

ABORTION DECISIONS AND THE DUTY TO SCREEN: CLINICAL, ETHICAL, AND LEGAL IMPLICATIONS OF PREDICTIVE RISK FACTORS OF POST-ABORTION MALADJUSTMENT

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Abortion defies categorization. It is a moral, religious, legal, political, health, and human rights issue. People concerned about population control, environmentalism, national security, international law, race relations, education, economics, bioengineering, sociology, and psychology — to name but a few—all approach the issue from different perspectives.

The great number of ways in which this controversial subject can be viewed always ensures lively debates. However, these intellectual debates are tepid, academic exercises compared to the intense, internal battles — between conflicting beliefs, desires, uncertainties, and fears — actually faced by women who are confronted with an unintended pregnancy and the prospect of abortion. For every intellectual argument for or against abortion, there are thousands of women who have struggled with the same issues before and after their choice.

Certainly there are some women for whom the decision to abort or carry to term is not a struggle. Years of pondering the “what if I became pregnant?” question, or the overwhelming pressures of immediate circumstances that lead them to conclude they have “no choice,” cause some women to make their decisions quickly, even immediately. Yet reports of a rapid, “easy” decision reflect only a relative freedom from internal conflicts over the decision. It does not eliminate the fact that the abortion experience may have immense

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ramifications on the woman's future physical, reproductive, emotional, social, spiritual, familial, and economic life.¹

In short, there are many ways to approach the abortion issue and many ways in which it affects both individuals and society. It is therefore important to realize, from the very start, that the views, opinions, and priorities of the physicians and institutions that provide abortions will generally vary from those of the individual women they serve. Moreover, this difference in beliefs and philosophy may result in substantive differences in what women considering abortion expect and what abortion providers provide. These differences in expectations, interests, and views about abortion have a direct bearing on the core issue that is the subject of this paper: the inadequate screening and counseling of women considering abortion.

Specifically, it is my position that proper pre-abortion screening and counseling of patients have been largely abandoned to the grave detriment of women. As a result, women seeking abortions are seldom being evaluated for risk factors that reliably predict higher rates of negative physical and psychological complications. Inadequate screening is a matter of negligence in two regards. First, the failure to screen for known risk factors means that the physician has neglected to develop an informed medical recommendation based on the individual woman's unique risk factors and circumstances. Since the medical counsel the physician gives the woman does not include information about known risk factors, it is not properly grounded on medical evidence. Second, inadequate screening is the direct cause of inadequate disclosure of risks to the woman. When women are not informed of the risk factors they possess and the negative outcomes associated with those particular factors, their consent is uninformed.

As an overview of this paper, I shall review the literature regarding risk factors of abortion sequelae with a special emphasis on risk factors associated with subsequent psychological problems. The purpose of this section is not to completely describe and define all risk factors but rather to give a reasonable understanding of the range of risk factors that have been identified in statistically validated research. I will then present specific examples of women who were ill-served by inadequate screening and counseling. These examples were also chosen to

1. It would appear that the Supreme Court has acknowledged the complex and multifaceted impact of abortion when it states that abortion has "implications far broader than those associated with most other kinds of medical treatment." *Bellotti v. Baird*, 443 U.S. 622, 649 (1979). For examples of the complexity of the abortion decision and its ramifications on women's lives, see THERESA BURKE & DAVID C. REARDON, *FORBIDDEN GRIEF: THE UNSPOKEN PAIN OF ABORTION* (2002).

highlight how the perspectives of the women and their medical providers on the multifaceted aspects of abortion often clash, as alluded to above.

After establishing that risk factors are known and that women suffer harm when screening for these risk factors is neglected, I will examine evidence that the need for adequate pre-abortion screening is recognized by the medical community, at least in theory. I will then present evidence to support my contention that what is proposed in theory is not generally acted upon in practice. In part, as will be discussed, this is due to a division or confusion between respect for patient autonomy and the exercise of the physician's duty to protect the patient's health. The lack of adequate screening is also due in part to conflicts of interest, alluded to above, which will be explored in greater detail. I will then examine the question of how the risks of abortion can be compared to the risks associated with unintended childbirth and the need for research to identify the individual characteristics and circumstances for which abortion is most likely to produce the most positive results. Next, I will explore the legal theories under which abortion providers might be held liable for negligent screening and inadequate disclosure of risks. Finally, I will address questions that might be raised about the constitutionality of requirements for screening.

Individually and together, these sections are intended to develop and support the following thesis. Some women suffer serious emotional and/or physical injuries from induced abortions. Research has identified characteristics and circumstances that can be used to identify those women at greatest risk of suffering negative reactions to abortion. Screening for these risk factors is often inadequate, resulting in women suffering avoidable injuries. In the face of social, ideological, and economic forces which mitigate against adequate screening, legal remedies are necessary to improve the standard of care by holding abortion providers strictly liable for proper screening and counseling.

Better screening and counseling will improve medical care for women in several ways. In some cases, women who are better apprised of the risks of abortion that are associated with their unique risk profile may choose not to undergo the abortion. This is especially likely if the woman is ambivalent, with both reservations about the abortion and some desire to carry to term. In some other cases, where the exposure to risks appears to be high and the likelihood of benefits low, the attending physician may be ethically obligated to counsel against the option of abortion. Some women will accept this counsel; others will not. In still other cases, the doctor may have an ethical, and even legal, obligation to refuse to perform the requested abortion if, in

his best medical judgment, the abortion is contraindicated because (1) it is likely to cause serious harm to the woman, and/or (2) it is unlikely to produce the benefits she seeks. The woman would, of course, be free to seek an abortion from another physician who might not share the same opinion. By all three of these mechanisms, improved screening and counseling would result in a reduction in abortion rates among women who are most ambivalent about a choice for abortion and those who are at highest risk of severe negative reactions to abortion.

PREDICTIVE RISK FACTORS ARE KNOWN

In general, research regarding the emotional aftereffects of abortion is complicated by numerous methodological limitations. It is especially difficult to quantify complication rates because (1) the cooperation of the study population is inconsistent and unreliable, typically involving dropout or concealment rates in excess of fifty percent;² (2) the variety of negative reactions reported by women is so broad that it may be impossible to examine every claimed dysfunction in a single study;³ (3) the intensity of many reactions appears to be time variant, with many women reporting delayed reactions;⁴ (4) the use of questionnaires and

2. Elise F. Jones & Jacqueline D. Forrest, *Underreporting of Abortion in Surveys of U.S. Women: 1976 to 1988*, 29 DEMOGRAPHY 113, 115-16 (1992); Nancy E. Adler, *Sample Attrition in Studies of Psychosocial Sequelae of Abortion: How Great A Problem?*, 6 J. APPLIED SOC. PSYCHOL. 240, 240-59 (1976); Hanna Söderberg et al., *Emotional distress following induced abortion: A study of its incidence and determinants among abortees in Malmö, Sweden*, 79 EUR. J. OBSTETRICS & GYNECOLOGY & REPROD. BIOLOGY 173, 173-178 (1998).

3. CATHERINE A. BARNARD, *THE LONG-TERM PSYCHOLOGICAL EFFECTS OF ABORTION* (1990); E. Joanne Angelo, *Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief*, LINACRE QUARTERLY, May 1992, at 69-80; D. Brown, T. E. Elkins, & D.B. Larson, *Prolonged Grieving After Abortion: A Descriptive Study*, 4 J. CLINICAL ETHICS 118, 118-123 (1993); David C Reardon, *Psychological Reactions Reported After Abortion*, 2 POST-ABORTION REV., 4, 4-8 (1994); Anne C. Speckhard & Vincent M. Rue, *Postabortion Syndrome: An Emerging Public Health Concern*, 48 J. SOC. ISSUES 95, 95 (1992).

4. BURKE & REARDON, *supra* note 1, at 93-104, 299-300; Warren B Miller et al., *Testing A Model Of The Psychological Consequences Of Abortion*, in THE NEW CIVIL WAR: THE PSYCHOLOGY, CULTURE, AND POLITICS OF ABORTION 235-36 (Linda J. Beckman & S. Maria Harvey eds., 1998); Jesse R Cogle et al., *Psychiatric admissions following abortion and childbirth: a record-based study of 107,883 low-income women*, 3 (Supp. 2) ARCHIVES OF WOMEN'S MENTAL HEALTH

other standardized survey instruments may be inadequate for uncovering repressed reactions;⁵ and (5) the large number of variations among women in prior and subsequent experiences confound attempts to establish causal connections.

Given such complexities, it is understandable that former Surgeon General C. Everett Koop concluded, in 1989, that the research in this field is entirely inadequate for drawing any incontrovertible conclusions about the extent of benefits and/or harms experienced by the general population of women who have abortions.⁶ The same criticism holds to this day.

For the purposes of this discussion, however, there is no need to know how many women who have abortions will suffer from this or that ailment. The legal and ethical duties described herein arise immediately from the uncontested fact that a minority of women do suffer significant negative physical and/or psychological reactions to induced abortion.⁷ Even more importantly, the large body of research that has been done, even though imperfect in so many ways, has succeeded in identifying risk factors that are statistically significant and reliable predictors of which women are at higher risk of suffering adverse post-abortion reactions.

