominant; all of the stories recounted in the introduction occurred in Manhattan, at a time when abortion was constitutionally protected and public funding financed abortion for the poor. Contemporary patterns of medical practice do not support free choice.

Part III considers objections that might be raised against applying principles of medical malpractice and medical ethics to counseling pregnant women in settings other than abortion clinics. It concludes that the physician's own moral views about abortion cannot excuse the doctor from her ordinary ethical and legal obligations to facilitate choice for pregnant women through counseling and referrals.

Part IV demonstrates that neither common law nor constitutional remedies are likely to provide effective legal incentives to encourage physicians to provide relevant medical information and referrals to women who seek to terminate pregnancy. It demonstrates that a variety of factors make it unlikely that these sources of law will provide appropriate protection of the reproductive choices of pregnant women.

Finally, Part V argues that professional associations, medical educators, women's groups, and state legislatures should take the initiative in addressing these issues. It defends a model of responsible professional behavior that requires the practitioner to help the patient reach an informed decision and find the medical services that meet her needs. The model builds upon the ethical principles and practices of responsible abortion providers. Part V further argues that existing ethical and legal norms should encourage ordinary physicians to provide a pregnant patient with appropriate medical referrals to enable her to locate the services she seeks. Recognition of such norms would have an important effect on interactions between individual patients and providers and also would have an impact on the larger political and social status of abortion.[11] In many parts of the country, women seeking abortion confront large obstacles, such as travel, cost and delay, and risks of harassment and violence.[12] Mainstream medicine's current failure to provide responsible medical referrals for pregnant women is mainly responsible for the invisibility, unavailability, and vulnerability of abortion services.

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reported that at the end of four years of specialized training they had acquired *no* experience in performing first trimester abortions. Carolyn Westhoff, Frances Marks & Allen Rosenfeld, *Residency Training in Contraception, Sterilization and Abortion*, 81 OBSTETRICS & GYNECOLOGY 311 (1993).

11. For example, to make an appropriate referral for a pregnant patient who seeks an abortion, the physician must be informed about the availability of such services.

12. *See* Roberts, *supra* note 3.

I

PHYSICIANS' OBLIGATIONS TO PROVIDE MEDICAL INFORMATION AND REFERRALS TO PATIENTS

A. Informed Consent

> Under a free government at least, the free citizen's first and greatest right, which underlies all the others—the right to the inviolability of his person, in other words, his right to himself—is the subject of universal acquiescence. . . .[13]
> Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .[14]

Since 1973, these historic principles have been applied to women.[15] In keeping with the reasoning in the above opinions, the Supreme Court has affirmed that when a woman decides whether to have an abortion or a child, "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law."[16] A woman's decision about her own body and life "[is] too intimate and personal for the State to insist . . . upon its own vision of the [woman's] role."[17]

Patients' rights to self-determination and autonomy in medical decision-making have deep historic roots and command broad respect as abstract principles.[18] Physicians' ethical obligation to obtain patients' informed consent was first given legal force in 1957.[19] Every United States jurisdiction—as well as the nations of Europe and the British

13. Pratt v. Davis, 118 Ill. App. 161, 166 (1906), *aff'd*, 79 N.E. 562 (Ill. 1905) (holding that a physician who removed a patient's uterus and ovaries to treat her epilepsy, without obtaining consent from her or her husband, was liable for malpractice).

14. Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (holding that hospitals are not liable for physicians who perform operations without the consent of their patients), *overruled by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

15. Roe v. Wade, 410 U.S. 113 (1973).

16. Planned Parenthood v. Casey, 112 S. Ct. 2791, 2807 (1992) (reaffirming that the woman's right to an abortion is a constitutionally protected liberty).

17. *Id.*

18. *See* DIETER GIESEN, INTERNATIONAL MEDICAL MALPRACTICE LAW Vol. 15, § II (1988).

19. Salgo v. Leland Stanford J. Univ. Bd. of Trustees, 317 P.2d 170 (Cal. App. 1951). In this case, the plaintiff's legs were paralyzed when the physician performed an aortography to locate a blockage in his abdomen. The physician had not informed the patient of the risks inherent in the operation. The court held:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. . . . [I]n discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.

Id. at 181. Prior to this case, courts held physicians liable only when they provided treatment contrary to patients' specific instructions, *see, e.g.*, Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914), *overruled by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957), or where no consent, either expressed or implied, had been obtained, *see, e.g.*, Pratt v. Davis, 118 Ill. App. 161 (1905), *aff'd*, 79 N.E. 562 (Ill. 1906).

Commonwealth—has since adopted the core principle that obligates a physician to obtain a patient's informed consent to treatment.[20]

Through the 1960s, courts applied a negligence standard that defined a physician's duty to disclose as a duty to provide information that "a reasonable medical practitioner would disclose under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment."[21] Professionally based standards provided little incentive for doctors to communicate with patients and facilitate patient choice for two reasons. First, professional norms supported notions that doctors, not patients, should make treatment decisions. Second, professional standards incorporated a paternalistic view that patient involvement was not helpful, or even counterproductive, because it generated undue anxiety.[22]

Beginning with *Canterbury v. Spence*[23] in 1972, U.S. courts have given greater legal force to the requirement of informed consent by demanding that physicians communicate the information that reasonable patients need to know in order to make informed decisions about their medical care.[24]

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research observes that "[a]lthough the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative." 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 2 (1982) [hereinafter MAKING HEALTH CARE DECISIONS].

20. *See* Daniel E. Feld, Annotation, *Malpractice: Physician's Duty to Inform Patient of Nature and Hazards of Treatment in Pregnancy and Childbirth Cases Under the Doctrine of Informed Consent*, 69 A.L.R.3D 1250 (1976) (summarizing recent case law regarding physicians' duty to disclose in pregnancy and childbirth cases). *See also* Dieter Giesen & John Hayes, *The Patient's Right to Know: A Comparative View*, 21 ANGLO-AM. L. REV. 101 (1992) (comparing the laws and customs of informed consent in England to those of other countries).

21. Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960), *on reh'g*, 354 P.2d 670 (Kan. 1960). Contradictorily, the court also offered a ringing affirmation of the patient's right to self-determination. "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment." *Id.* at 1104.

22. Giesen & Hayes, *supra* note 20, at 102 (recognizing the common law view that physicians may not be held negligent if they conform to professionally accepted practices that do not encourage disclosure of information to patients). *See also* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 65-71 (1984) (discussing the limited efficacy of the early consent doctrine); Marjorie M. Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 221 (1985) (describing the traditional system in which patients delegate to physicians all decision-making authority). *See generally* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986) (examining the origins and evolution of the informed consent doctrine).

23. 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (holding that the adequacy of information provided to obtain consent to surgery should be evaluated by asking what a reasonable patient would want to know, not what a typical doctor ordinarily provides).

24. *See, e.g.*, Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (holding that a physician must disclose to a patient the risks of death or serious bodily harm of a procedure, and any

The standard is objective and directed toward patient need: the doctor must communicate information that might influence the decision of a reasonable person.[25] *Canterbury* recognized that the core justification for informed consent—the patient's right to control her body and life—required a standard defined by the patient's need for information. *Canterbury* rejected prior traditions of professional silence and paternalism that did not serve the patient's interest in self-determination.[26] *Canterbury's* patient-oriented informed consent standard has been adopted by other common law courts.[27] It has also been adopted by most European and British commonwealth courts.[28]

Apart from malpractice standards of informed consent, professional medical ethics also support the notion that physicians should facilitate informed choice. For example, the ethical standards of the American College of Obstetricians and Gynecologists (ACOG) explicitly address the issues of informed consent for pregnant women.[29] These standards require doctors to treat patients with respect and dignity; for example, they state that "every effort should be made to incorporate a commitment to informed consent within a commitment to provide medical benefit to patients and thus to respect them as whole and embodied persons."[30] In addition, they urge physicians to counsel women patients on options for the management of an unwanted pregnancy and to ensure that women patients are aware of methods for family planning.[31]

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additional information that a particular patient would need to know to grant informed consent). *See also* SYLVIA A. LAW & STEVE POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 273 (1978).

25. 464 F.2d at 786.

26. *Id.* at 780.

27. LAW & POLAN, *supra* note 24, at 109-10. Many physicians found patient-oriented informed consent standards deeply disturbing. Such standards challenge historic patterns of paternalism and silence. *See* KATZ, *supra* note 22, at chs. 1-2. On a practical level, patient-oriented informed consent standards represent a stark contrast to the general rule that a physician can be held liable in a medical malpractice action only on the basis of expert testimony. *Id.* at 113-14. Even though very few malpractice claims rely on informed consent theories, abolition of patient-oriented informed consent standards has been a core element of organized medicine's malpractice reform agenda. Some states have responded by adopting informed consent standards that require expert testimony concerning the defendant physician's failure to comply with local professional practice. *See, e.g.*, N.Y. Pub. Health Law § 2805-d(1) (Consol. 1994). Such laws are most reasonably understood as a response to concern about the costs of malpractice insurance, rather than as an affirmation of the notion that professional, and not patient-oriented, standards should define informed consent.

28. Giesen & Hayes, *supra* note 20, at 105.

29. *Ethical Dimensions of Informed Consent*, ACOG COMM. OP. No. 108, at 4 (Am. College of Obstetricians and Gynecologists, Washington, D.C.), May 1992.

30. *Id* at 1.

31. *See Ethical Decision-Making in Obstetrics and Gynecology*, ACOG TECH. BULL. No. 136 at 5-6 (Am. College of Obstetricians and Gynecologists, Washington, D.C.), Nov. 1989 [hereinafter *Ethical Decision-Making*].

The legal standards that define a physician's obligation to facilitate informed choice have changed over the past thirty years. But changes in medical practice and the general culture have been far deeper than those mandated by the law. According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "the vast majority of people surveyed by the Commission felt that patients have a right to information and ought to participate in decisions regarding their health care."[32] The civil rights movement, the feminist movement, and other consumer movements on behalf of the aged, the disabled, and people with particular diseases have created popular expectations of informed choice and patient autonomy that transcend specific legal requirements.[33] However, as Part II demonstrates, these principles of informed patient choice have not been applied to pregnant women confronting the question of whether to continue or terminate a pregnancy.

B. The Duty to Provide Referrals

In modern specialized medical practice, one of physicians' most important tasks is to provide appropriate referrals for services that they are unable to perform.[34] About 9 percent of all physician visits include a referral to another professional.[35] Further, in a much greater number of cases, the doctor must assess whether a referral, with attendant cost and inconvenience to the patient, is warranted.[36] As the Mississippi Supreme Court explained in a 1985 case in which plaintiff alleged that a physician should have sought a consultation or made a referral:

> [Each physician] has a duty to have a practical working knowledge of the . . . resources (including personnel in health related

32. MAKING HEALTH CARE DECISIONS, *supra* note 19, at 17. More than 80 percent of patients and 90 percent of physicians believe physicians should initiate the informed consent discussion. *Id.* at 79. Eighty-eight percent of the public and 76 percent of physicians think informed consent should be protected by law. *Id.* at 105.

33. *See, e.g.*, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 388-93 (1982) (describing popular movements that challenged professional dominance); BOSTON WOMEN'S HEALTH COLLECTIVE, THE NEW OUR BODIES, OURSELVES, A BOOK BY AND FOR WOMEN 585, 598-610 (1984) (describing the way in which medical paternalism hurts women and denies them choice, educating women about their bodies, and describing collective and individual strategies to gain greater control of medical care).

34. Jerald J. Director, Annotation, *Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment Which Physician is Not Qualified to Give*, 35 A.L.R.3D 349(5) (a)(1971).