In other words, while most studies are inadequate for drawing incontrovertible conclusions regarding the overall incidence of post-abortion reactions over time, they have proven to be very effective in identifying the factors that place women at higher risk for a negative reaction, at least within the scope of the time and reactions studied. This is due to the fact that researchers have consistently found that some portion of women, usually a minority, report negative symptoms within the time frame of the studies. In an attempt to understand why

1, 47 (2001); Brenda Major et al., *Psychological Responses of Women After First-Trimester Abortion*, 57 ARCHIVES OF GEN. PSYCHIATRY 777, 777-84 (2000).

5. Arthur Lazarus & Roy Stern, *Psychiatric Aspects of Pregnancy Termination*, 13 CLINICS IN OBSTETRICS & GYNAECOLOGY 125, 125-134 (1986); Ian Kent et al., *Emotional Sequelae of Elective Abortion*, 20 BRIT. COLUM. MED. J. 118, 118-119 (1978); Ian Kent & William Nicholls, *Bereavement in Post-Abortive Women: A Clinical Report*, 13 WORLD J. PSYCHOSYNTHESIS, 14, 14-17 (1981).

6. BARNARD, *supra* note 3, at 83-86 (reprinting the letter dated Jan. 9, 1989, from C. Everett Koop, Surgeon General, to President Ronald Reagan.).

7. Brenda Major et al., *supra* note 4, at 777-84; Mika Gissler et. al., *Suicides After Pregnancy in Finland, 1987-94: Register Linkage Study*, 313 BRIT. MED. J. 1431, 1431-4 (1996); Christopher L. Morgan et al., *Mental Health May Deteriorate as a Direct Effect of Induced Abortion*, 314 BRIT. MED. J. 902 (1997); Gregory H. Wilmoth, *Abortion, Public Health Policy, and Informed Consent Legislation*, 48 J. SOC. ISSUES 1, 5-6 (1992).

and how these women react differently from those who do not report the difficulties under study, the researchers have naturally attempted to identify the individual characteristics or situational factors that are statistically associated with negative post-abortion reactions.

For example, using just five screening criteria — (1) a history of psychosocial instability; (2) a poor or unstable relationship with the male partner; (3) few friends; (4) a poor work pattern; and (5) failure to take contraceptive precautions — Elizabeth Belsey, et al., determined that sixty eight percent of the 326 abortion patients she studied were at higher risk for negative reactions and should have been referred for more extensive counseling.⁸ Of this high risk group, seventy-two percent actually did develop negative post-abortion reactions (guilt; regret; disturbance of marital, sexual, or interpersonal relationships; or difficulty in coping with day-to-day activities) during the three-month follow-up period.⁹

It is noteworthy that Belsey and her colleagues hold a favorable opinion of elective abortion. The intent of their study was not to justify restrictions on abortion, but merely to identify how women's health could be better served.¹⁰ In this context, the researchers concluded that a simple questionnaire identifying known risk factors could be used to identify women presenting for an abortion who are (1) at higher risk of negative emotional reactions; and conversely, (2) most likely to cope well with an abortion.¹¹ Though the five criteria resulted in both false negatives (missing eighteen percent of the women who did have one or more negative reactions) and false positives (twenty-eight percent of the women identified as higher risk did not have any apparent negative reactions at the three month follow-up interview), the researchers concluded that appropriate screening could provide a "reasonable forecast of subsequent attitude and emotional reaction[s]."¹² While some women who did not subsequently report problems would have been referred for additional counseling, Belsey argues, "From the clinician's point of view this result can be viewed as erring on the right side, for a [pre-abortion screening] system that tends to select more women for counseling than is actually necessary is preferable to the reverse."¹³

8. Elizabeth M. Belsey et al., *Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV*, 11 SOC. SCI. & MED 71, 71-82 (1977).

9. *Id.* at 71.

10. *Id.* at 71.

11. *Id.* at 80-81.

12. *Id.* at 81.

13. *Id.*

The Belsey study is just one of at least thirty-four studies identifying statistically validated risk factors for emotional maladjustment to abortion.¹⁴ The findings of a rather typical one of these studies are

14. C.A. BARNARD, THE LONG-TERM PSYCHOSOCIAL EFFECTS OF ABORTION (1990); H.P. VAUGHAN, CANONICAL VARIATES OF POST ABORTION SYNDROME (1990); MARY K. ZIMMERMAN, PASSAGE THROUGH ABORTION (1977); Henry P. David, *Post-abortion and Post-partum Psychiatric Hospitalization*, in ABORTION: MED. PROGRESS & SOC. IMPLICATIONS 150 (1985); Warren B. Miller et al., *Testing a Model of the Psychological Consequences of Abortion*, in THE NEW CIVIL WAR: THE PSYCHOLOGY, CULTURE, AND POLITICS OF ABORTION 235-36 (Linda J. Beckman & S. Maria Harvey, eds., 1998); Joy D. Osofsky et al., *Psychological Effects of Abortion: with Emphasis upon the Immediate Reactions and Followup*, in THE ABORTION EXPERIENCE 188-89 (H. J. Osofsky & J.D. Osofsky eds., 1973); Larry G. Peppers, *Grief and Elective Abortion: Implications for the Counselor*, in DISENFRANCHISED GRIEF: RECOGNIZING HIDDEN SORROW 135 (Kenneth J. Doka ed., 1989); J.R. Ashton, *The Psychosocial Outcome of Induced Abortion*, 87 BRIT. J. OBSTETRICS & GYNAECOLOGY 1115 (1980); Robert Athanasiou et al., *Psychiatric Sequelae To Term Birth And Induced Early And Late Abortion: A Longitudinal Study*, 5 FAM. PLAN. PERSP. 227 (1973); Belsey, *supra* note 8, *passim*; Bruce D. Blumberg et al., *The Psychological Sequelae of Abortion Performed for a Genetic Indication*, 122 AM. J. OBSTETRICS AND GYNECOLOGY 799 (1975); Michael B. Bracken et al., *The Decision to Abort and Psychological Sequelae*, 158 J. NERVOUS & MENTAL DISEASE 154 (1974); Michael B. Bracken, *A Causal Model of Psychosomatic Reactions to Vacuum Aspiration Abortion*, 13 SOC. PSYCHIATRY 135-145 (1978); Nancy B. Campbell et al., *Abortion in Adolescence*, 23 ADOLESCENCE 813 (1988); Larry Cohen & Susan Roth, *Coping With Abortion*, 10 J. HUMAN STRESS 140 (1984); Wanda Franz & David Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 ADOLESCENCE 161 (1992); Regina M. Furlong & Rita B. Black, *Pregnancy Termination for Genetic Indications: The Impact on Families*, 10 SOC. WORK IN HEALTH CARE 17 (1984); Mika Gissler et al., *Suicides After Pregnancy In Finland: 1987-94: Register Linkage Study*, 313 BRIT. MED. J. 1431 (1996); Bryan Lask, *Short-term Psychiatric Sequelae to Therapeutic Termination of Pregnancy*, 126 BRIT. J. PSYCHIATRY 173 (1975); A. Lazarus, *Psychiatric Sequelae of Legalized Elective First Trimester Abortion*, 4 J. PSYCHOSOMATIC OBSTETRICS & GYNECOLOGY 141 (1985); J. Lloyd & K.M. Laurence, *Sequelae and Support After Termination of Pregnancy for Fetal Malformation*, 290 BRIT. MED. J. 907 (1985); John Lydon et al., *Pregnancy Decision Making as a Significant Life Event: A Commitment Approach*, 71 J. PERSONALITY & SOC. PSYCHOL. 141 (1996); Brenda Major & Catherine Cozzarelli, *Psychosocial Predictors of Adjustment to Abortion*, 48 J. SOC. ISSUES 121 (1992) [hereinafter Major & Cozzarelli, *Psychological Predictors*]; Brenda Major et al., *Attributions, Expectations and Coping with Abortion*, 50 J. PERSONALITY & SOC. PSYCHOL. 585 (1985) [hereinafter Major et al, *Attributions*]; Alan J. Margolis et al., *Therapeutic Abortion Follow-up Study*, 110 AM. J. OBSTETRICS & GYNECOLOGY 243 (1971); Cynthia D. Martin, *Psychological Problems of Abortion for Unwed Teenage Girls*,

shown in Table 1.¹⁵ In this study by Brenda Major, women completed questionnaires within an hour before undergoing an abortion, within thirty minutes after the abortion, and three weeks after the abortion. Twenty-one items on the pre-abortion questionnaire, most of which were related to the factors women identified as at “blame” for their pregnancy, were examined for statistical correlation to the negative effects measured at three weeks post-abortion. Of 247 women who initially participated in the interviews at the abortion clinic, only forty percent returned for the final three-week post-operative evaluation.¹⁶ In this last evaluation, the questionnaire evaluated depression, negative moods (regret, sadness, and guilt), anticipation of more negative consequences in the future, and reports of physical complaints related to the abortion up to the three-week post-operative interview.¹⁷ As shown in Table 1, Major identified eight risk factors related to one or more of the negative effects examined. The percentage of women in the original sample who were at a higher risk ranged from fifty-two percent of the women who tended to blame their pregnancy and abortion on chance, down to twelve percent of the women who had a higher degree of intention to carry the pregnancy to term.¹⁸ In a more recent study, employing one-month and two-year follow-up surveys, Major found that twenty-two items on a pre-abortion questionnaire

88 GENETIC PSYCHOL. MONOGRAPHS 23 (1973); Warren B. Miller, *An Empirical Study of the Psychological Antecedents and Consequences of Induced Abortion*, 48 J. SOC. ISSUES 67 (1992); D.T. Moseley et al., *Psychological Factors That Predict Reaction to Abortion*, 37 J. CLINICAL PSYCHOL. 276 (1981); Pallas Mueller & Brenda Major, *Self-blame, Self-efficacy and Adjustment to Abortion*, 57 J. PERSONALITY & SOC. PSYCHOL. 1059 (1989) [hereinafter Mueller & Major, *Self-blame*]; Joy D. Osofsky & Howard J. Osofsky, *The Psychological Reaction of Patients to Legalized Abortion*, 42 AM. J. ORTHOPSYCHIATRY 48 (1972); Edmund C. Payne et al., *Outcome Following Therapeutic Abortion*, 33 ARCHIVES OF GEN. PSYCHIATRY 725 (1976); Lisa R. Shusterman, *Predicting the Psychological Consequences of Abortion*, 13A SOC. SCI. & MED. 683 (1979); Hanna Söderberg et al., *Emotional Distress Following Induced Abortion: A Study Of Incidence And Determinants Among Abortees In Malmö Sweden*, 79 EUR. J. OBSTETRICS & GYNAECOLOGY & REPROD. BIOLOGY 173 (1998); Gail B. Williams, *Induced Elective Abortion and Pre-natal Grief*, 53 DISSERTATION ABSTRACTS INT’L 1296-B (1992).

15. Major et al., *Attributions*, *supra* note 14, at 590-592.

16. *Id.* at 590.

17. *Id.*

18. *Id.* at 592.

were significantly correlated to subsequent distress, well-being, and decision satisfaction.¹⁹

Like Belsey, Major has recommended that her findings can be used for pre-abortion screening to identify women who need more extensive pre-abortion counseling.²⁰ Indeed, the statistically validated items used in these questionnaires could be readily adapted for use in pre-abortion screening and counseling to identify which women are most likely to respond well to an abortion and which are most likely to have negative reactions. Such screening was first recommended in a 1973 study published in the Alan Guttmacher Institute's *Family Planning Perspectives*. The authors of that study concluded that low self-esteem, low contraception knowledge, high alienation, and delay in seeking abortion were related to subsequent psychopathology and other negative symptoms.²¹ They concluded that computer scored "screening procedures to identify such [higher risk abortion] patients could easily and inexpensively be instituted by hospitals and private physicians" at a cost of less than a dollar each.²²

While research continues to identify and refine our understanding of risk factors for post-abortion emotional maladjustment, there is general agreement regarding at least ten to fifteen key areas. For example, as shown in Table 2, three expert sources that have presented summaries of the major risk factors reveal considerable overlap in most major areas. These three sources, however, have used rather broad groupings for risk factors. An attempt to more completely and systematically classify and summarize the predictive risk factors of post-abortion emotional sequelae as reported in the literature is

19. Brenda Major et al., *Personal Resilience, Cognitive Appraisals, and Coping: An Integrative Model of Adjustment to Abortion*, 74 J. PERS. SOC. PSYCHOL. 735, 742-44 (1998).

20. Major & Cozzarelli, *supra* note 14, at 138.

21. Robert Athanasiou et al., *Psychiatric Sequelae to Term Birth and Induced Early and Late Abortion: a Longitudinal Study*, 5 FAM. PLAN. PERSP. 227, 231 (1973).

22. *Id.* The researchers, who strongly favored liberal abortion laws, identified several risk factors for psychological distress following an abortion in this very early study, and advised that screening for these risk factors would be beneficial to patients without adding exorbitant costs:

The short form of the MMPI, for example, can be administered in 45 minutes and scored by a nurse in 10 minutes; interpretation is actuarial. The attitude scales used here can be administered and scored in about 15 minutes. For large populations, the MMPI can be computer scored and analyzed at a cost of about 85 cents per patient.

Id.

presented in Table 3. This list reflects the findings of primary sources that report on statistically validated data (indicated by bold type), expert opinion reflecting clinical experience and case studies (indicated by italic type), and review articles (indicated by bold type) which are included as useful for demonstrating a consensus of authorities who have reviewed the literature. Please note that due to the large number of references incorporated into Table 3, these are provided separately from the text references in the Appendix of this paper.

In the schema presented in Table 3, the risk factors for post-abortion maladjustments have been divided into two general categories. The first category includes risk factors for women for whom there exist significant emotional, social, or moral conflicts regarding the contemplated abortion. The second category includes risk factors relevant to developmental problems, such as immaturity or psychological instability.

It should be noted that the risk factors in Table 1 must be interpreted in light of the complexity of post-abortion reactions, particularly the existence of multiple symptoms and the time variant experience of negative sequelae. Some of these risk factors are useful for predicting only particular reactions, such as depression or regret. Most often, these risk factors have been identified in studies with a relatively short follow-up period, typically within six months post-abortion. In such cases, the absence of a risk factor should not be interpreted as a reliable predictor that the symptoms at issue will not occur as a delayed effect, for example as part of an anniversary reaction. Finally, it should be noted that characteristics that appear to be opposites (i.e., a teenager versus an older woman with children) may both be risk factors—but for different symptoms.

EXAMPLES OF HARM FROM INADEQUATE SCREENING

The need for full disclosure of risk factors and their associated risks is especially important because many abortion patients, perhaps even the majority, are ambivalent about their choices in the first place. In some surveys, as many as eighty percent have stated they would have kept their pregnancies under better circumstances or if they were supported to do so by their significant others.²³ Because the initial decision to abort is often tentative, or even made solely to please others, “upsetting” information about risks may be exactly what a

23. See DAVID C. REARDON, *ABORTED WOMEN: SILENT NO MORE* 11-20 (1987). See generally MARY K. ZIMMERMAN, *PASSAGES THROUGH ABORTION*, 110-12, 143 (1977).

woman is looking for as an excuse to keep her child when everyone else is pressuring her into an unwanted abortion. It is often far easier for a reluctant woman to resist her pressuring boyfriend with an exaggerated “the doctor says abortion is dangerous,” than an “I want this baby, even if you don’t.”

Full disclosure is also important because reports of inadequate, inaccurate, or biased counseling are statistically associated with reports of more frequent and more severe negative psychological reactions post-abortion.²⁴ Proper screening and full disclosure, therefore, are important because they reduce the risk that the patient will subsequently feel that: (1) she is “alone” in feeling negative reactions that “no one else feels”; (2) she was ill-prepared for the adjustments that must follow an abortion; or (3) she was exploited by “abortion profiteers” who hid the full truth from her in a time of crisis and confusion.

Three examples will suffice to put a human face on the tragic effects of poor counseling prior to an abortion. At the time she consented to her abortion, Joanna had little difficulty in deciding that it was her best option. It was only afterward, when the reality of the choice sank in, that she belatedly realized her desire to keep her baby:

Everything happened too fast. When I found out I was pregnant I panicked. The woman at the clinic told me I better decide quickly. I was afraid to tell my parents. I wanted to spare my father the disappointment I knew he would feel that I had gotten myself into this situation. I was pregnant, unmarried and trying to complete a degree in business.

Abortion seemed pretty logical. I was not prepared for the feelings of loss and unremitting grief which followed. The whole experience was worse than the most horrible nightmare I could ever imagine. This has been a pain I wouldn’t wish on anyone.

Abortion is not what I really wanted—but I acted so fast without thinking. I wanted to have that baby, but I was afraid.²⁵

Unlike Joanna, Marguerite never even imagined that an abortion would benefit her. She underwent an abortion merely to satisfy the demands of her abusive boyfriend. Her testimony reveals the severe

24. See HELEN P. VAUGHAN, CANONICAL VARIATES OF POST ABORTION SYNDROME *passim* (1990); see also Terre Nicole Steinberg, *Abortion Counseling: To Benefit Maternal Health*, 15 AM. J. L. & MED. 483, 483-517 (1989). See generally Wanda Franz & David C. Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 ADOLESCENCE 161, 161-172 (1992).

25. BURKE & REARDON, *supra* note 1, at 225.

problems that can arise when doctors fail to screen for known risk factors.

[T]he Ghost of Grief is ruling my life. . . . I wanted my baby. I unequivocally wanted my baby.

I was a twenty-three-year-old student living with a man who was prone to violence, resorted to violence, loathed violence, was violent. I had recently suffered a breakdown. My friends and my family were absent. He said I did not need them. He took hold of my hand and said that he would be there for me always. But now, we must act responsibly. He said he was not ready for children. He said I was not ready for children. . . .

A week later I was in the hospital for the abortion.

I remember the preceding week fairly well. I spent most of it in bed dreaming of my baby. Pretending to myself that if I lay long enough, I'd give birth before the abortion took place. . . .

Protocol had me meet with a doctor. My partner was present. I could not speak. Were they going to ask me if I wanted the abortion? I waited. No questions asked. The day drew nearer and panic set in. I remember one night being so alarmed by pain in my womb that I was convinced I was miscarrying. I ran to the hospital and burst in, tears streaming down my face. "What does it matter?" a nurse scolded. "You're going to have an abortion anyway." I slunk away.