35. The Core Survey of the AMA's 1991 Socioeconomic Monitoring System gathered data from 4,057 physicians. It shows that "[p]hysicians see an average of 118 patients per week in all settings and refer approximately ten of these patients (9%) to other physicians." Julie Foreman, *Physicians Refer 9% of Patients*, 110 ARCHIVES OF OPHTHALMOLOGY 1539, 1539 (1992).

36. Dr. David Hilfiker provides eloquent descriptions of situations that a conscientious primary-care doctor confronts when helping patients make decisions whether to seek a more intensive, costly, and distant secondary care center. David Hilfiker, *Facing Our Mistakes*, 310 NEW ENG. J. MED. 118 (1984).

> fields and their general level of knowledge and competence), and options (including what specialized services or facilities may be available in large communities . . .) reasonably available to him or her as well as the practical limitations on same . . . .[37]

The Mississippi court rejected the view that doctors are isolated within their communities or practices. Contemporary physicians are required to provide expert guidance to help their patients obtain care that they are unable to provide.[38] Professional standards require physicians to be reasonably knowledgeable of alternative facilities and services. Courts in malpractice actions enforce these professional standards. When a patient requires a medical service for which the physician lacks the necessary skill, knowledge, or facilities, the physician has a duty to refer the patient to a specialist or a physician "qualified in a method of treatment that the [first] physician is not qualified to give."[39]

The ethical standards of the American Medical Association (AMA) require doctors to make referrals when they believe it would be beneficial to the patient[40] and to obtain a consultation whenever they believe it may

37. Hall v. Hilbun, 466 So. 2d 856, 871 (Miss. 1985).

38. *Id.* at 872-73.

39. *See* Director, *supra* note 34, at 354. Federal law similarly requires hospitals and physicians to make appropriate referrals. Consolidated Social Security Amendments of 1986, 42 U.S.C. § 1395DD (1988). If a patient has an emergency condition which has not been stabilized, or is in active labor, she may not be transferred to another facility unless the physician certifies that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer," 42 U.S.C. § 1395DD(c)(1)(A)(ii), and that the facility to which the patient is transferred "has available space and qualified personnel for the treatment of the patient, and has agreed to accept transfer of the patient and to provide appropriate medical treatment. . . ." 42 U.S.C. § 1395DD (c)(2)(B)(i)-(B)(ii). Patients are entitled to recover money damages for transfers made in violation of these requirements. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991) (holding that hospitals may be fined for violation of the federal requirements); Burditt v. United States Dep't of Health & Human Serv., 934 F.2d 1362 (5th Cir. 1991) (holding that hospitals and physicians may be fined). Because the federal law applies only to medical emergencies and pregnant women in active labor, it does not directly govern the referral obligations of physicians treating women at early stages of pregnancy. It does, however, underscore and support the importance of physician referrals.

40. CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMA § 3.04 (1992) [hereinafter CURRENT OPINIONS].

Virtually every professional organization promulgates ethical standards. Each physician specialty also promulgates its own ethical standards. Nursing standards are somewhat different from those of doctors, and osteopathic physicians have standards somewhat different from those of the allopathic doctors who are represented by the AMA. This Article focuses on the AMA's standards for allopathic physicians and on the ACOG's standards for obstetric and gynecologic specialists because these organizations are most influential in shaping medical treatment for pregnant women. *See* ELLIOT FRIEDSON, PROFESSIONAL DOMINANCE (1970) (arguing that medical care has become more personalized through the use of legal and administrative rules which encourage physicians to follow high standards of care for each patient).

be helpful or when a patient requests it.[41] A legal advisor with the AMA explains:

> The physician is obligated to refer to someone else if he does not have the necessary level of competence or confidence with reference to the diagnosis or course of treatment. . . . The referring physician must not refer to a physician whom he does not have good reason to believe is competent. I would not condone a physician looking in the yellow pages for a referral. The referring physician must have factual knowledge that the physician is competent.[42]

Courts enforce these ethical obligations in malpractice actions where the physician's unreasonable failure to provide referral or to seek consultation results in a preventable injury to a patient.[43]

The ethical standards of ACOG also require a physician to recommend appropriate alternatives for care that she will not provide.[44] When a physician feels "morally unable to cooperate in pursuing the medical goals of a particular patient . . . appropriate alternatives for care should be recommended."[45]

Patients are right to expect their doctors to possess special skills in helping locate and evaluate medical care that they are unable or unwilling to provide.[46] Both ordinary malpractice norms and principles of medical ethics require doctors to make referrals and to exercise reasonable care in doing so.

C. Prohibitions Against Physician Abandonment

Traditionally doctors enjoy a great deal of freedom in deciding whether to enter a doctor-patient relationship. But once such a relationship is established, the physician's freedom to abandon the patient is limited:

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41. CURRENT OPINIONS, *supra* note 40, at § 8.04.

42. Telephone Interview with Bill Smith, Legal Advisor with the AMA (July 7, 1993).

43. The case that set this standard is Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966). Darling was a high-school football player who broke his leg during a game. He was taken to a small community hospital. The physician, who had no recent experience in this type of case, applied a cast that interfered with blood circulation, resulting in gangrene and subsequent amputation. The hospital and doctor were held liable for violating medical staff bylaws that required "consultation between medical staff members in complicated cases" and "calling consultants as needed." *Id.* at 256, 258. For the contemporaneous AMA reaction, see *The Darling Case*, 206 JAMA 1665 (1968).

44. *Ethical Decision-Making*, *supra* note 31, at 6.

45. *Id.*

46. *See* Director, *supra* note 34, at § 5.

> The law is well-settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires.[47]

These principles apply to physicians treating pregnant patients. Both ethical and common law norms assume that the physician has knowledge of available medical resources superior to that of her patient.[48] Pregnancy, and fear of pregnancy, are common phenomena confronting doctors. Many women consult doctors to confirm or deny pregnancy.[49] Sometimes primary care doctors discover that women are pregnant in course of treatment for other conditions. Women who do not want to be pregnant often deny or ignore the evidence that they are. This is particularly true of younger women and older women, whose menstrual cycles are irregular.[50] Other women seek physician confirmation of pregnancy because they do not trust their ability to use a home testing kit or prefer a free or reimbursable physician visit to the out of pocket cost of a home testing kit. Any notion that the patient knows as much about abortion providers as the physician is unpersuasive. Most doctors will see many women confronting crisis pregnancies[51] in the ordinary course of their medical practice, while

47. Ricks v. Budge, 64 P.2d 208, 211-12 (Utah 1937). *Cf.* Hiser v. Randolph, 617 P.2d 774, 777-78 (Ariz. Ct. App. 1980), *overruled on other grounds*, 688 P.2d 605 (Ariz. 1984) (holding that the attending emergency room physician has a duty to treat all emergency patients to the best of her ability).

48. *See supra* part I.B.

49. *See, e.g.*, Laurie Schwab Zabin, Valerie Sedivy & Mark R. Emerson, "Subsequent Risk of Childbearing Among Adolescents with a Negative Pregnancy Test," 26 *Fam. Plan. Pros.* 212 (1994).

50. McRae v. Califano, 491 F. Supp. 630, 672, 683 (E.D.N.Y. 1980), *rev'd sub nom.* Harris v. McRae, 448 U.S. 297 (1980).

51. Crisis pregnancies are those that occur when the pregnant woman strongly believes that she cannot adequately provide for a child. Women who are poor or young often feel that they cannot care for a child. Many women who become pregnant as a result of rape or incest feel that the circumstances of conception impair their ability to give a child the round-the-clock, 18-year attention that every child deserves. More commonly, women who are not in stable relationships with the men who impregnated them and who work many hours a week to support themselves and their families feel that a new, unplanned child would present a crisis to fragile existing relationships. A woman in a long-term marital relationship

most women will deal with pregnancies only occasionally. Furthermore, because the medical risks inherent in abortion increase quickly as the pregnancy progresses,[52] a woman seeking medical attention does not have the luxury of time needed to develop a knowledge of alternative sources of care. The common law notion that physicians must not abandon their patients supports the requirement that doctors make an informed referral for patients seeking abortions which a doctor is unable or unwilling to provide.

D. The Wrongful Birth Cases

Since *Roe v. Wade*,[53] over twenty states have recognized parents' claims for wrongful birth.[54] Wrongful birth claims arise when a physician who provides prenatal care fails to disclose information that suggests that the woman could give birth to a child with serious disabilities. The woman's claim is that if she had been informed of the risk, she would have sought an abortion. Most courts have upheld a patient's wrongful birth claims.[55] While courts diverge on the measure of damages, most provide compensation for the extraordinary costs of raising a disabled child.[56]

The core holding of the wrongful birth cases is supported by ordinary principles of medical negligence and informed consent, as well as standards of medical practice and ethics. These principles respect the patient's rights to self-determination and autonomy in medical decision-making.[57] The essence of the interest protected in wrongful birth cases is the patient's right to choose whether to continue or terminate her pregnancy.

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with a man strongly opposed to having another child also confronts a crisis pregnancy. Another woman may be at a point in a multi-year career where high performance for the immediate future is essential. All of these are crisis pregnancies.

52. The Center for Disease Control reports that the risks of complications from abortion increase 20 percent for each week abortion is delayed, and that the death risk increases 50 percent for each week of delay. McRae v. Califano, 491 F. Supp. 630, 656 (E.D.N.Y. 1980), *rev'd sub nom.* Harris v. McRae, 448 U.S. 297 (1980) (holding that a woman's freedom to choose abortion does not entitle her to state funding for the abortion).

53. 410 U.S. 113 (1973).

54. *See* Gregory G. Sarno, Annotation, *Tort Liability for Wrongfully Causing One to Be Born*, 83 A.L.R.3D 15 (1978) (discussing the circumstances under which a defendant will be held liable for the birth of an infant who allegedly would not have been born "but for" the defendant's act or omission). *See generally* Proffitt v. Bartolo, 412 N.W.2d 232, 236 (Mich. App. 1987) (summarizing wrongful birth cases).

Suits based on informed consent are part of a larger international trend in which claims for wrongful birth are recognized. *See* Giesen & Hayes, *supra* note 20, at 104. *See also* GIESEN, *supra* note 18, at 242-43 (discussing recent trends in damages for failing to inform pregnant women of their potential to give birth to children with serious disabilities).

55. Appellate courts in only four jurisdictions have rejected the wrongful birth claim. Atlanta Obstetrics v. Abelson, 398 S.E.2d 557 (Ga. 1990); Wilson v. Kuenzi, 751 S.W.2d 741 (Mo. 1988), *cert. denied*, 488 U.S. 893 (1988); Azzolino v. Dingfelder, 337 S.E.2d 528 (N.C. 1985), *cert. denied*, 479 U.S. 835 (1986); Spencer v. Seikel, 742 P.2d 1126 (Okla. 1987). These cases are discussed more fully *infra* at note 65 and accompanying text.

56. Sarno, *supra* note 55, at 29-40.

57. *See* Alexander M. Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618 (1979) (arguing that courts should allow recovery for "wrongful life" based on common

Wrongful birth claims are limited to circumstances in which the physician's failure to facilitate informed patient choice results in the birth of a disabled child. A woman's interest in making an informed choice about whether to continue her pregnancy, however, is not limited to such circumstances. Indeed, by limiting the common law remedy to those situations in which a woman might choose an abortion because of a problem with the fetus, the law discriminates on the basis of disability.[58] Professor Martha Field argues that laws allowing or funding abortion only when the fetus is likely to be born with a "defect" constitute impermissible discrimination based on disability.[59] She observes that while many women who seek late-term abortions do so because amniocentesis has revealed a fetal defect, "other factors that surface late in pregnancy . . . make a woman desire abortion. For example, a woman whose husband died late in pregnancy, or whose boyfriend left her, or who herself became incapacitated [may wish to terminate her pregnancy]. . . ."[60] The remedy for such a discriminatory policy is not to deny information and reproductive choice to women who may give birth to disabled children, but rather to extend this obligation to inform and refer to all pregnant women.[61]

Although the wrongful birth cases explicitly recognize doctors' duty to enable pregnant women to make informed choices about whether to have an abortion or to carry a fetus to term, few cases in the United States specifically address physicians' obligation to refer patients for an abortion. One clear summary of the law in this area states:

> Although the courts have refused to impose the duty of becoming genetic counselors upon all obstetricians, there exists a clear legal duty to refer patients to specialists in the field of genetic counseling. This duty to refer exists, for example, when the physician is unable to make a diagnosis, perhaps due to the complications involved; when the physician is unable to perform a procedure, perhaps due to a lack of training or facilities; or when the physician

law tort theory); Rachel T. Grobe, *The Future of the 'Wrongful Birth' Cause of Action*, 12 PACE L. REV. 717 (1992) (arguing that recent Supreme Court abortion decisions have threatened sustainable wrongful birth actions); Ellen E. Wright, *Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L.J. 1488 (1978) (arguing that under tort theory, only parents should be able to recover from physicians for negligent genetic counseling).