The day of the procedure . . . they proceeded to administer the anaesthetic. I looked into the anaesthetist's face. I said "no." But they performed the operation anyway. No last minute absolution in this place.²⁶

As a final example, consider the case of Barbara who told her doctor she didn't want an abortion. Barbara was thirty-nine and a mother of four who had always wanted to have six children. When she became unexpectedly pregnant while using a copper IUD, she experienced "great delight in fantasizing that I might be pregnant again . . . and felt like dancing in the sun,"²⁷ but she worried about having promised her husband that they wouldn't have any more children. She was also concerned about the possible effects a copper IUD might have on her baby.

The doctor said he did not know about the copper but it was definitely a poison. This aside, he said I was a very "unusual" woman wanting a baby at thirty-nine, it was unfair to my

26. MELINDA TANKARD REIST, *GIVING SORROW WORDS: WOMEN'S STORIES OF GRIEF AFTER ABORTION* 45-46 (2000).

27. *Id.* at 62.

husband, the doctor would expect his wife to have an abortion under the circumstances, it would ruin our social life and be detrimental to our other four children.

The doctor referred me to the specialist who had inserted the IUD. . . . I had an internal examination and was now no doubt pregnant. I was still worried about the copper. The specialist yelled at me that it did not matter: I had two children already (actually four), I was thirty-nine and had no right to do this to anyone. I was “odd.” My husband would probably beat up all the children (he did have a history of violence). I signed the abortion papers with tears dripping over them. . . . Things were made even more difficult for me because I would not consent to a tubal ligation at the same time. . . .

Once in the hospital I began to get some fight back. I decided that once and for all I would insist on information on my copper problem and would just go home if all seemed OK. Eventually a doctor came into my room. . . . I said I did not want the abortion but had a husband and copper problems and could he give me some info. He said I would have to speak to my private specialist who would not be in until the next morning. He then left the room . . . all of a sudden he stormed back, put his head in the door and said: “It is just not done to have children at your age under your circumstances.”

I had been told my doctor always spoke to his patients first thing in the morning and I was anxiously waiting for him to turn up. At about 9 a.m. I asked a nurse when I would see him and was informed he was already in the theatre. I was to be prepped immediately . . . I was shocked. I was given a pethidine injection and after eleven weeks of avoiding aspirin, artificial colorants, insecticides, this was the final blow. I was wheeled crying through miles of corridors to the theatre feeling defeated. . . . I thought of getting off the trolley and running and have often wondered if anyone has ever done this. While I was still crying they said they would give me an injection in the hand. I said, “Won’t anyone save me?” The specialist laughed and that was the end.²⁸

For a time after her abortion Barbara was filled with hatred of others, including her husband and four children, “seeing it as unfair that they had been allowed to live and my last baby had been killed.”²⁹ Deciding she could not live without another baby, she tricked her husband into making her pregnant again and succeeded on the anniversary date of her abortion. This child was accepted by her

28. *Id.* at 61-67.

29. *Id.* at 65.

husband and became the spoiled favorite of all. As a footnote to her story, Barbara underscores the importance of the issue at hand with this testimony to the depth of her grief:

In October 1988 my youngest son (twenty) was killed in a car accident and it was this that made me realise the terrible trauma and guilt I had been through with the abortion. I loved my son as much as any other mother but compared to the abortion, the effect of my son's death was nothing. I had the ears of understanding friends . . . and grief counsellors and a supportive husband and family to listen, share and help through the grief process. This was in total contrast to the lonely helpless feeling I experienced before and after the abortion.³⁰

The examples of Joanna, Marguerite and Barbara may not be typical. Certainly many women do freely desire abortions to satisfy their own self interests. But neither do these cases appear to be rare exceptions. In a survey of women participating in post-abortion support groups, only four percent felt their abortion counselors were helpful and informative and two-thirds believed that their abortion counselors were biased toward their choosing abortion.³¹

THE VULNERABLE PATIENT

The importance of adequate pre-abortion screening and counseling is underscored by an understanding of crisis theory. "Every crisis presents an opportunity for psychological growth and the danger of psychological deterioration. It is a way station on a path leading away from or toward mental disorder."³²

Experts on crisis counseling have found that those who are in a state of crisis are increasingly vulnerable to outside influences and have less trust in their own opinions and abilities to make the right decision. Such "heightened psychological accessibility"³³ can lead to a situation where parents, counselors, or others in authority can have enormous influence over a woman's decision. "A relatively minor force, acting for a relatively short time, can switch the whole balance from one side or to the other—to the side of mental health or to the side of ill health."³⁴ Persons in crisis "are less in touch with reality . . . and more

30. *Id.* at 66-67.

31. REARDON, *supra* note 23, at 335.

32. GERALD CAPLAN, *PRINCIPLES OF PREVENTIVE PSYCHIATRY* 53 (1964).

33. HOWARD W. STONE, *CRISIS COUNSELING* 20 (1976).

34. CAPLAN, *supra* note 32, at 293.

vulnerable to change than they are in non-crisis periods.”³⁵ They often experience feelings of tiredness, lethargy, hopelessness, inadequacy, confusion, anxiety, and disorganization.³⁶ Thus, they are more likely to stand back and let other people make their decisions for them, instead of protecting themselves from decisions that may not be in their best interests.

A person who is upset and trapped in a crisis wants to reestablish stability, and is therefore very susceptible to any influence from others who claim to be able to solve the crisis, especially those who have status or authority.³⁷ Thus, with a minimal effort on the part of a mental health professional, family member, minister, or male partner, an enormous amount of leverage may be exerted upon a woman who is in a crisis situation.³⁸

This can be a dangerous situation for a woman who doesn't really want an abortion but has others around her who push for it. Women facing an unexpected pregnancy often feel completely overwhelmed by their situation.³⁹ Even when their hearts tell them that abortion is not the right answer, they are very vulnerable to the suggestions of others who insist that abortion is the “best” solution. This is especially true when pregnant women cannot immediately see where they can find the financial resources and social support they will need to care for their children.

For many women, their deep ambivalence about an abortion decision is centered on the conflict between a heart that says, “don't do it,” and a mind that says, “it's the only thing I can do.” Indeed, some women describe going into the clinic and waiting for someone — their boyfriend or husband, a parent, even the counselor — to burst into the room and stop the abortion from happening.⁴⁰ When no one attempts to prevent the abortion, this reaffirms in the women's minds that abortion is the only choice that their loved ones will support. One woman described her feeling of powerlessness in this way:

I didn't want to kill my child; I just made the decision to be weak and not care about any of it. I made a decision not to make a conscious choice at all. In fact, Planned Parenthood and all the

35. STONE, *supra* note 33, at 20.

36. *Id.* at 15.

37. Wilbur E. Morely, *Theory of Crisis Intervention*, 21 PASTORAL PSYCHOLOGY 16-17 (1970).

38. CAPLAN, *supra* note 32, at 50-54.

39. Vincent M. Rue & Anne C. Speckhard, *Informed Consent and Abortion: Issues in Medicine and Counseling*, 6 MED. & MIND 75, 75-94 (1992).

40. See, e.g., LINDA BIRD FRANCKE, *AMBIVALENCE OF ABORTION* 6 (1978).

abortion mills tell you that you have No Choice but to get an abortion. This is the irony of the “pro-choice” rhetoric.⁴¹

Since any element of coercion is not only a risk factor for psychological problems after abortion, but also a fundamental violation of the dignity and rights of women, abortion providers should carefully screen for any signs of coercion toward an unwanted abortion. Whenever this is observed, the pressuring parties should be counseled as to why the abortion is contraindicated. It should be explained that the fact that the abortion goes against the woman’s maternal or moral beliefs exposes her to a much greater risk of subsequent emotional problems, and that pressuring her into the abortion is only likely to worsen the relationships between the woman and those pressuring her. If the pressuring parties exert considerable control over the woman, any subsequent claim by the woman that the request for the abortion is “her decision” should not be accepted at face value, but should invite additional counseling to ensure that the decision is truly in conformity with her own beliefs and desires—excluding the desire to please others at her own expense.

THE STANDARD OF CARE FOR PROPER SCREENING

In every other area of medicine, patients are familiar with the experience of being screened for risk factors prior to treatment. As a result, women seeking abortions may naturally assume that their abortion counselors will be screening them for any known risk factors. Indeed, as seen above, screening for risk factors has been repeatedly recommended by researchers and is described as part of the standard for treatment in textbooks on obstetrics.⁴² The general rights and

41. REARDON, *supra* note 23, at 143.

42. For example, Max Borten, *Induced Abortion*, in OBSTETRICAL DECISION MAKING 44-45 (Emanuel A. Friedman et al. eds., 2d ed. 1987) states:

Psycho-social assessment and counseling are done at the very first visit. In addition to the medical history, an in depth social history including relationships with others, attitudes about abortion, and support systems must be obtained at this time. Pre-abortion counseling should be open and understanding. No decision should be made by the gravida in haste, under duress, or without adequate time and information. Special attention should be given to feelings of ambivalence, guilt, anger, shame, sadness, and sense of loss.

Id. See generally AMERICAN PUBLIC HEALTH ASSOCIATION, AMBULATORY MATERNAL HEALTH CARE AND FAMILY PLANNING SERVICES: POLICIES, PRINCIPLES, PRACTICES (Florence E. F. Barnes ed. 1978).

duties of physicians regarding screening, full disclosure, and alternatives counseling are widely recognized in medical textbooks on abortion.⁴³ In addition, the American College of Obstetricians and Gynecologists (ACOG),⁴⁴ the National Abortion Federation,⁴⁵ the Planned Parenthood Federation of America,⁴⁶ and the International Planned Parenthood Federation Medical Advisory Panel⁴⁷ have all issued documents reaffirming, or at least alluding to, these duties.

After a proper psychosocial evaluation to screen for risk factors, patients could reasonably expect the attending physician or a qualified counselor to (1) disclose to the patient the identified risk factors and the post-abortion symptoms to which they may be related; (2) provide additional counseling to explore issues such as maternal or moral ambivalence, to assist the woman in making a decision that is consistent with her fundamental desires and belief system, and/or to resolve issues prior to the abortion so as to reduce the risk of subsequent post-abortion maladjustment; and (3) provide an informed medical recommendation as to the advisability of undergoing an abortion.

About this last point: the attending physician has a right and duty to recommend against and even refuse to perform an abortion that is contraindicated.⁴⁸ For example, a physician would be justified in refusing to perform an abortion on a woman who has a major infection that may be exacerbated by an abortion. Alternatively, in the case of a

43. See Patricia S. Stewart, *Psychosocial Assessment, in* OBSTETRICAL DECISION MAKING 30-31, 44-45 (Emanuel A. Friedman et al. eds., 2d ed. 1987); WARREN W. HERN, ABORTION PRACTICE 86 (1984). See generally Borten, *supra* note 42.

44. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES (1981); see also THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STATEMENT OF POLICY - FURTHER ETHICAL CONSIDERATIONS IN INDUCED ABORTION (1977).

45. NATIONAL ABORTION FEDERATION, STANDARDS FOR ABORTION CARE (1987) (on file with the author).

46. LORI SALTZMAN & MICHAEL S. POLICAR, THE COMPLETE GUIDE TO PREGNANCY TESTING AND COUNSELING (1985).

47. IPPF Int'l Medical Advisory Panel, *IMAP Statement on Abortion*, 27 IPPF MED. BULL., Aug. 1993, at 1 [hereinafter *IMAP Statement*].

48. THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES, 65 (1974) "It is recognized that although an abortion may be requested by a patient or recommended by a physician, the final decision as to performing the abortion must be left to the medical judgment of the pregnant woman's attending physician, in consultation with the patient." *Id.*; see also *Roe v. Wade*, 410 U.S. 113, 165-66 (1973).

minor who is being coerced into an unwanted abortion by domineering parents, the physician is legally and ethically obligated to refuse to perform the involuntary abortion. The proper response in such cases would be (1) to counsel the pressuring parents and explain how a coerced abortion will inflict emotional harm on their daughter and damage their relationship with her; and (2) to refer the parents and daughter to a qualified family counselor.

Sylvia Stengle, executive director of the National Abortion Federation, which represents numerous abortion clinics, has stated that at least one in five patients is at psychological risk from abortion due to prior philosophical and moral beliefs contrary to abortion.⁴⁹ Regarding this “worrisome subset” of patients, she concurs that there may be an ethical obligation for abortion practitioners to refuse to participate in the violation of a woman’s conscience.⁵⁰

In evaluating a patient’s psychological risks, therapists and abortion counselors should not rely simply on whatever information the patient may volunteer. Instead, counselors should actively look for “red flags” which would suggest the presence of risk factors. Uta Landy, a former executive director of the National Abortion Federation, encourages counselors to be aware of the fact that

Some women’s feelings about their pregnancy are not simply ambivalent but deeply confused. This confusion is not necessarily expressed in a straightforward manner, but can hide behind such outward behavior as: (1) being uncommunicative, (2) being extremely self assured, (3) being impatient (how long is this going to take, I have other important things to do), (4) being hostile (this is an awful place; you are an awful doctor, counselor, nurse; I hate being here).⁵¹

According to other leading experts on abortion counseling, “When [abortion] patients feel overwhelmed by emotions such as fright or shame, their ability to think, act, and even respond to the clinician is impaired.”⁵² This crisis-related disability may lead them to make poor decisions that may subsequently result in serious feelings of regret. Landy defines four types of defective decision-making observed in

49. Junda Woo, *Abortion Doctors’ Patients Widen Scope of Their Malpractice Suits*, WALL ST. J., Oct. 28, 1994, at B12.

50. *Id.*

51. Uta Landy, *Abortion Counseling - A New Component of Medical Care*, 13 CLINICS IN OBSTETRICS & GYNECOLOGY 33, 34 (1986).

52. Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation*, in A CLINICIAN’S GUIDE TO MEDICAL AND SURGICAL ABORTION 26 (Maureen Paul et al. eds., 1999).

abortion clinics. She calls the first defective process the “spontaneous approach,” in which the decision is made too quickly, without taking sufficient time to resolve internal conflicts or explore options. A second defective decision-making process is the “rational-analytical approach,” which focuses on the practical reasons for terminating the pregnancy (financial problems, single parenthood, etc.) without consideration of emotional needs (attachment to the pregnancy, maternal desires, etc.). A third defective process is the “denying-procrastinating” approach, which is typical of women who have delayed deciding precisely because of the many conflicting feelings they have about keeping the baby. When such a “denying-procrastinator” finally agrees to an abortion, it is likely that she has still not resolved her internal conflicts, but is submitting to the abortion only because she has “run out of time.” Fourth, there is the “no-decision-making approach” in which a woman refuses to make her own decision but allows others, such as her male partner, parents, counselors, or physician, to decide for her.⁵³

Moreover, abortion patients will often indicate that they understand information when they are in fact confused or distracted. Psychiatrist Nada Stotland, while an advocate of liberal abortion policies, warns abortion counselors that the only way they can “know that a client has understood something is to have her explain it back to the counselor.”⁵⁴ These considerations explain why the screening and assessment of a woman’s understanding and consent should not be limited to reliance on computer-evaluated questionnaires, but should also include an interview with a qualified health care worker.

OBSTACLES TO MAINTAINING HIGH STANDARDS FOR SCREENING

The abortion providers’ legal and ethical obligation to screen for risk factors, and to inform the patient of the risk factors identified, would appear to be beyond dispute. As seen above, the medical standards of ACOG, Planned Parenthood, and the National Abortion Federation all identify pre-abortion psychosocial screening as part of the process.

But examination of depositions and testimony in abortion malpractice cases, and published literature regarding “insider

53. *Id.* at 35.

54. NADA L. STOTLAND, ABORTION: FACTS AND FEELINGS: A HANDBOOK FOR WOMEN AND THE PEOPLE WHO CARE ABOUT THEM 154 (1998).

accounts” of practices in abortion clinics,⁵⁵ reveals that, in practice, very little screening for psychological risk factors is actually done, and certainly not in a systematic, documented fashion. Instead, most abortion clinics allow very limited time periods for individual counseling (as little as five minutes) and many rely solely on group counseling sessions lasting between fifteen and thirty minutes. In addition, many clinics delegate counseling to staff members who have no formal education in medicine or counseling. The use of licensed counselors who have been trained in accredited programs appears to be the exception rather than the rule.

How can this difference between the ideal for screening and counseling and the actual practice (or non-practice, as the case may be) of screening and counseling be explained?

I would suggest that the difference between theory and practice has arisen from fundamental conflicts of interest. The best interests of each individual woman are not easily separated from the beliefs and ideology of the women, men, and institutions that are passionately committed to providing abortion services.

Before examining these conflicts of interest, however, it is worth our time to consider the bottom line: financial liability. Unless there is appropriate financial liability regarding negligent screening and counseling, there is no “feedback” mechanism for correcting deviations from the ideal standard of care. If there is no liability for inadequate screening and counseling, investment in this aspect of abortion counseling — in both the time and the expertise of the staff — will naturally tend to decline over time.

In fact, peculiarities in the law often tend to shield abortion providers from liability for purely emotional injuries. In most jurisdictions, courts have rejected the right of persons to recover damages for emotional injury resulting from acts of negligence unless the injury is concurrent to a significant physical injury.⁵⁶ Since abortion does not normally entail severe physical injury, this limitation on liability shields abortion providers from liability for injuries arising from negligent psychosocial screening, except in cases where there is also a physical injury. In addition, given the high costs of litigation, malpractice attorneys are naturally reluctant to take a case alleging “only” emotional injury, since there is considerable doubt that juries

55. See generally MARK CRUTCHER, *LIME 5: EXPLOITED BY CHOICE* (1996); Pamella Zeckman & Pamella Warrick, *Abortion Profiteers*, *CHICAGO SUN-TIMES*, special reprint Dec. 3, 1978 (original publication Nov. 12, 1978).

56. Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 *NOTRE DAME L. REV.* 639, 648-49 & n.70 (1996).

would be as generous in making an award for clinical depression as they would for the loss of a uterus.

Another important limitation on liability is found in the statutes of limitation and repose. These laws limit the time frame in which a suit for injury may be brought. The most severe psychological reactions to abortion, however, typically include strong feelings of shame, guilt, self-blame, denial and avoidance behavior.⁵⁷ Among one sample of women reporting negative emotional reactions, fifty-five percent stated the effects were so severe that they were unable to “function normally at home, work, or in personal relationships.”⁵⁸ Among all the women experiencing negative emotional reactions, sixty-three percent reported a period of denial when they were unable to confront their negative feelings lasting an average of five years or more.⁵⁹ On average, in the same sample, women reported that it was 7.1 years after their abortion before they began to reconcile themselves to their past abortions.⁶⁰ Considering the fact that severe psychological reactions to abortion may persist for long periods of time, during which they are either suppressed or so overwhelming that women find it difficult or impossible to discuss their abortion experience, it may be difficult or impossible for such women to bring a lawsuit for damages within the period normally allowed for claims of medical malpractice. The fact that many women experience disabling levels of shame and self-blame following an abortion also tends to reduce abortion providers’ liability risks. In some cases, even when women have suffered serious physical injuries, the emotionally fragile state of post-abortive women has resulted in their abandonment of lawsuits once the women are exposed to the emotional rigors of active litigation and withering depositions.⁶¹

SUBSERVIENCE TO WOMEN’S CHOICES OR ABDICATION OF MEDICAL RESPONSIBILITY?