58. Martha A. Field, *Killing 'the Handicapped'—Before and After Birth*, 16 HARV. WOMEN'S L.J. 79 (1993) (arguing that governments should be prohibited from allowing abortion of disabled fetuses more readily than abortion of non-handicapped fetuses).

59. *Id.* at 111. Field's claim does not rely on an assertion about the personhood of the fetus. Rather she argues that living people with disabilities suffer discrimination when the law allows the destruction of fetuses that would, if born, be people with disabilities.

60. *Id.* at 114.

61. Practical concerns about manageable standards for determining damages and malpractice insurance costs may justify extending the duty to provide informed consent through education and ethical principles, rather than through an expansion of common law malpractice remedies. *See infra* part IV.A.

> may be unwilling to provide a service which violates his personal moral values. Even the objecting physician should have a duty to refer, as the right of prospective parents to make their own procreative decisions should outweigh any moral values a physician may have.[62]

Other courts have declined to impose a duty to refer for abortion. For example, in *Spencer v. Seikel*,[63] the plaintiff was twenty-three weeks pregnant when the doctor discovered the fetus was hydrocephalic, a condition that causes skull enlargement and brain atrophy. The physician did not perform abortions and did not refer the woman to a physician who did. The plaintiff sued for avoidable costs, pain and trauma of continued pregnancy, and delivery and care of the child during the child's brief life. The court rejected her claim. The court assumed that abortion was illegal in Oklahoma at the plaintiff's stage of pregnancy and that the doctor had no duty to inform the plaintiff that abortion was legally obtainable in other states.[64] It stated that physicians were not required to become experts in the law of other states.[65]

This case seems wrongly decided. Abortion under these circumstances was in fact legal in Oklahoma.[66] In addition, despite the law's protection, a patient will have a difficult time finding a physician who will perform an abortion at this stage of pregnancy, even when the fetus is dead. Over the past twenty years, at any given time, only one or two doctors in the nation would perform an abortion at this stage of pregnancy.[67] It appears that the physician in *Spencer* failed to comply with traditional ethical and legal requirements for providing information and for making needed referrals.

Unfortunately, recent legislative action in several states has narrowed the already limited area in which the law explicitly requires physicians to provide informed choice to pregnant women.[68] In the late 1980s, the anti-choice movement promoted laws to abolish patients' right to recover damages for malpractice when physicians negligently failed to inform them of a

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62. Carolyn L. Brown, *Genetic Malpractice: Avoiding Liability*, 54 U. CIN. L. REV. 857, 869 (1986) (categorizing acts and omissions that may lead to malpractice liability under basic tort law principles).

63. 742 P.2d 1126, 1129 (Okla. 1987) (holding that requiring physicians to inform patients of treatment alternatives not available in Oklahoma but available in other states is beyond what the law expects from physicians).

64. *Id.* at 1129.

65. *Id.*

66. Indeed, at that time, prior to the end of the second trimester, states were prohibited from regulating abortion except to promote compelling interests in the protection of maternal health. *See* Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992).

67. Henshaw, *supra* note 9, at 251. In 1988, only 9 percent of the limited number of abortion providers offer services beyond 20 weeks of gestation.

68. *See Wrongful Birth Actions: The Case Against Legislative Curtailment*, 100 HARV. L. REV. 2017, 2017-19 (1987) (arguing that a Minnesota Supreme Court decision upholding a statute barring wrongful birth actions was unconstitutional) [hereinafter *Wrongful Birth*].

risk that their fetuses were damaged.[69] Six states have enacted such laws.[70] While the language of these laws varies, each essentially embodies the following prohibition, which is contained in model anti-choice legislation: "There shall be no cause of action on behalf of any person based on the claim that but for an act or omission, a person would not have been permitted to have been born alive but would have been aborted."[71] These laws directly contravene fundamental ethical and legal principles requiring that physicians respect patient choice.

Principles of medical malpractice and ethics require physicians to respect patient choice. This respect mandates that physicians provide patients both with the necessary medical information for them to make informed choices and with informed referrals for medical services that the physician is unable or unwilling to provide. Despite this support for patient choice, however, contemporary patterns of medical practice have proven to be systemically anti-choice and anti-abortion.

II

CONTEMPORARY PATTERNS OF MEDICAL EDUCATION, ETHICS, AND PRACTICE IN RELATION TO ABORTION CHOICE

Despite the strong legal, ethical, and popular commitment to doctor-patient communication and patient choice, Dr. Jay Katz demonstrates in his widely praised study, *The Silent World of Doctor and Patient*, that the continuing tradition in actual medical practice is one of physician silence and paternalism, rather than dialogue and patient autonomy.[72] Katz states that for most of human history, "[d]isclosure and consent, except in the most rudimentary fashion, [were] obligations alien to medical thinking and practice."[73]

In practice, the tradition of medical paternalism is particularly strong in relation to women patients; doctors often assume authority to determine what is in women's best interest without soliciting their views.[74] Furthermore, physicians frequently communicate less information to their women patients than to male patients. For example, in an authoritative study of

69. *Id.* at 2019.

70. Indiana, Minnesota, and Missouri prohibit causes of action based on negligent conduct. IND. CODE ANN. § 34-1-1-11 (Burns 1986 & Supp. 1993); MINN. STAT. ANN. § 145.424 (West 1989); MO. ANN. STAT. § 188.130 (Vernon 1988 & Supp. 1993). Idaho, Pennsylvania, and South Dakota prohibit actions based on intentional as well as negligent conduct. IDAHO CODE § 5-334 (1990); 42 PA. CONS. STAT. ANN. § 8305 (1989 & Supp. 1993); S.D. CODIFIED LAWS ANN. § 21-55-2 (1993).

71. *Wrongful Birth*, *supra* note 68, at 2019.

72. KATZ, *supra* note 22, at 1-4.

73. *Id.* at 1.

74. BARBARA EHRENREICH & DEIRDRE ENGLISH, FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN (1979); JUDITH W. LEAVITT, BROUGHT TO BED: CHILD BEARING IN AMERICA 1750-1950, at 4 (1986) (describing the male-dominated medical profession as a paradigm of professional authority over women).

medical practice at Yale-New Haven Hospital, Doctors Raymond Duff and August Hollingshead found that physicians only informed affluent male patients of the fact that they were likely to die.[75] Female and poor patients were never informed of impending death, but were left to confront their mortality without a complete and realistic prognosis.[76]

These traditions of paternalism and silence are particularly common in situations where a medical condition relates to the sexuality of the patient. Although sexuality is an important aspect of many medical conditions, including abortion, many physicians are uncomfortable exploring with their patients medical issues that touch upon sexuality.[77] Conventional medical training has remained deficient in exposing medical students to the sensitive subject of human sexuality.[78]

Although all primary care physicians regularly confirm or discover that a patient is pregnant, ethical standards, medical texts, common patterns of medical education, and standards of professional accreditation do not assure that physicians will provide appropriate medical referrals to pregnant women. While at an abstract level, the ethical standards of ACOG strongly affirm the importance of choice for pregnant women,[79] they address the specific question of counseling about abortion choice only in the context of genetic problems of the fetus.[80]

ACOG standards are deficient in several respects. First, apart from issues of genetic risk, ACOG provides no guidance to physicians counseling women about informed choice concerning abortion or providing referrals to women who seek abortions. While genetic risk surely provides one reason that a woman might consider abortion, it is not the only reason.[81] Furthermore, ACOG's silence about abortion undermines its general ethical standards, which recognize that reproductive choices are primarily a matter of personal moral beliefs and practical life choice. Given the high proportion of pregnancies that end in abortion, the omission is startling. An ACOG Committee Opinion regarding genetic counseling never mentions

75. RAYMOND S. DUFF & AUGUST B. HOLLINGSHEAD, SICKNESS & SOCIETY 313 (1968).

76. *Id.* at 312-13.

77. SEX EDUCATION IN MEDICINE 2 (Harold I. Lief & Arno Karlen eds., 1976).

78. In 1973, when Governor Jerry Brown added feminist consumer advocates to the California Medical Licensing Board, the Board promoted a rule that graduates of California medical schools must receive minimal training in human sexuality in order to be licensed. The California legislature, approving this requirement, noted that physicians know less about this vital subject than ordinary lay people. *See* LAW & POLAN, *supra* note 24, at 187. *See also* SEX EDUCATION IN MEDICINE, *supra* note 79, at 1-3 (suggesting a trend in medical schools toward recognizing the need to provide training in human sexuality).

79. *See supra* note 29-31 and accompanying text.

80. *Ethical Dimensions of Informed Consent*, *supra* note 29, at 5. In this context, the physician is instructed, appropriately, to remain neutral as to whether "to continue or terminate" the pregnancy. *See also Ethical Issues in Pregnancy Counseling*, ACOG COMM. OP. No. 61 (Am. College of Obstetricians and Gynecologists, Washington, D.C.), May 1988.

81. Field, *supra* note 58, at 79.

the word abortion, although the opinion could be interpreted to allude to abortion under the euphemistic rubric "potential therapy."[82] ACOG's Opinions never suggest that the gynecologist should provide a referral to a qualified and responsible abortion practitioner even if a woman or the fetus faces a serious threat or if a woman actively seeks an abortion.[83]

ACOG publishes forty-nine patient-education booklets and four books on topics which include or involve gynecological problems, physiology and sexuality, special procedures, general women's health, and prepartum, antepartum, and postpartum care.[84] While general ACOG principles affirm the importance of patient choice, none of these patient-education materials addresses abortion.

ACOG also publishes a standard patient-history form to guide physicians providing prenatal care.[85] Although the form seeks information about women's menstrual, medical, and pregnancy histories, it does not ask physicians to inquire how patients feel about the fact that they are pregnant. Regardless, an ACOG spokesperson states that the articulated items represent comprehensive initial prenatal care.[86] The ACOG spokesperson explained:

> [I]f a woman shows up for a prenatal appointment, then it is assumed she is saying that prenatal care is what she wants. If she comes for an abortion, then she should get counseled on all the options. If she comes for prenatal care, we can assume that is what she wants. It is up to her to say that she wants an abortion.[87]

This view is unreasonable, anti-choice, and anti-abortion. Just as abortion clinics do and should offer option counseling to ensure that women seeking abortions have made informed, uncoerced choices,[88] so should doctors treating pregnant women in other contexts explore whether a particular woman's apparent choice to have a child is informed and uncoerced.

Indeed, women in abortion clinics probably have less need for option counseling than pregnant women who see doctors in primary medical care or prenatal care programs. Abortion clinics tend to be specialized providers.[89] Typically, women go to abortion clinics because they believe that they want an abortion. By contrast, a woman may discover that she is pregnant during a routine visit to her primary care physician or gynecologist

82. *Ethical Issues in Pregnancy Counseling*, *supra* note 80, at 1.