The legal issues described above tend to reduce the financial risks involved if an abortion provider curtails counseling services. Since expenditures on screening do not provide an identifiable benefit to the bottom line, at least in terms of reducing liability risks, there is very

57. See BURKE & REARDON, *supra* note 1, *passim*.

58. *Id.* at 299.

59. *Id.*

60. *Id.* at 300.

61. Telephone Interviews with Ted Amshoff and Tom Smith, Amshoff & Smith, PC (1994).

little economic advantage to providing exemplary screening. But while the desire to reduce costs may partially explain the inattention to careful screening practices, other issues, both noble and base, may be involved.

In this section, let us limit our attention to the noblest reason why abortion providers may de-emphasize screening and counseling. Quite simply, many abortion providers are dedicated to giving women full autonomy and control over their own bodies. From this perspective, counseling practices that might be perceived as intrusive or questioning of a woman's motives may be viewed as infringing on the right of women to make their own choices — a right for which many abortion advocates have fought and will do nothing to undermine. The establishment and use of a screening standard implies, by its very nature, that some high risk patients should be discouraged from having abortions, and might even be refused abortions. In this context, pre-abortion screening may be seen as undermining abortion providers' ideological commitment to protecting women's unfettered right to abortion.

In fact, many abortion counselors have great ambivalence about the reasons why many of their patients are choosing abortions, particularly in cases of late-term or multiple abortions that appear to involve obsessive-compulsive tendencies.⁶² However, these counselors are also ideologically committed to swallowing their doubts and accommodating every request for abortion.⁶³ In addition, abortion counselors are often trained to see themselves in the role of facilitators rather than as challengers of the abortion decision.⁶⁴ From this perspective, it is presumed that by the time a woman enters an abortion clinic her decision has already been made. Thus, proponents of this view might argue, the counselor's role is not to raise doubts about what is already settled but rather to prepare and ease the woman through a difficult day. The guidelines of the National Abortion Federation, an umbrella organization for private abortion providers, state that "counseling is not therapy and, therefore, is not intended to extend over a long period of time. . . . Abortion counseling is also to prepare the woman for her procedure by reducing her level of anxiety. Counseling must not create a barrier to service and must be

62. Diane M. Gianelli, *Abortion Providers Share Inner Conflicts*, AMERICAN MEDICAL NEWS, July 1993, at 1.

63. *Id.*

64. REARDON, *supra* note 23, at 248-49.

voluntary.”⁶⁵ In the interest of reducing a patient’s level of anxiety, many counselors justify evading questions about what the fetus looks like, minimizing the discussion of risks, and assuring women that everything will be fine afterwards.⁶⁶ Opponents of risk counseling cite evidence that women who expect fewer emotional reactions after abortion do indeed have fewer negative reactions over the first two subsequent weeks, though this advantage could no longer be seen at a three-week follow-up.⁶⁷ Based on this finding, some researchers have argued against “counseling that stresses the negative aftereffects of abortion,” since such counseling may reduce the potential benefits associated with higher expectations of positive results.⁶⁸

At best, this is a dubious argument for the philosophy that “ignorance is bliss.” At worst, it represents a paternalistic view of fragile pregnant women who simply cannot handle the full truth about all the possible implications of their pregnancy options. Unfortunately, the failure to adequately inform women of risks is most likely to result in even greater emotional problems in the long term. As previously noted, women with a history of abortion who subsequently complained that their counseling was inadequate, inaccurate, or biased are significantly more likely to report more severe negative psychological reactions to their abortions.⁶⁹ Feeling

65. National Abortion Federation, *1998 Clinical Policy Guidelines*, in *A CLINICIAN’S GUIDE TO MEDICAL AND SURGICAL ABORTION* 256 (Maureen Paul et al. eds., 1999).

66. For a review of examples in the literature, see REARDON, *supra* note 23, at 248-53.

67. See Major & Cozzarelli, *Psychosocial Predictors*, *supra* note 14, at 138. Subsequent research by Major has revealed that negative reactions to abortion and dissatisfaction with the choice to abort tend to increase with time, see Major et al., *supra* note 4, at 781, suggesting that the benefits of positive expectations and other coping mechanisms may be eroded by time. See generally Mueller & Major, *Self-blame*, *supra* note 14.

68. Major & Cozzarelli, *Psychosocial Predictors*, *supra* note 14, at 139. Lower reporting of negative feelings after an abortion by those who expect to cope well most likely suggests that some women are simply astute at recognizing what their reactions will be. To artificially encourage those women who are less confident of a positive reaction to believe that they will not have negative reactions is not necessarily a prophylactic against negative reactions but may instead make negative reactions more severe as the woman is likely to blame others and herself more for having ignored her intuitive expectation that she might not cope well with the abortion.

69. HELEN P. VAUGHAN, *CANONICAL VARIATES OF POST ABORTION SYNDROME* (1990); Wanda Franz & David C. Reardon, *Differential Impact of*

“caught off guard” by negative reactions, or “crazy” for having feelings that “no one else has,” or angry at being deceived, may all exacerbate post-abortion grief reactions.⁷⁰

This elevated view of a woman’s right to choose abortion, without regard to medical screening or counseling, is at odds with the traditional view of medical ethics applied in all other fields of medicine. Normally, the first ethical obligation of physicians is to “do no harm,” to protect the patient’s health while trying to improve it. In this context, while it is ethical to allow patients a choice between two or more proven treatment options, it would not be ethical to present a treatment option, or undertake a treatment, that the physician knows is contraindicated for that particular patient.

Allowing women to choose abortion without adequate screening from the physician to develop an informed medical opinion for her individual case is also contrary to the type of medical care envisioned by the Supreme Court when it struck down blanket laws against abortion.⁷¹ The Court has consistently rejected the idea that women may have an unrestricted right to abortion.⁷² The interest of the State aside, the Court has held that a woman’s request for abortion is always subject to the review and recommendation of a physician, who bears

Abortion on Adolescents and Adults, 27 ADOLESCENCE 161, 161-172 (1992); Terre Nicole Steinberg, *Abortion Counseling: To Benefit Maternal Health*, 15 AM.J.L. & MED. 483, 483-517 (1989).

70. BURKE & REARDON, *supra* note 1, at 41-43, 61.

71. The view that physicians would limit access to abortion to those cases in which it was most likely to be beneficial to women is most clearly reflected in Chief Justice Burger’s concurring opinion in *Doe v. Bolton*:

I do not read the Court’s holdings today as having the sweeping consequences attributed to them by the dissenting Justices; the dissenting views discount the reality that the vast majority of physicians observe the standards of their profession, and act only on the basis of carefully deliberated medical judgments relating to life and health. Plainly, the Court today rejects any claim that the Constitution requires abortions on demand.

410 U.S. 179, 208 (1973). By 1986, in his dissent in *Thornburgh v ACOG*, 476 U.S. 747, 782, Burger had begun to question this presumption and appeared concerned that at least some physicians might not be making “carefully deliberated medical judgments” but were instead simply providing abortions on request.

72. *Roe*, 410 U.S. at 153. “The privacy right involved, therefore, cannot be said to be absolute. . . . The Court has refused to recognize an unlimited right of this kind in the past.” *Id.* at 154. “Even an adult woman’s right to an abortion is not unqualified.” *H.L. v. Matheson*, 450 U.S. 398, 419 (1981) (Powell, J. & Stewart, J. concurring); *see also* *Planned Parenthood v. Casey*, 505 U.S. 833, 868-69 (1992); *Planned Parenthood v. Danforth*, 428 U.S. 51, 60 (1976).

“basic responsibility” for making that recommendation.⁷³ This is so because the Supreme Court has repeatedly found that abortion has serious health risks, mental and physical.⁷⁴ Therefore, abortion is not an arbitrary right of women but is rather a medical right which derives from her health needs, and can therefore only be exercised after appropriate and sufficient consultation with a “responsible physician.”⁷⁵ It is by thus intertwining the rights of the patient and the duties of the physician that the Court has attempted to simultaneously advance and protect the health of women.

In describing the duties and obligations of the physician, the Court has been very clear. Physicians are free to provide abortions when, in consultation with their patients, it is medically determined to be in their patient’s health interests.⁷⁶ This important distinction was made in *Roe* where the Court concluded its decision with the emphatic statement that “the abortion decision in all its aspects is inherently, and primarily, a medical decision, and *basic responsibility* for it must rest with the physician.”⁷⁷ If an abortion is contraindicated for medical reasons, which includes physical, psychological, and social reasons,⁷⁸ the physician has a right and duty to refuse to perform the abortion.

Unfortunately, the model of physician oversight envisioned by at least some members of the Supreme Court⁷⁹ does not appear to be the universal practice. In most abortion clinics, the doctor does not see the

73. *Roe*, 410 U.S. at 166.