83. *Id.*

84. *See* ACOG Patient Education Order Form (Am. College of Obstetricians and Gynecologists, Washington, D.C.), May 1994.

85. ACOG Antepartum Record (Am. College of Obstetricians and Gynecologists, Washington, D.C.), *revised* Apr. 1992.

86. Telephone Interview with Joan Personett, Administrator of Clinical Practice Committees, ACOG (Mar. 12, 1993).

87. *Id.*

88. *See* Section IV.A. *infra.*

89. Henshaw & Van Vort, *supra* note 8, at 107.

and then need information about her options. Many prenatal care programs reach out to all pregnant women without distinguishing between those who wish to continue their pregnancies and those who might prefer abortion. Further, physicians and other health care providers working in settings other than prenatal care clinics widely use ACOG's general prenatal form.[90] Neither internists nor family practitioners nor obstetrics-gynecology specialists have any basis for knowing how a woman feels about being pregnant. The standard patient-history form presumes that every pregnancy is desired.

In addition to promulgating ethical standards for board-certified obstetricians and gynecologists, ACOG plays a key role in defining the educational requirements for certification in these specialties.[91] Accreditation standards are consistently anti-choice and anti-abortion.[92] ACOG accreditation standards for residency programs require that obstetrician-gynecologists "achieve the knowledge, skills and attitudes essential to the practice of obstetrics and gynecology. . . ."[93] The detailed obstetrics-gynecology residency standards demand that the resident have a wide variety of operative experiences and master:

> [the] management of patients by personal evaluation of . . . physical and laboratory findings leading to a diagnosis and decision for therapy as well as the performance of technical procedures. An acceptable residency program in obstetrics-gynecology must be able to provide substantial, diverse and appropriate surgical experience . . . .[94]

ACOG standards for the accreditation of residency programs identify many requirements, among them specific obstetrics training, including high-risk obstetrics, genetic testing and counseling, operative vaginal deliveries, including obstetric forceps vacuum extractor, breech deliveries, vaginal births after cesarean delivery, obstetrical anesthesia, immediate care of newborns, and other common obstetrical diagnostic procedures.[95] The

90. Telephone Interview with ACOG Resource Center staffperson (July 5, 1994).

91. While individual states license physicians, they rely heavily on private professional organizations to accredit medical schools and residency programs. To become a doctor, an individual must complete a four-year program at an accredited medical school. Medical schools are accredited by the Liaison Committee on Graduate Medical Education, which calls itself "a private credential organization supported by the AMA and the American Association of Medical Colleges." Most states require that medical school graduates complete a one-year internship to qualify for a license. These internships are provided in about 5000 residency programs, located in more than 1700 hospitals and health care facilities in the United States and accredited by 24 separate specialty review committees. GEORGE ANNAS, SYLVIA A. LAW, RAND ROSENBLATT & KEN WING, AMERICAN HEALTH LAW 697-98 (1991).

92. DIRECTORY OF GRADUATE MEDICAL EDUCATION PROGRAMS 71 (78th ed., 1992-93).

93. *Id.*

94. *Id.* at 73.

95. *Id.* at 74.

standards do *not* require physicians to learn to perform abortions. Most medical students, including those training as specialists in obstetrics and gynecology, are not trained to perform abortions.[96] Most students are never offered the opportunity to obtain such training.[97] Furthermore, the few who are offered the opportunity for training are discouraged from accepting it.[98] Medical education and residency programs are notoriously demanding.[99] When abortion training is offered solely as an optional addition to an already full program, few students have incentives to learn. "Busy residents with multiple competing responsibilities are unlikely to take advantage of elective activities. Written and oral board examinations do not include questions about abortion. While board certification in obstetrics/gynecology is contingent, in part, on presenting evidence of an adequate surgical caseload, abortion cases are not required."[100]

The failure to expect that all doctors will learn to perform abortions has a serious adverse impact on overall physician competence. The techniques used to perform abortions are also useful in doing other medically necessary procedures, e.g., removal of a fetus that has died.[101] Because students are not expected to learn to do abortions, they lack the skill to provide both abortions and other medical care.

In the obstetrics and gynecology profession, ACOG is not alone in its silence on abortion and choice counseling. The most commonly used and widely respected textbooks fail to explore the subject. For example, Dr. Kenneth R. Niswander's basic textbook suggests that when a physician obtains information about a woman's history, the physician should encourage the pregnant woman to talk about her ideas on childbearing, sex, marriage, her role as a woman, and what she expects from the doctor-patient

96. *See supra* note 10 and accompanying text.

97. *See supra* note 10 and accompanying text.

98. Steven B. Arrington, a student in my Health Law class (Fall 1993) earned an M.D. degree at the University of Virginia. He explained that although the school offered voluntary early abortion training to medical students, strong social pressure discouraged students from accepting this training.

While students who have sincere conscientious objections to abortion should be free to decline such training, the norm should be that young physicians are trained in this common surgical procedure. Medical education should give students who are conscientiously opposed to abortion guidance about counseling and referral for patients who hold different views. See *infra* note 123 and accompanying text.

99. *See, e.g.*, N.Y. Admin. Code tit. 10, Sec. 405 (1989) limiting the hours that residents may work to 12 shifts in emergency rooms and 80 hours per week in non-emergency care. See discussion David A. Asch & Ruth M. Parker, *The Libby Zion Case*, 318 N. ENG. J. MED. 771 (1988).

100. Westhoff, *supra* note 10, at 151.

101. *Id.* ("Some techniques that are routinely used in gynecology and are taught to residents in the hospital are relevant for the performance of first-trimester abortions, including dilation of the cervix with metal dilators and sharp curettage of the nonpregnant uterus for diagnostic reasons and sharp curettage of the pregnant uterus to complete emptying and stop hemorrhage during a spontaneous abortion.").

relationship.[102] Dr. Niswander, however, does not mention the need to discuss the abortion option or the woman's views on abortion unless the woman has an illness that might be dangerous to her or the fetus, or if genetic counseling indicates an irregularity in the fetus.[103] Dr. Niswander's text does not recognize childbirth as a choice.

Williams on Obstetrics, another popular and highly regarded text, is similarly defective.[104] It does not suggest that the doctor ask the woman how she feels about her pregnancy or provide her with referral for abortion. The text asks the doctor to obtain information about the woman's medical history and current medical condition to enable the physician to decide what course of treatment is necessary to continue the pregnancy.[105] The text mentions that prenatal care should begin as early as possible if the woman desires an abortion.[106] Although this passage could be read as an implicit recognition that the provision of prenatal care may include abortion, the message is subtle and provides no guidance to the physician to facilitate informed patient choice or abortion referral.

Other leadership organizations of the medical profession do even less than ACOG to encourage informed consent in relation to reproductive choice. Medical professionals often consider the AMA's Code of Ethics a standard of medical ethics. Although abortion is the most common surgical procedure in the United States,[107] the AMA's ethical standards say nothing about abortion.[108] Further, AMA legal advisors assert that doctors have no ethical obligation to provide knowledgeable professional advice to women confronting a crisis pregnancy:

> No physician has an obligation to perform an abortion. No physician should be obligated to put a patient in the hands of a person who will perform the abortion. The physician can say, 'I will not refer you to a physician who does this. You can find them through the usual channels. I don't want to be part of it.'[109]

Similarly, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the major organization in the United States to set

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102. KENNETH R. NISWANDER, CURRENT OBSTETRIC & GYNECOLOGIC DIAGNOSIS & TREATMENT 641 (Ralph C. Benson ed., 5th ed. 1984).

103. *Id.* at 642.

104. *Id.* at ch. IX.

105. JOHN W. WILLIAMS, F. GARY CUNNINGHAM, PAUL C. MACDONALD, KENNETH J. LEVENO, NORMAN F. GRANT & LARRY C. GILSTRAP, WILLIAMS ON OBSTETRICS (19th ed. 1993).

106. *Id.* at 247.

107. *See supra* note 7 and accompanying text.

108. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS (1980).

109. Smith, *supra* note 42. Contrast the AMA's broad view of the doctor's duty to make referrals for medical services other than abortion. *See* CURRENT OPINIONS, *supra* note 40, at § 8.04.

standards of quality for hospitals, does not address the issue of abortion.[110] Its standards affirm "the patient's right to make decisions regarding his/her medical care," and require hospitals to assist "the patient in the exercise of his/her rights."[111] Hospitals seeking accreditation must answer thirty-one detailed questions demonstrating compliance with these norms, including questions on the management of pain, termination of treatment, and "consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness."[112] Nothing in the JCAHO standards suggests that hospitals must provide abortions, counsel pregnant women, or provide referrals for abortion services that the hospital does not provide.

The American Hospital Association (AHA) also has a major impact on hospital policy. It publishes an influential *Patient's Bill of Rights* that provides detailed guidance on patients' right to "know the identity of physicians, nurses, and others involved in their care . . ." and the "immediate and long-term financial implications of treatment choices. . . ."[113] The AHA's *Patient's Bill of Rights* supports patients' rights in the newly-emerging contexts of experimental treatments, living wills, access to medical records, and referrals to other providers, yet it is silent on issues of reproductive choice for pregnant women.

Although norms of medical ethics and malpractice support the notion that abortion choice belongs to the patient, contemporary patterns of medical education, practice, and even the best standards of medical ethics are systematically anti-choice and anti-abortion. To make this abstract right to choose practically effective, it must be integrated into ordinary medical practice, education, and ethics. Silence is not sufficient to make a norm reality. Indeed, silence affirms anti-choice attitudes.

III
ANSWERING COMMON OBJECTIONS TO OBLIGATIONS TO PROVIDE MEDICAL INFORMATION AND REFERRAL

A. Physicians' Capacity to Provide Information About Medical Aspects of Abortion and Abortion Referral

The most important factors influencing a woman's decision to have a child are ethical and practical, rather than medical.[114] Thus, some argue that the physician has no special role in promoting choice on the core

110. Most states and the federal Medicare program rely upon JCAHO to design and implement standards for health care organizations. *See* ANNAS, LAW, ROSENBLATT & WING, *supra* note 91, at 524-25.

111. JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS 105 (1993).

112. *Id.* at 105-06.

113. AMERICAN HOSPITAL ASSOCIATION, A PATIENT'S BILL OF RIGHTS 1 (1992).

114. Planned Parenthood v. Casey, 112 S. Ct. 2791, 2807 (1992) (O'Connor, Kennedy, and Souter, JJ., announcing the judgment of the Court).

question of whether to have an abortion or a child.[115] Further, so-called informed consent laws have required physicians to give women seeking abortion subjective moral and social information about which the physician has no special knowledge or experience.[116] For example, anti-choice informed consent laws often require physicians to inform women about the moral status of the fetus, the availability of welfare, adoption services, legal requirements of paternal support, and so forth.[117] Not only is the required information often misleading, but physicians' knowledge and experience typically do not enable them to help women evaluate such social and moral factors. These laws do not promote informed choice, but rather conscript physicians as messengers of the state's anti-abortion stance.

Still, physicians should be required to provide pregnant patients with medical information about abortion and abortion referral. Physicians possess significant knowledge, training, and experience which enable them to provide information that can facilitate informed choice for pregnant women. This information, unlike the information required above, is neutral and factual. For example, a physician can counsel a pregnant patient about the known range of physical and mental health factors that can make pregnancy unusually demanding for the woman or particularly risky for the fetus.[118] Physicians can inform pregnant patients of the genetic risks and diagnostic procedures available for these and other potential problems.[119] Doctors also have superior capacity to know about the range of medical services available to the patient, whether she chooses to have a child or an abortion.[120] In many cases, the patient may have no alternative source of information about these medical issues.[121] If the physician says nothing about abortion, silence carries the implicit message that abortion is unavailable, immoral, dangerous, unfeasible, or irrelevant to the patient's situation. That message is flatly wrong, since abortion is legal. The scarcity

115. *See supra* note 42 and accompanying text. Similarly, B.J. Anderson, another attorney with the AMA, asserts that a physician practicing in "obstetrics-gynecology has no affirmative obligation to inform the woman about abortion. I can't imagine a woman old enough to be pregnant who does not know about abortion." Telephone Interview with B.J. Anderson, Esq. (June 23, 1993).

116. Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986) and City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) struck down such informed consent requirements as unconstitutional. Planned Parenthood v. Casey, 112 S. Ct. at 2823, afforded the state much greater latitude to impose informed consent requirements designed to discourage abortion.

117. *Akron*, 462 U.S. at 442-46; *Thornburgh*, 476 U.S. at 759-64.

118. For a good judicial summary of the medical risks inherent in pregnancy, see McRae v. Califano, 491 F. Supp. 630, 662, 666-68 (E.D.N.Y. 1980) (citing Roe v. Wade, 410 U.S. at 153 and Doe v. Bolton, 410 U.S. at 192), *rev'd on other grounds sub nom.* Harris v. McRae, 448 U.S. 297 (1980).

119. *Id.* at 679.

120. *Id.* at 666-68.

121. Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 495 (1993) (describing the attempts made by the medical profession to exert control over reproductive issues).

of quality abortion services in many parts of the country[122] underscores the need for physician guidance to help the patient find the medical services that she wants and needs. Health care providers should give pregnant patients medical information to enable them to evaluate their available choices.

B. Physicians' Conscientious Objections to Abortion

A second possible objection to applying ordinary ethical and legal norms of informed consent and patient choice to the health care providers treating pregnant women is that such requirements would violate the rights of those providers who believe that abortion is wrong. Some argue that health care providers who conscientiously object to abortion should not be required to provide abortions. State and federal laws support this view by providing broad employment protection for health care providers who are conscientiously opposed to abortion.[123]

Respect for individuals' conscientious objections to abortion, however, does not justify the current practice of physician silence. Most physicians do not have conscientious objections to abortion.[124] Instead, physicians decline to perform or counsel on abortion because they find it more convenient to avoid involvement in a controversial issue, have not been encouraged by medical education or ethics, or prefer to discuss abortion only when the physician believes it is best.[125] As with military service, society and the professions should not simply assume that every disinclination to serve is conscientious, rather than merely a matter of personal convenience.[126] Only physicians with true conscientious objections to abortion should be excused from the duty to learn to perform abortions.

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122. *See supra* note 8 and accompanying text.

123. *See* Bruce G. Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 3 DET. C.L. REV. 847, 867-68 (1986). In addition to laws providing special protection to health care providers with conscientious objections to abortion, Title VII of the Civil Rights Act of 1964 prohibits discrimination on the basis of religion and requires employers to make reasonable accommodation for workers' religious beliefs and practices. *See, e.g.*, Kenny v. Ambulatory Ctr. of Miami, Inc., 400 So. 2d 1262, 1266 (Fla. Dist. Ct. App. 1981) (holding that a hospital could accommodate a worker's religious objections by transferring her to a section performing non-gynecological procedures when no undue hardship on the employer would result); Ravenstahl v. Thomas Jefferson Hosp., 37 Fair Empl. Prac. Cas. (BNA) 568, 569 (E.D. Pa. 1985) (approving a hospital accommodation for an employee with religious objections to abortion).

124. John M. Westfall, Ken J. Kallail & Anne D. Walling, *Abortion Attitudes and Practices of Family and General Practice Physicians*, 33 J. FAM. PRAC. 47, 48 (1991) (reporting that only 8 percent of U.S. physicians believe that abortion is always wrong).

125. *See* Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1442-43 (1991) (documenting and criticizing physician practices coercing abortion and sterilization when the doctor determines that a woman does not deserve to become a mother).

126. While the selective service laws permit individuals who have conscientious objections to all wars to avoid military service, neither the statutes nor the Constitution allow individuals to avoid military service because they object to particular wars. *See* Gillette v. United States, 401 U.S. 437, 463 n.1 (1971) (Douglas, J., dissenting) (citing to the Military

Physicians whose conscientious beliefs do prevent them from providing patients with abortion services or counseling should be required to inform patients of that limitation. By analogy, Jehovah's Witnesses are conscientiously and intellectually committed to the use of therapies that avoid blood transfusions, and the law respects those choices.[127] A Jehovah's Witness physician treating patients who have no ethical objection to blood transfusion, however, is not free to remain silent about the ethical limits on the services that she is willing to provide. Billy E. Moore, an attorney who has represented many patients and physicians who are Jehovah's Witnesses, explains:

> Of course the doctor needs to explain his beliefs to the patient and offer the patient alternative treatment and referrals. Whatever the doctor's conscientious or scientific beliefs, the patient is also entitled to their own beliefs. It is the patient's body.
>
> We all owe one another the duty to communicate. Witnesses are committed to seeking to share our understanding with others. Why would we refuse to communicate in the context of medical treatment?
>
> If my wife were pregnant, and it came to be a matter of either abortion or her death, I can't imagine that a Catholic doctor could decide to deny her an abortion and force her death or refuse to talk with her about it. If she made a decision he could not conscientiously proceed with, he would have to refer her to some other physician that was not offended by her decision in such a situation. Whether to accept or reject any form of medical treatment must remain with the patient.[128]

No reported case charges a Jehovah's Witness physician with malpractice for failure to administer blood or to inform patients about the doctor's objection to this standard form of treatment. Few such physicians practice in settings in which these issues arise.[129] Those physicians who do practice in settings that traditionally involve the use of blood inform patients of

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Selective Service Act of 1967, 50 U.S.C.A. § 456(j) (1964 ed.)). This approach to the scope of conscientious objection to military service seems unduly restrictive, because it seems feasible for the government to allow a broad range of conscientious objection, even to particular wars, without undermining the ability to raise an effective military force. Conscientious objection, even if broadly defined, is not the same as objection on grounds of personal convenience or accommodation to popular opinion. The success of the voluntary draft suggests that the state can meet its military needs without overriding claims of individual conscience. The same principle could apply to the abortion context.

127. *See, e.g.*, Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990) (affirming vacation of order authorizing transfusion of competent, adult patient despite her clear refusal, and that the State's *parens patriae* interest in the welfare of patient's newborn child does not override a patient's common law right of bodily self-determination).

128. Telephone Interview with Billy E. Moore, Esq. (April 5, 1993).

129. *Id.*

their views and offer them alternatives.[130] Respect for physicians' religious views would not absolve a doctor of responsibility for injury to a patient due to the practitioner's unwillingness to provide blood.

John C. Fletcher, one of the nation's leading moral philosophers and medical ethicists, has addressed the issue of conflict between the doctor's conscientious belief and the patient's wishes in the context of artificial insemination by donor (AID) for lesbians.[131] He argues that "any physician with specific religious or ethical objections to AID itself may conscientiously decline to perform it but has a duty to refer. . . ."[132] Fletcher's discussion of the ethical obligations of physicians responding to a lesbian patient's request for AID highlights two points relevant to the abortion context. First, Fletcher argues that while a doctor is free to act on a conscientious belief that AID is always wrong, she should not selectively provide or withhold the service based on her judgment about the moral qualities of the patient. In selectively providing service, the doctor appropriates a moral decision-making role that belongs to the patient.[133] Second, even if the doctor conscientiously objects to all insemination, the physician nonetheless has a duty to refer.[134]

No reported case addresses a claim of a physician that her moral beliefs justify failure to inform a patient of the possibility of abortion and provide an appropriate medical referral. Supreme Court Justice William Souter did address the issue in dicta as a judge on the New Hampshire Supreme Court.[135] The plaintiff asserted a wrongful birth claim against her physicians, because they failed to test her for rubella and to advise her of her options in a timely manner.[136] A unanimous court upheld the woman's wrongful birth claim.[137] Although the physicians did not assert that they

130. *Id.*

131. John C. Fletcher, *Artificial Insemination in Lesbians: Ethical Considerations*, 145 ARCH. INTERN. MED. 419 (1985).

132. *Id.* at 420. In 1986, a New Jersey appellate division court grappled with the conflict between a mentally competent patient who sought to refuse artificial feeding and a hospital that adopted a policy declining to participate in withholding or withdrawing artificial feeding or fluids. The hospital offered to transfer the patient to a comparable facility 17 miles away. The patient, who had been in the hospital for 15 months, did not want to move. The court ruled for the patient, holding that the hospital's policy is "valid and enforceable only if it does not conflict with a patient's right-to-die decision and other protected interests. . . ." *In Re* Requena, 517 A.2d 869, 869 (N.J. Super. Ct. App. Div. 1986). The trial court reasonably determined that the "subverting of hospital policy and offending the sensibilities of hospital administrators and staff were . . . subordinate to the psychological harm to be visited upon Mrs. Requena [by forced transfer]." *Id.* at 870.

133. *See* Fletcher, *supra* note 131, at 419.

134. *Id.* at 419-20.

135. Smith v. Cote, 513 A.2d 341 (N.H. 1986) (holding that a mother has a cause of action for wrongful birth against a physician who negligently failed to test her for rubella, but that a child has no cause of action for wrongful life).

136. *Id.* at 342-43.

137. *Id.* at 348.

had conscientious objections to abortion, Judge Souter concurred specially and *sua sponte* observed:

> [The] trial court did not ask whether, or how, a physician with conscientious scruples against abortion, and the testing and counselling that may inform an abortion decision, can discharge his professional obligation without engaging in procedures that his religious or moral principles condemn.[138]

Having raised the question, Judge Souter did not undertake to answer it. Instead, he simply observed:

> [Whether proof] of timely disclosure of professional limits based on religious or moral scruples, combined with timely referral to other physicians who are not so constrained [constitutes a defense to a wrongful birth claim], is a question open for consideration in any case in which it may be raised.[139]

Judge Souter's brief comment seems correct in recognizing that a physician must disclose any moral or religious objections to a patient in a timely manner. The doctor's moral beliefs, however deeply held, cannot justify silence that in effect denies a woman a choice that another professional would offer. Judge Souter also recognizes that the physician's obligation includes referral to another physician in a timely manner.[140] His concurrence, however, does not explore the issues involved in reconciling respect for a physician's moral beliefs and a pregnant woman's right to information and referral.

A physician who provides medical information and referral does not thereby promote abortion.[141] If physicians do not customarily discuss abortion except to prescribe it,[142] this claim may be plausible. But if informed consent and referral to facilitate patient choice were the norm, physician inquiry about the wishes and options of pregnant patients would not be construed as a recommendation of abortion.

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138. *Id.* at 355.

139. *Id.*

140. *Id.*

141. The North Carolina Supreme Court relied on this reasoning to reject a common law action for wrongful birth. The court predicted that allowing such an action "will place increased pressure upon physicians to take the 'safe' course by recommending abortion." Azzolino v. Dingfelder, 337 S.E.2d 528, 535 (N.C. 1985), *cert. denied*, 479 U.S. 835 (1986). The court offers an example that is common in anti-choice literature.

> A clinical instructor asks his students to advise an expectant mother on the fate of a fetus whose father has chronic syphilis. Early siblings were born with a collection of defects such as deafness, blindness, and retardation. The usual response of the students is: "Abort!" The teacher then calmly replies: "Congratulations, you have just aborted Beethoven."

None of the authors considering this example notes that the choice belongs to the woman, rather than the physician or the medical student.

142. *See supra* note 125 and accompanying text.

IV
THE INADEQUACY OF COMMON LAW AND CONSTITUTIONAL REMEDIES

While ethical and legal informed consent norms support the notion that physicians must provide informed consent and appropriate referrals for pregnant patients,[143] the law provides insufficient incentives to encourage compliance with the underlying norms.