74. The Supreme Court has affirmed that the “medical, emotional, and psychological consequences of an abortion are serious and can be lasting . . .” *Matheson*, 450 U.S. at 411, 413; *Danforth*, 428 U.S. at 67; *Casey*, 505 U.S. at 833.

75. *Roe*, 410 U.S. at 153.

76. “The [*Roe v. Wade*] 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.” *Roe*, 410 U.S. at 165-166.

77. *Roe*, 410 U.S. at 166 (emphasis added).

78. A physician’s determination whether to abort should be made “in light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well being of the patient.” *Colautti v. Franklin*, 439 U.S. 379, 394 (1979). Family size, financial concerns, mental health, and physical health are all issues in making a medical recommendation for abortion. “All these are factors the woman and her responsible physician necessarily will consider in consultation.” *Roe*, 410 U.S. at 153. The duty to evaluate this medical decision is especially weighty, because “[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.” *Harris v. McRae*, 448 U.S. 297, 325 (1980).

79. *Bolton*, 410 U.S. at 208.

patient until the abortion is about to commence. He or she knows little about why the woman is seeking an abortion, nor if she has any of the emotional risk factors identified by researchers. The abortion is not taking place because the physician recommended it, based on an informed valuation of the known risks and benefits of abortion given this patient's psychosocial profile. Instead, the abortion is taking place simply on the basis of the woman's request for it.

This approach honors the woman's autonomy, but it also involves an abdication of the traditional duties and responsibilities of the physician. In the normal practice of medicine, it is the duty of physicians to determine what treatment alternatives are available, including the option of "watchful waiting" during which nothing is done, and to evaluate whether or not a proposed treatment is likely to benefit a patient. The patient's opinion that one or another option is desirable may weigh into the physician's medical recommendation, but it does not free the physician from the duty to carefully review the patient's individual case, to review the known risks and benefits in light of the individual patient's profile, and to act accordingly.

This distinction is perhaps clarified by examining the distinction between a customer and a client. According to Webster's Dictionary, a customer is "one that purchases a commodity or service"⁸⁰ whereas a client is "a person who is under the protection of another."⁸¹ Customers merely buy what they think they need. Clients hire professionals to advise them, guide them, and provide them with what they really need. Clients are aware of their limited knowledge and depend on professionals to protect them from making mistakes.

The role of the patient as a client and the physician as a professional is reflected in the three models of medical decision that have been seriously proposed: paternalistic, informed, and shared.⁸² In the paternalistic model, the physician decides on the treatment and the patient complies. In the shared model, the physician identifies appropriate treatments, discloses information about the appropriate options, and works with the patient to reach a consensus on the treatment that best satisfies the preferences of both the physician and the patient. In the informed model, the physician identifies the medically appropriate options and discloses all information about the options, and the patient chooses which option they will pursue. In general, it would appear from journal articles on the subject of medical

80. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 308 (11th ed. 2003).

81. *Id.*, at 231.

82. Cathy Charles et al., *What do we mean by partnership in making decisions about treatment?* 319 BRIT. MED. J. 780, 780-82 (1999).

decision-making that the shared model is considered most ideal, but in practical situations some blend of the paternalistic, informed, and shared models is applied depending on circumstances, the personality of the physician, and the desire of the patient. The shared model is also the model which the Supreme Court has appeared to describe in its decisions where it has emphasized the idea that the abortion decision must be made by the woman in consultation with her physician.⁸³

A fourth model, which I will call the subservient model, has been scornfully described as occurring when patients tell the doctor what to do, and the doctor simply complies with little or no discussion.⁸⁴ This approach is scorned precisely because it turns the physician into a hired hand rather than a professional; the patient into a customer rather than a client.

Table 4 illustrates how responsibility for the various steps in making a treatment decision is divided between women and their physicians under the four models for decision-making. In the paternalistic model, the physician is fully responsible for the medical correctness of the treatment choice. In the shared model, the doctor is responsible for the quality of disclosure of risks and options and has shared responsibility for the choice of treatment. In the informed model, the physician can properly be held responsible for the quality of disclosure of risks and the appropriateness of the options offered to the patient, but not for the final choice between the offered options. Only in the subservient model is the physician not held liable for the information disclosed or the choice of treatment. In this last case, the physician would only be held liable for his skills in performing the treatment.

The problem with the subservient model is perhaps most pointedly made by a ludicrous example. Imagine a woman who entered a surgeon's office and declared that she had a lump in her breast and needed a mastectomy. If the surgeon proceeded to do a mastectomy—without forming his own medical opinion after examination, consultation, and consideration of other non-surgical treatments such as chemotherapy (assuming that a malignancy was confirmed)—we would all rightly accuse him of gross negligence. But why is this scenario different simply because the woman announces she is pregnant and needs an abortion?

83. *Roe*, 410 U.S. at 163, 166.

84. Sydney Morss, *A Fourth Model* (Feb. 15, 2000) [hereinafter Morss, *A Fourth Model*] at <http://bmj.bmjournals.com/cgi/eletters/319/7212/780#6687> (last visited January 16, 2004). This is a “rapid response” letter to Charles, *supra* note 82.

In their defense, abortion providers may insist that they are using the informed model, which leaves the final decision of treatment options to the woman. But this begs two questions. First, was abortion a medically appropriate option to offer in each woman's particular case? And second, was the disclosure of information about the risks and benefits of this option adequate?

To answer the first question, it is necessary to look more closely at how the informed model may be ethically employed. Consider the case of a physician who has determined that a diabetic patient's stomach pains are the result of an ulcer. He has at his disposal the option of three drugs for treating an ulcer. The first is the most expensive and is associated with a twenty percent risk of headaches. The second, mid-priced drug has a ten percent risk of causing outbreaks of acne. The lowest priced drug, a fifth of the cost of the most expensive option, is associated with strokes among diabetics. Since the patient is diabetic, the physician believes either of the first two drugs would be appropriate to prescribe. But since the differences in risks and cost, while relatively minor from a strictly medical view, may be subjectively significant to the patient, the doctor offers the patient a choice between these two drugs after explaining the differences in costs and risks. This is an ethical application of the informed model of decision-making.

In the same example, however, it would be negligent for the doctor to recommend the drug contraindicated for diabetics without first verifying that the patient was not diabetic. It would also be unethical, if not legally negligent, to comply with a known diabetic's demands for the least expensive (but contraindicated) drug simply because the patient was convinced by magazine ads that this was the drug he wanted to use. The physician's failure in this latter case is even more pronounced if he fails to inform the patient that it is associated with severe risks for diabetics. But even if the patient is fully informed of the risks to diabetics, the doctor who prescribes such a contraindicated drug is no longer operating within the informed model of decision-making. He is no longer acting as a professional advisor who is responsible for protecting the health of his client; he is instead simply acting, under the subservient model, like a drug dealer serving the demands of his customer even when his best judgment tells him the customer is making a foolish decision.

This example demonstrates that the informed model, properly understood, is really just a special case of the shared model in that the physician has already made a medical determination of what treatments are medically appropriate to recommend. If the best medical evidence indicates that more than one treatment option is appropriate in a specific individual's case, and the physician has no

medical basis for preferring one option over the other, it is entirely appropriate to leave the final choice to the patient after full disclosure of the differences involved in terms of likely benefits, risks, and costs. It is not appropriate to justify providing options that are contraindicated. Nor does the informed model justify shifting the burden of investigating and weighing very complex medical decisions to the patient. When the ramifications of treatment options (abortion versus the “watchful waiting” option — which will most likely result in a live birth) are highly complex and involve numerous risk factors, the informed model is not at all appropriate. In cases involving such complex issues, the type of dialogue envisioned in the shared model is the only appropriate one. This is especially true in the case of unintended pregnancies where there will be great variations in women’s emotional states, expectations, and backgrounds. In such cases, the information exchange and decision-making process must be highly collaborative.

DISCLOSURE IS RELATIVE TO ASSUMED RESPONSIBILITY

This returns us to the question of the quality of disclosure. Is the information about treatment alternatives that is given to women seeking abortions adequate to meet the requirements of the informed model for decision-making?

Comprehensive reviews of the physical and psychological complications associated with abortion literally fill entire books.⁸⁵ Is it reasonable to believe that this body of knowledge can be adequately summarized in five minute counseling sessions or on one piece of paper attached to the consent form? Notably, even the small portion of relevant information that is already included on consent forms is often presented at a reading level that is too complex for the average patient to understand.⁸⁶ Moreover, most women approaching an

85. See generally THOMAS W. STRAHAN, *DETRIMENTAL EFFECTS OF ABORTION: AN ANNOTATED BIBLIOGRAPHY WITH COMMENTARY* (3d ed., 2001); ELIZABETH RING-CASSIDY & IAN GENTLES, *WOMEN’S HEALTH AFTER ABORTION: THE MEDICAL AND PSYCHOLOGICAL EVIDENCE* (2002).

86. According to one consultant for abortion providers, the standard consent forms are simply not readable for the average patient:

They say that in order for the public to read and easily understand something, it should be written at the 5th grade level. I went to one of the clinics, a really good one and I took their consents and I did a SMOG readability study on the consents. And the consents—one I saw in several facilities, so I know it’s probably one that you all use . . . and after I did a

abortion decision are unaware of the fact, which will be discussed in this paper in greater detail, that there is no medical evidence that abortion will actually produce the benefits they desire.