A. Common Law Remedies

All courts that recognize a cause of action for failure to provide informed consent apply the traditional negligence standard that liability depends on undisclosed risk.[144] This principle severely limits the scope of the malpractice remedy. Consider as an example a patient who consents to an invasive diagnostic procedure. She subsequently learns that it is of only marginal utility as a diagnostic tool and poses significant risks of death or paralysis. None of this information was communicated to her. As a risk-averse person, she is convinced that, had she been informed, she would not have consented to the procedure. Fortunately, she survives the procedure without physical harm. While she is grateful and relieved, she also believes that she was injured by the doctor's failure to provide information that a reasonable person would want and that would have influenced her decision to consent. Although she has suffered a serious injury to her right to control her own body and life, she has no legal claim. Judge Robinson in *Canterbury* recites the traditional requirement that the undisclosed risk must materialize to establish liability.[145] He laments that "[t]he omission, however unpardonable, is legally without consequence."[146] This concept of injury is seriously limited; a plaintiff who suffers injury that consists only of her denied choice cannot recover for malpractice.

Furthermore, most courts limit physicians' liability for failure to facilitate choice to those situations in which the doctor proposes an invasive treatment, even though the informed consent doctrine requires communication in a much broader range of situations.[147] This limitation on liability

143. *See supra* part I.A.

144. Schultz, *supra* note 22, at 226-27.

145. Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972) (holding that the duty to disclose risk in surgery is not actionable unless the risk materializes), *cert. denied*, 409 U.S. 1064 (1972).

146. *Id.*

147. For example, although patients often need information to make choices whether to undertake further diagnostic procedures, most courts deny liability when doctors fail to provide such information. *See, e.g.*, Kelton v. District of Columbia, 413 A.2d 919, 922 (D.C. 1980) ("[A] breach of duty to disclose is not actionable in negligence unless it induces a patient's uninformed consent to a risky operation from which damages actually result."). *See also* Arato v. Avedon, 858 P.2d 598, 602 n.3 (Cal. 1993) (rejecting a ruling of a lower court that a physician has a legal duty to inform a patient of the statistical life expectancy associated with pancreatic cancer where the trial court had instructed the jury that "it is the

undermines the law's ability to provide redress in many situations in which ethical norms and values of patient autonomy require that doctors communicate with patients to facilitate patient choice.[148] Dr. Katz comments:

> Interferences with self-determination occur in all situations in which a person's dignitary interests have been violated. They are not limited to those in which physical harm has occurred. Lack of informed consent is itself a violation. It is the harm. The additional presence of physical harm only adds injury to insult.[149]

Thus, the injury that can be redressed by an action for lack of informed consent is narrowly defined.

Even if a patient establishes that a physician failed to communicate relevant information about risk, and the risk materialized, the plaintiff must also prove that the lack of informed consent caused her injury. Even those courts recognizing that physicians must provide information to facilitate choice have applied causation standards that deny liability unless the patient can demonstrate that no reasonable patient, if fully informed, would have consented to the treatment proposed.[150] These holdings have been criticized for undermining the purpose of the patient-oriented informed consent standard.[151]

Despite these criticisms, traditional limits on malpractice remedies are well established and not likely to be abandoned. Further, in light of strong

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duty of the physician to disclose to the patient all material information to enable the patient to make an informed decision regarding the proposed . . . treatment").

148. Schultz, *supra* note 22, at 232.

149. KATZ, *supra* note 73, at 79.

150. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 790, and Cobbs v. Grant, 502 P.2d 1, 7 (Cal. 1972) (reversing judgment against surgeon because record did not show whether jury found negligence in the surgery itself or in the failure to inform the patient of the risks involved). The plaintiffs in these cases failed to recover damages, even though both courts found that the physicians had failed to communicate information that a reasonable person would want to know in contemplating treatment. The plaintiffs were not able to demonstrate that the physicians' failure to provide information caused the injuries. The *Cobbs* court stated: "There must be a causal relationship between the physician's failure to inform and the injury to the plaintiff. Such causal connection arises only if it is established that had revelation been made consent to treatment *would not have been given.*" *Cobbs*, 502 P.2d at 11 (emphasis added).

151. Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979) (rejecting the *Canterbury/Cobb* standard of causation as "backtracking on its own theory of self-determination"); McPherson v. Ellis, 287 S.E.2d 892, 897 (N.C. 1982) (noting that the objective standard of causation gives "no consideration to the peculiar quirks and idiosyncracies of the individual"). *See generally* RUTH R. FADEN, TOM L. BEAUCHAMP, & NANCY M.P. KING, A HISTORY AND THEORY OF INFORMED CONSENT (1986) (arguing that the reasonable person standard does not adequately capture the intent of the informed consent doctrine which aims to protect patients' rights to self-determination); CHARLES W. LIDZ, ALAN MEISEL, EVIATAR ZERUBAVEL, MARY CARTER, REGINA M. SESTAK & LOREN H. ROTH, INFORMED CONSENT: A STUDY OF DECISION-MAKING IN PSYCHIATRY (1984) (discussing the controversy within the legal system surrounding the standard of disclosure applied to informed consent cases).

public concern about the costs of malpractice liability premiums, it is unclear whether monetary remedies should be expanded.[152] The current trend in relation to malpractice reform is to limit, not expand, physician liability.[153]

Even if the law were changed to recognize patient claims for violation of dignitary interests where providers do not ensure informed consent and appropriate medical referral, lawyers are unlikely to pursue these claims.[154] It is difficult to attach monetary value to the injury a woman suffers when she is not informed of the availability of abortion services. The difficulty of measuring damages undermines the ability of malpractice law to give appropriate force to the legal and ethical norms that underlie actions for lack of informed consent and negligent failure to provide referrals.[155] In the wrongful birth cases, courts have a practical means of determining significant money damages: the difference in cost between raising a typical child and one with serious physical or mental challenges.[156] Damages are not so easy to measure when a woman, denied her right to informed choice, gives birth to a healthy child, or when a woman has a more costly and risky late term abortion after finding services on her own. The violation of dignitary interest could be recognized through nominal damages, but such damages would trivialize the woman's injury and would not provide attorneys with incentives to take cases on a contingent-fee basis. It seems unlikely that any court will award substantial damages that appropriately recognize the seriousness of the woman's interest in informed choice.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research, while endorsing the notion that physicians have an ethical obligation to facilitate patient decision-making, adopts a pessimistic view of the role of malpractice law in enforcing this duty.[157] One can assume that the Commission would be even less hopeful about using malpractice as a remedy for denial of abortion choice. The Commission looks instead to medical training and public education to bring about shared decision-making and patient autonomy.[158]

152. *See generally* TORT LAW AND THE PUBLIC INTEREST: COMPETITION, INNOVATION AND CONSUMER WELFARE 24-27, 176-204, and 205-37 (Michael J. Trebilcock, Donald N. Dewess, and David G. Duff eds., 1991).

153. *Id.*

154. LAW & POLAN, *supra* note 24, at 86-94 (noting the impossibility of obtaining legal representation to assert claims that are unlikely to result in large monetary damage awards).

155. Marjorie M. Schultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297, 356-60 (addressing the difficulty of assigning a dollar value to reproductive injuries).

156. *Id.*

157. *See* MAKING HEALTH CARE DECISIONS, *supra* note 19, at 152.

158. *Id.*

B. Constitutional Remedies

Constitutional remedies are even less adequate than malpractice incentives in protecting free decision-making by pregnant women. These remedies redress state, rather than private, interference with individual liberty. Even where the state acts to limit choice for pregnant women, the Constitution, as currently interpreted by the Court, provides only the most limited protection of individual freedom of choice. Even the fairly comprehensive constitutional protection for women's rights to reproductive choice articulated in *Roe v. Wade*[159] only extends to physicians' right to make professional judgments regarding the termination of pregnancy free from state interference. It does not protect women's freedom to obtain treatment from other responsible and competent health care providers.[160]

Issues of informed consent for pregnant women acquire a constitutional dimension only when government action denies women's right to informed choice.[161] In the United States, most medical facilities are private, not public, organizations.[162] Further, states have delegated to private professional organizations the authority to approve hospitals, medical schools, and specialty certification.[163] Thus, constitutional norms simply do not apply to most of the decisions of doctors, hospitals, and medical schools that promote or deny informed choice for pregnant women.

Since 1992, the Court has interpreted the Constitution to allow states great latitude to deny pregnant women informed choice.[164] From *Roe* in 1973 until *Casey* in 1992, the Supreme Court had recognized that a woman's right to choose whether to bear a child is a fundamental, constitutionally protected right of liberty and privacy. More specifically, the Court had held that women's right to choose whether to bear a child encompasses the right not to be subjected to biased or inaccurate counseling.[165] In these pre-*Casey* cases, the Court had applied traditional constitutional principles, holding that if an individual liberty is considered fundamental, state actions restricting that liberty must survive strict scrutiny; thus, state action will be

159. 410 U.S. 113 (1973).

160. *Id.* at 165-66 ("The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.").

161. *See e.g.*, Walker v. Pierce, 560 F.2d 609 (4th Cir. 1977), *cert. denied*, 434 U.S. 1075 (1978) (dismissing on state action grounds a constitutional claim against a physician's policy of conditioning his obstetrical services upon patients' consent to sterilization, despite public funding of a large portion of the doctor's services, including those provided to the plaintiff).

162. ANNAS, LAW, ROSENBLATT & WING, *supra* note 91, at 55.

163. *See, e.g.*, Treister v. American Academy of Orthopaedic Surgeons, 396 N.E.2d 1225 (Ill. App. Ct. 1979) (holding that because the defendant is a private organization, constitutional due process norms do not apply, and therefore it is not required to give individuals notice or an opportunity for a hearing when certification is denied).

164. Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992).

165. Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983).

sustained only if it is narrowly tailored to further a compelling state interest.[166]

The *Casey* decision significantly modified the constitutional standard used to evaluate restrictions on abortion. In that case, physicians and pregnant women challenged an omnibus abortion regulation act. The Pennsylvania law required physicians to provide women with information designed to discourage abortion.[167] After receiving information about the procedure, women were required to wait at least twenty-four hours before having an abortion. Moreover, married women seeking an abortion were required to notify their husbands beforehand. In *Casey*, Pennsylvania, joined by the federal government, asked the Court to overrule *Roe*.[168]

Drawing on stare decisis principles, the Court held that "the essential holding of *Roe v. Wade* should be retained and once again reaffirmed."[169] Four Justices dissented from the holding that women's right to choose abortion should continue to be recognized as a fundamental liberty.[170]

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166. Both *fundamental liberty* and *compelling state interest* are terms of art in American constitutional jurisprudence. Fundamental liberties include the rights to free speech, religious expression, travel, marry, form a family, procreate, or use contraceptives. Compelling state interests are those of such pressing importance that they may encroach on an individual's fundamental liberty, if pursued by the most narrowly tailored means. *See generally* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 772-84 (2d ed. 1988).

By contrast, many individual liberties are not considered fundamental—for example, the right to smoke marijuana, Leory v. United States, 395 U.S. 6 (1969). The state may constitutionally restrict exercise of these ordinary, nonfundamental liberties if it can assert some rational basis to support the restriction or if the court can construct a hypothetical application that would make the law reasonable. *See, e.g.*, Williamson v. Lee Optical, Inc., 348 U.S. 483, 487 (1955) (upholding a statute limiting the services that could be provided by opticians after finding that the legislature might have seen the measure as rational).

167. 112 S. Ct. at 2822-23 (citing to 18 PA. CONS. STAT. ANN. § 3205).

168. *Id.* at 2803.

169. *Id.* at 2804. *Casey* also affirmed the approach to the definition of liberty protected by the Fourteenth Amendment and developed by the Court over the past 100 years. This approach recognized that under our Constitution "there is a realm of personal liberty which the government cannot enter." *Id.* at 2805. The *Casey* Court stated: "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Id. Casey* relied on the principles articulated in Justice Harlan's dissent from an earlier decision upholding Connecticut's restriction on contraceptives:

> The full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. This liberty is not a series of isolated points pricked out in terms of [specific constitutional provisions] . . . . It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment.

Poe v. Ullman, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting).

170. Chief Justice Rehnquist, joined by Justices White, Scalia, and Thomas, reaffirmed the earlier principle that "[a] woman's interest in having an abortion is a form of liberty protected by the Due Process Clause, but States may regulate abortion procedures in ways

While formally upholding *Roe*, *Casey* offered a new standard for determining the constitutionality of a state restriction on fundamental liberty. According to the joint opinion, state restrictions are unconstitutional only if they impose an undue burden on fundamental liberty:[171] "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."[172] The concrete meaning of such general standards can only be understood when applied to particular cases.

In fact, *Casey* raised more questions than it answered. On one hand, the Court struck down the mandatory spousal notification provision, holding that it constitutes an undue burden on a woman's right to choose abortion.[173] The joint opinion rejected the State's argument that the law impacts very few women: "The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant."[174] On the other hand, the joint opinion upheld the biased counseling and mandatory twenty-four hour waiting period, while recognizing that:

> The findings of fact by the District Court indicate that because of the distances many women must travel to reach an abortion provider, the practical effect will often be a delay of much more than a day because the waiting period requires that a woman seeking an abortion make at least two visits to the doctor. The District Court also found that in many instances this will increase the exposure of women seeking abortions to "the harassment and hostility of anti-abortion protestors demonstrating outside a clinic. . . . [T]he District Court found that for those women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to

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rationally related to a legitimate state interest." 112 S. Ct. at 2867 (Rehnquist, C.J., concurring in part and dissenting in part). Under this deferential standard, the opinion approves all of the Pennsylvania restrictions because each might possibly serve some legitimate state goal, including the goal of discouraging abortion. *Id.* at 2867-73. For example, the opinion approves the spousal notification requirement, because petitioners have failed to "show that no set of circumstances exists under which the [provision] would be valid. . . ." *Id.* at 2870.

The Chief Justice further stated: "We believe that *Roe* was wrongly decided, and that it can and should be overruled. . . ." *Id.* at 2855. Justice Scalia, joined by the Chief Justice and Justices White and Thomas, was even more blunt. "The permissibility of abortion, and the limitations upon it, are to be resolved like most important questions in our democracy: by citizens trying to persuade one another and then voting. . . . We should get out of this area, where we have no right to be." *Id.* at 2873, 2885 (Scalia, J., concurring in part and dissenting in part).

171. *Id.* at 2821 (O'Connor, Kennedy, and Souter, JJ., announcing the judgment of the court).

172. *Id.*

173. *Id.* at 2833.

174. *Id.* at 2829.

husbands, employers, or others, the 24-hour waiting period will be "particularly burdensome."[175]

The joint opinion labeled these findings "troubling," finding that the waiting period increases the costs and risks of abortion. Nevertheless, it concluded that these facts "do not demonstrate that the waiting period constitutes an undue burden."[176]

In sum, seven Justices voted to approve all of the restrictions in the Pennsylvania statute except the requirement of spousal notification.[177] These Justices indicated they would uphold the constitutionality of state regulations discouraging abortion or making it more difficult and more costly to obtain.[178] Only Justices Blackmun and Stevens strongly rejected the constitutionality of such laws.[179]

Other recent Supreme Court cases confirm the Court's unwillingness to extend strong constitutional protection to people's right to informed choice and control of their bodies. For example, in *Rust v. Sullivan*,[180] the Court upheld regulations prohibiting employees of federally funded clinics from discussing abortion with their patients.[181] This holding rejected plaintiffs' claims that the content- and viewpoint-based requirements violated the First Amendment and the due process and privacy rights of women and

175. *Id.* at 2825 (citing to Planned Parenthood v. Casey, 744 F. Supp. 1323, 1352 (E.D. Pa. 1990)).

176. *Id.*

177. Justices Blackmun and Stevens reaffirmed *Roe*'s holding that abortion restrictions may be justified only if they are narrowly designed to promote compelling state interests. *Id.* at 2838-53 (Blackmun & Stevens, JJ., concurring in part and dissenting in part).

178. *Id.* at 2867-73 (Rehnquist, C.J., joined by White, Scalia, and Thomas, JJ., concurring in part and dissenting in part).

179. *Id.* at 2840-42, 2848-51 (Stevens and Blackmun, JJ., concurring in part and dissenting in part).

180. 500 U.S. 173 (1991).

181. Adopted in 1970, Title X supports nearly four thousand clinics throughout the nation that provide reproductive health services to over four million poor and low-income women. 500 U.S. at 176. For service data, see Steven V. Roberts, *U.S. Proposes Curb on Clinics Giving Abortion Advice*, N.Y. TIMES, July 31, 1987, at A1. In 1988, the Reagan administration promulgated regulations prohibiting these clinics' personnel from discussing abortion or from providing referrals for abortion, even if the woman requested such information and the physician knew that pregnancy posed a serious medical risk to the woman. The regulations banned Title X personnel from counseling patients about abortion, referring a pregnant woman to an abortion provider, or informing her where she could obtain this information. 42 C.F.R. § 59.8(a)(1) (1989). The regulations required Title X projects to provide pregnant patients with a referral list of health care providers "that promote the welfare of mother and unborn child," but prohibited the inclusion of any health care providers that offered abortion as their "principle business." *Id.* at § 59.8(a)(2)-(a)(3). For a description of the legislation and summary of the regulations, see C. Andrew McCarthy, *The Prohibition on Abortion Counseling and Referral in Federally-Funded Family Planning Clinics*, 77 CAL. L. REV. 1181, 1183-88 (1989). For a strong critique of *Sullivan*, see Dorothy E. Roberts, Rust v. Sullivan *and the Control of Knowledge*, 61 GEO. WASH. L. REV. 587 (1993) (arguing that the enforced ignorance imposed by the regulations is linked to historic efforts to oppress Black women).

physicians.[182] In addition, in 1990, the Court in *Cruzan v. Missouri Dep't of Health* upheld a Missouri law that makes it exceedingly difficult for individuals to authorize their families to refuse treatment on their behalf in the event that they suffer from an irreversible and persistent vegetative state.[183]

Finally, constitutional remedies at their strongest provide very limited protection to pregnant women's rights to informed choice. Even during the period between *Roe* and *Casey*, when the Court interpreted the Constitution to demand that state restrictions on abortion serve compelling state interests, it often characterized the right as that of the *physician* and permitted states to bar non-physician professionals from providing abortions. The initial recognition of the right to abortion in *Roe* focused on the physician's right to practice medicine free from state interference.[184] Certainly, doctors have a strong interest in being free to meet their patients' needs without unreasonable state interference. In fact, physicians who were unable to save the lives of women who underwent illegal abortions led the movement for the liberalization of abortion laws in the 1960s.[185] Many

182. 500 U.S. at 203.

183. 497 U.S. 261 (1990). This case arose when Nancy Cruzan was injured in an automobile accident that left her in a persistent vegetative state. Her parents, asserting that they sought to effectuate the desires that their daughter had expressed while she was competent, sought to terminate the artificial feeding that sustained her vegetative life. Missouri, asserting a state interest in the protection of life and the prevention of suicide, insisted that the artificial feeding continue.

Five Justices were unwilling to characterize the patient's right to refuse treatment as fundamental and deferred to Missouri's judgment about the appropriate evidentiary standard for determining whether the incompetent patient would refuse medical treatment. Justice O'Connor concurred separately, in part to make plain that the majority had not addressed the question whether a state is constitutionally compelled to respect the choice of a patient who has appointed a surrogate decision-maker through a durable power of attorney or living will. *Id.* at 289. Justice Scalia, concurring in the result, rejected the proposition that the Constitution protects the individual's right to determine whether to accept or reject life-saving medical treatment. *Id.* at 293.

Four Justices dissented. They would have given greater weight to the individual's constitutionally protected right to refuse medical treatment, regarding the right as fundamental. Justices Brennan, Marshall, and Blackmun stated that "accuracy . . . [in determining her wishes] must be our touchstone." *Id.* at 316. According to these Justices, the state has no legitimate authority to use evidentiary presumptions to interfere with patient choice. *Id.* at 317. Justice Stevens, in a separate dissent, held that "the best interests of the individual, especially when buttressed by the interests of all related third parties, must prevail over any general state policy that simply ignores those interests." *Id.* at 350.

184. 410 U.S. 113, 165-66 (1973) ("The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.").

185. FREDERICK S. JAFFE, BARBARA L. LINDHEIM & PHILLIP R. LEE, ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY 63 (1981).

abortion providers today are older doctors who remember this tragic history.[186] Yet while physicians' liberty to provide abortions to patients who need it is significant, the core right should be considered the woman's, not the doctor's.[187]

An additional negative consequence of defining the right to abortion as belonging to the doctor is that the Court has easily approved state laws requiring that only physicians perform abortions.[188] Abortion, however, is a simple procedure;[189] part of doctors' reluctance to provide abortion stems from the fact that it is not technically challenging.[190] Indeed, states such as Vermont, which have allowed nurses and other trained professionals to provide abortions,[191] have demonstrated high levels of quality care.[192]

Thus, constitutional remedies provide weak protection for informed choice for pregnant women. Constitutional norms only apply to state law, which under *Casey* may constitutionally burden women's access to abortion. Even under the more demanding standards of *Roe*, the Court has interpreted the Constitution to protect physicians rather than patients.

V
PROSPECTS FOR REFORM

Reforms are needed to encourage informed choice for pregnant women. The National Abortion Federation (NAF), the professional association of the nation's abortion clinics, provides one model for promoting effective informed choice. Moreover, real prospects of reform exist through the actions of individual medical schools, state legislatures, and professional medical organizations.

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186. Sara Rimer, *Abortion Clinics Seek Doctors But Find Few*, N.Y. TIMES, Mar. 31, 1993, at A14.

187. Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1020 (1984) (contending that laws which restrict access to abortion are oppressive to women). *See* Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281 (1991) (discussing theories of gender equality and their relation to control over reproduction issues).

188. Connecticut v. Menillo, 423 U.S. 9 (1975).

189. Elizabeth A. Kowalczyk, *Access to Abortion Services: Abortions Performed by Mid-Level Practitioners*, 8 TRENDS IN HEALTH CARE, LAW & ETHICS 37 (1993).

190. Westhoff, Marks & Rosenfeld, *supra* note 10, at 314.

191. VT. STAT. ANN. tit. 13, § 101 (1974).

192. Donna Leiberman & Anita Lalwani, *Physician-Only and Physician Assistant Statutes: A Case of Perceived but Unfounded Conflict*, 49 J. AM. MED. WOMEN'S ASS'N 146 (1994) (arguing that the perceived conflict between physician-only abortion states and physician assistant statutes do not preclude physician assistants from providing abortions). *See* Frank H. Olmstead, *Abortion Choice and the Law in Vermont: A Recent Study*, 7 VT. L. REV. 281, 306 (1982); Kowalczyk, *supra* note 189, at 38; Patricia Donovan, *Vermont Physician Assistants Perform Abortions, Train Residents*, 24 FAM. PLAN. PERSPEC. 225 (1992) (noting study of complication rates in first-trimester abortions).

A. The National Abortion Federation Model

NAF offers one model of counseling and referral for pregnant patients seeking services at an abortion clinic. NAF requires its member clinics to provide informed consent counseling, or decision counseling, for every patient seeking an abortion.

> Decision counseling seeks no predetermined outcome, but encourages exploration of all possible alternatives, the final choice resting entirely with the woman. By establishing a relationship based on empathetic understanding and nonjudgemental [sic] support, the counselor attempts to assist women as necessary with decision-making, anxiety reduction, and informed consent. The woman's autonomy and control should be supported to the fullest. The counseling contract should be agreed upon by the woman and the counselor at the beginning, and should clearly identify the counseling objectives. These should be distinguished from other issues and objectives such as the provision of information.
>
> It should be assumed, unless evidence is otherwise presented, that the woman is mentally competent. Like other major life decisions, decisions around pregnancy can involve confusion, ambivalent feelings, and value conflicts which make counseling an important part of the service provided. . . . Counseling should be offered but not imposed, and it should not constitute a barrier to appropriate service. Counseling should always be consistent with the needs of the woman.[193]

Dr. Warren Hern expands on these principles in his widely used and respected text, *Abortion Practice*.[194] According to Dr. Hern, option counseling allows a counselor to allay anxiety, provide information, screen for serious psychopathology, enable women to understand and cope with their feelings, and help prevent future unplanned pregnancies.[195] Through empathetic, active listening, counselors assist patients in exploring issues of conflict and choice.[196] A counselor tries to ensure that a woman is seeking

193. NATIONAL ABORTION FEDERATION, STANDARDS FOR ABORTION CARE 3 (1988). The standards go on to define the specific objectives for informed consent and the qualifications of counselors:

> A counselor should be an empathetic, responsive, caring person who understands how to discipline himself or herself in order to be helpful to others[;] . . . comfortable with his/her own sexuality and non-judgemental [sic] in his/her attitude toward the sexuality of others[;] . . . well informed about the nature of the [abortion] procedure[;] . . . and should understand and observe a professional code of ethics based on respect for the patient's privacy and autonomy.

Id. at 5.

194. WARREN M. HERN, ABORTION PRACTICE 78 (1984).

195. *Id.*

196. *Id.* at 79.

an abortion because that is what she wants and not what others have pressured her to do.[197] Along with addressing issues of counselor qualification and relations with physicians, Dr. Hern also provides concrete advice on facilitating choice in common counseling situations.[198]

The medical profession presumes that pregnant women who seek prenatal care *never* need option counseling,[199] while those who seek an abortion *always* need such counseling.[200] In fact, the reverse is often true. Prenatal services provide extensive outreach and advertising, striving to make their services easily accessible and encouraging women to seek help early in pregnancy. By contrast, most women seeking abortion clinics confront significant informational, geographic, economic, and cultural barriers.[201] Women who make this effort to locate an abortion provider arguably manifest a clearer intent in relation to their choice than women who discover they are pregnant at a routine visit to their internist or gynecologist. Thus, option counseling may be more necessary at prenatal care services than at abortion clinics. Physicians should facilitate informed choice both during prenatal care services and at abortion clinics.

B. Medical Educators

Doctors are the actors who can most effectively encourage physicians to provide informed choice and medically appropriate referrals to pregnant women. Medical schools should assure that every student is trained to perform abortions, unless a student presents persuasive evidence of sincere conscientious objection. Further, medical schools should train every student in the basic principles of informed consent counseling and abortion referral. Residency programs—particularly those in obstetrics and gynecology, family practice, and general surgery—should continue this educational process. Pediatric residencies also should train in consent counseling, since many women confronting crisis pregnancies are young.

Students and faculty at many schools around the nation have begun this effort. In 1993, Medical Students for Choice was formed to create a national student network to "ensure women's access to abortion by including abortion service in comprehensive women's primary health care and by making sure doctors get trained in abortion."[202] The founding students acted in response to the murder of Dr. David Gunn in 1993 and a threatening

197. *Id.* at 80-85.

198. *Id.* at 81-88; *see also* ANNE BAKER, PROBLEM PREGNANCY COUNSELING (1981); DR. TERRY BERESFORD, SHORT-TERM RELATIONSHIP COUNSELING (1977).

199. *See supra* text accompanying note 89.

200. HERN, *supra* note 194, at 77-95.

201. Roberts, *supra* note 3, at 588-89 (telling the story of a woman who faced these barriers).

202. PLANNED PARENTHOOD OF NEW YORK CITY, INC., CLINICAL TRAINING INITIATIVE: CREATING A NEW GENERATION OF PROFESSIONALS COMMITTED TO COMPREHENSIVE WOMEN'S HEALTH CARE 8 (1994).

anti-abortion mailing that was sent to the homes of thousands of medical students throughout the country.[203] The group publishes a quarterly newsletter, organizes training programs, and provides a forum for joint activism on women's reproductive health care and rights.[204] It is affiliated with both the American Medical Students Association and the American Medical Women's Association.[205] In 1993, it collected over two thousand signatures on a petition requesting formal incorporation of abortion education and training in residency programs.[206] In 1994, the American Medical Women's Association launched a campaign to bring abortion training into the mainstream of medical education.[207]

C. State Legislatures

State legislatures could also play an important role in encouraging these changes. They could adopt laws that require doctors to provide pregnant women with medically appropriate referrals, hospitals to notify patients that abortion or abortion referrals are available, and medical schools and residency programs to train physicians in both abortion practice and informed consent counseling. Ample precedent exists for state legislative action to define and mandate informed choice in situations in which the medical profession has failed to do so.[208]

In order to succeed, state legislative action to facilitate choice for pregnant women must meet the three most common objections of critics. The first relies on a notion that state interference in the doctor-patient relationship is always inappropriate. In *Thornburgh v. American College of Obstetricians & Gynecologists*,[209] Justice Blackmun, writing for the Court, wrote that a state law requiring doctors to provide specific information to women seeking abortions is

> nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician. . . . Forcing the physician or counselor to present the materials . . . makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon . . . the materials. . . . All this is, or comes close to being, state medicine

203. Susan Gilbert, *Clinic Violence Sets Off Push for Wider Abortion Training*, N.Y. TIMES, Jan. 11, 1995, at C11.

204. PLANNED PARENTHOOD OF NEW YORK CITY, INC., 1993 FINAL REPORT: CLINICIAN TRAINING INITIATIVE 5-6 (1993).

205. PLANNED PARENTHOOD OF NEW YORK CITY, INC., *supra* note 202, at 8.

206. PLANNED PARENTHOOD OF NEW YORK CITY, INC., *supra* note 204, at 5.

207. *See Medicine and Abortion*, J. AM. MED. WOMEN'S ASS'N, Sept. 1994 (special issue).

208. *See, e.g.*, 42 C.F.R. §§ 50.201 - 50.206 (1993) (defining informed consent to sterilization); CAL. HEALTH & SAFETY CODE § 1704.5 (West 1990) (defining informed consent for treatment of breast cancer).

209. 476 U.S. 747, 762-63 (1986).

> imposed upon the woman, not the professional medical guidance she seeks. . . .[210]

Justice Blackmun has done much to protect women's rights to reproductive choice.[211] The so-called informed consent provision challenged in *Thornburgh* was highly biased and did not encourage effective patient choice.[212] A claim that the state can *never* regulate the content of the informed consent dialogue, however, is not defensible.

The history of physicians' roles in relation to reproductive health demonstrates the potential dangers of unregulated professional control over the delivery of reproductive health services. In an effort to exert professional control over medicine, doctors led the nineteenth-century movement to criminalize abortion.[213] Similarly, the twentieth-century movement of childbirth from home to the hospital was designed, in large part, to serve the interests of health care professionals.[214] While there were advantages to hospital-based birthing, the medical profession was also motivated by a desire to end competition from midwives and to limit women's control over the childbirth environment.[215] Sterilization abuse, in which doctors coerce consent from women whom they believe should not have children, is another pervasive and dramatic example of the danger in trusting professional judgment and discretion to protect women's health and autonomy.[216] In short, a blanket claim that the legislature must defer to physician discretion is not persuasive.

The second, more persuasive objection to seeking a state legislative response to these problems is that such legislation is only realistically possible in states that are strongly pro-choice. Though such legislation might be a useful model and could improve the situation in pro-choice states, most jurisdictions are not likely to adopt the laws advocated here. Nonetheless, a state legislative response can provide part of the solution.[217]

The third objection to state laws that encourage choice is that legislative mandates seeking to modify established medical practice usually fail

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210. *Id.*

211. *See* Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood v. Casey, 112 S. Ct. 2791, 2838-53 (concurring in part and dissenting in part); Webster v. Reproductive Health Services, 492 U.S. 490, 537 (concurring in part and dissenting in part).

212. *Thornburgh*, 476 U.S. 747.

213. JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900, at 147-70 (1978).

214. JUDITH W. LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA 1750-1950, at 204 (1986).

215. *Id.* at 171-90.

216. *See generally* THOMAS M. SHAPIRO, POPULATION CONTROL POLITICS: WOMEN, STERILIZATION AND REPRODUCTIVE CHOICE 89-94 (1985) (describing incidents of non-consensual sterilization).

217. New York State Assemblywoman, Debra Glick, is now preparing to introduce such legislation. Telephone conversation, Nov. 22, 1994.

when unaccompanied by effective enforcement mechanisms.[218] Criminal penalties are often considered harsh and are unlikely to be enforced. Regulatory remedies can be effective,[219] but depend upon a well-run regulatory agency.

As an additional measure, a state should fund an informed consent referral service. Even if doctors are required to facilitate informed consent, many now lack the knowledge and skills to help women work through the moral and practical issues involved. A state-sponsored referral service would provide an important, centralized source of information about the abortion services available in that particular location.

D. Professional Organizations

Medical professional and accreditation organizations are especially well suited to promote policies that facilitate choice. Since these organizations are knowledgeable about medical care and the challenges of providing informed choice, they can fashion policies that will serve the needs of both doctors and pregnant patients. Reform through the national professional and accreditation organizations will have an impact throughout the country, including those states where anti-choice forces control the political process.

The associations that accredit medical schools and residency programs should assure that abortion services, information, and referrals are provided in a way that meets patients' needs. The hospitals' national standard-setting organizations—the AHA and the JCAHO—should require that every hospital provide counseling to facilitate informed choice.[220] Further, hospitals should examine their policies to assure that, even if the institution is unwilling to provide abortion, their personnel are trained to provide appropriate counseling and referrals. Currently, the formal accreditation standards for obstetrics-gynecology programs do not require training in abortion, and such training is often not provided.[221] In 1994, the severe shortage of abortion providers in the United States prompted the Residency Review Committee (RRC) for Obstetrics and Gynecology to consider requiring training in abortion as a condition for accreditation of obstetrics-gynecology residency programs. The RRC has proposed the following language for accreditation:

> Experience with induced abortion and management of its complications must be part of residency training, except for residents with moral or religious objections to the former. This education can be provided outside the institution. If a residency program

218. *See* ANNAS, LAW, ROSENBLATT & WING, *supra* note 91, at 34-55 (discussing various efforts to require hospitals to provide emergency care to people unable to pay).

219. *Id.*

220. *See supra* text accompanying notes 110-113.

221. *See supra* part II.

> has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must insure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs must have mechanisms which insure that residents in their program who do not have a religious or moral objection received education and experience in performing abortion at another institution.[222]

This language, as well as language mandating training in counseling, should be adopted.

CONCLUSION

Realistically, neither the national professional organizations nor state legislatures are likely to act until some individual medical schools, residency programs, and hospitals adopt pro-choice policies, demonstrate the feasibility and value of a pro-choice approach, and promote a campaign to make choice a matter of national professional and educational policy. Change must be generated from a grassroots level. Today, women, pro-choice supporters, and feminists are a powerful force within hospitals, medical schools, and universities. Change will only occur when people committed to choice—both consumers and professionals—engage in a vigorous process of education and advocacy within their own institutions.

222. Residence Review Committee in Obstetrics and Gynecology, Special Requirements for Training in Obstetrics and Gynecology 11 (1994) (unpublished proposal, on file with Residency Review Committee for Obstetrics and Gynecology, Chicago, Ill.). *See also* Gilbert, *supra* note 203.