Drawing closer to the main point of this paper, some women face greater risks than others. How can the disclosure of risks on a standardized consent form be even remotely adequate without supplemental counseling and disclosure tailored to each woman's unique profile?

In addition, do women who seek abortion counseling understand that the abortion provider is not offering a medical recommendation for the abortion, and is assuming no responsibility for determining that it is more likely to benefit her than harm her, but is merely offering abortion on request as a customer service — “buyer beware?”

In all three normal models of medical decision-making (I exclude here the subservient model as abnormal), the physician is expected to have a relatively complete knowledge of the risks and alternatives. This is what qualifies the physician to be a medical expert. In all three models, the doctor is also expected to make some disclosure to the patient of the basis for his recommended treatment and risks. But as indicated in the last column of Table 4, the amount of disclosure may vary depending on the model employed.

In this section I am not trying to define the legal obligations for disclosure that are applicable under informed consent law. Instead, my purpose is to explore how the expectations of patients (and the clinical and ethical obligations of physicians) for disclosure interact with the distribution of responsibility for the final treatment decision.

As a general rule, I would suggest that the amount of information that patients require about a proposed treatment is inversely related to the responsibility that the physician is willing to accept for making the final decision. This application of this rule is most evident in the case of the paternalistic model, which was the general rule for medical practice in the nineteenth century. At that time, physicians often had few treatment options. Often they had only one treatment option, such as amputation of a gangrenous limb. In such cases, even today, the discussion with the patient is not to explore options but rather to explain what must be done.

readability test on it, it turned out to be 18th grade reading level. Which means 12 for high school and 4 for college, that's 16, which means that you have to have a master's degree to be able to understand this consent.

Pat Blanco, Remarks at the National Abortion Federation, 19th Annual Meeting, New Orleans, LA (April 2-4, 1995).

Under the paternalistic model, the information about risks was disclosed primarily so the patient would be prepared to inform the doctor if complications ensued. The decision that the benefits of treatment outweighed the risks of non-treatment or alternative treatments was one that the doctor had already made. Even in modern medical practice, some minority of patients prefer the physician to make all the decisions regarding treatment options. In doing so, they are electing the paternalistic model.

In many present day cases, however, physicians have several treatment options at their disposal. The proliferation of options, each with unique costs and risks and efficacy, has made medical decision-making more difficult and more prone to malpractice suits. This has led to the need for greater inclusion of patients in the decision-making process. Indeed, research shows that patients overwhelmingly want their physicians to take the responsibility for identifying the one right solution for their health problems, but they also want to be very much involved in selecting the most desired “bundle of outcomes” associated with their treatment options.⁸⁷ In other words, most patients expect the physician to make a good medical recommendation, but they also desire enough information about why the recommendation is the best one so they can be confident of their decision to follow that recommendation. In the same study, it was found that patients were more comfortable yielding the decision-making power to the physician when the treatment was related to a life-threatening condition than they were for decisions related to quality of life, such as fertility decisions.

Such findings suggest that most patients prefer the shared decision-making model. Some, however, are willing to yield the decision to the physician, whom they trust to make the best decision on their behalf. Faced with an immediately life-threatening disease, for example, a patient may prefer treatment under the paternalistic model and may essentially say, “I don’t want to know why. I don’t want to worry about all the little things that might go wrong. If in your best judgment this treatment will give me a chance, let’s do it.” However, the same patient, faced with a relatively minor ailment such as back pain, might be most concerned about even the most remote possible complications if she feels able to endure the pain if necessary. In such a case, she may prefer the informed model, where she wrings out of the physician every bit of information she can and doesn’t want to be pressured into any choice until she is completely comfortable with it.

87. Raisa B. Deber et al., *What role do patients wish to play in treatment decision making?*, 156 ARCHIVES OF INTERNAL MED. 1414, 1414-20 (1996).

In the last column of Table 4, I have indicated the degree of disclosure that I believe patients expect in relation to each model. Basically, the amount of disclosure is inversely related to the responsibility assumed by the doctor for the choice of medical treatment. Patients who trust their doctor to make a paternalistic decision for them may expect little disclosure and may not even welcome it. In this case, the patient is likely to hold the doctor fully accountable for making the “right” choice. On the other hand, patients who expect to participate in the decision under the shared decision-making model still assume that the physician is responsible for offering them a well-grounded medical recommendation, but they also want “enough” information to feel comfortable in making the choice for or between the treatment(s) recommended by their physician. Finally, patients who want to make their own decision under the informed model essentially want all the information they can get so they can make the final treatment decision. Such patients are often adverse to any medical intervention. In these cases, the patient may be employing the physician primarily as an information resource. In such cases, the patient may not hold the physician accountable for the “right” choice, since the patient treated the choice as hers alone, but if the choice turns out badly she will hold the physician accountable if the information disclosed was incomplete or inadequate.

To summarize, the less a physician takes responsibility for the choice between options, the more he is obligated to ensure that the options and risks are fully disclosed and understood by the patient. In the only three models of medical decision-making that are ethical (in at least some circumstances), the physician is either completely responsible for the decision (paternalistic), completely responsible for information that guides the decision between medically appropriate options (informed), or responsible for both the information given and the final choice between options (shared).

The subservient model of decision-making, which allows abortion providers to evade both a high standard for disclosure and a high standard of liability for making a well-grounded medical recommendation for abortion, is simply not an ethical practice of medicine. This model reduces patients to customers and physicians to technicians. This model of medical decision-making is irretrievably flawed by the fact that the one person who should know the most, the physician, accepts no liability for either the completeness of the information that goes into the woman’s decision or for the medical appropriateness of the decision itself. As a result, it virtually guarantees that many women will make ill-informed decisions to abort — especially those who are at highest risk of severe emotional complications due to duress or psychological instability — even in

cases where there is virtually no prospect that the abortion will benefit them and it is very likely that it will harm them.

The added danger with both the subservient and informed models is that many women faced with a problem pregnancy expect and want informed medical recommendations. They are uncertain, even confused. They do not necessarily want an abortion, but neither do they know how they will cope with pregnancy and delivery. In one survey of women who suffered post-abortion emotional complications, fifty-five percent of the women stated that they felt “forced” by others to choose the abortion, sixty-one percent said they felt as though others were in control of their lives, and forty-four percent were still hoping that the abortion counselor would present another alternative on the day they went to the abortion clinic.⁸⁸ Even if this sample is not representative of all women seeking abortions, it clearly undermines the notion that women want or expect abortion counselors to act solely as facilitators of a decision that has already been made.

For most women, the decision to abort is difficult and complex, involving a large number of considerations. The issues involved may be overwhelming, especially for women who are immature or emotionally unstable. For many, the act of seeking an abortion is primarily an act of seeking help. According to Belsey, “These observations tend to confirm our view that in many a request for abortion is a symptom of a more general underlying emotional disturbance — in essence a ‘*cri de couer*’ [a cry of the heart].”⁸⁹ For many women, the pregnancy itself is a manifestation of underlying, unresolved conflicts involving both a desire to be pregnant and a fear of pregnancy.⁹⁰ It is a mistake to assume that once a woman requests an abortion she has made up her mind and does not need any more information, intervention, or counseling.⁹¹

As former abortion clinic director and counselor Charlotte Taft explained, the mere fact that abortion is so readily available has imposed a burden on the choice of women. “For many women nowadays, they’re angry that they had a choice. It’s too bizarre, but it’s like, ‘If you weren’t here, I wouldn’t have had to make this choice.’”

88. REARDON, *supra* note 23, at 11, 15.

89. Belsey et al., *supra* note 8, at 80.

90. Michael Blumenfield, *Psychological Factors Involved in Request for Elective Abortion*, 39 J. CLINICAL PSYCHIATRY 17, 25 (1978).

91. Anna Glasier, *Counselling for Abortion*, in MODERN METHODS OF INDUCING ABORTION 115-117 (David T. Baird et al. eds., 1995)(Page 115 conflicts with page 117, which identifies risk factors, and page 116, which notes that what doctors often give is not the same as that which women desire.).

. . . The woman herself may be anti-abortion.”⁹² Taft’s firsthand observations reflect the fact that many women fundamentally do not want an abortion, but its easy availability, without any hindrance or question, compels them to consider it as an option. Faced with many situational and personal pressures to choose this option, many women submit to abortions even when it violates deeply held moral beliefs or maternal desires. In such cases, the social pressures to abort are simply too great to resist.⁹³ Without screening and shared responsibility for the decision to proceed with the abortion, these women will inevitably become victims of abortion, not its beneficiaries.

CONFLICTS OF INTEREST

The discussion above presumed that abortion providers do not have a vested interest in women choosing an abortion and have simply “gone too far” in allowing women to make their own choice with minimal counseling. Up to this point, I have simply tried to show how shifting complete responsibility for the abortion decision to the pregnant woman is unethical and exposes her to unexpected but avoidable risks. The problems identified above exist even if the abortion providers are entirely neutral in their views about the advisability of abortion - but in reality, abortion providers may have other conflicts of interests with the pregnant women they serve. These conflicts of interest may lead them to guide women into consenting to abortions which may be contraindicated, inappropriate, or even unwanted.

The most obvious conflict of interest is financial. Abortion providers, particularly in urban settings, complain of intense competition for customers.⁹⁴ As described in a recent front page article in the *New York Times*, the subsidized abortion services of Planned Parenthood, which runs 147 abortion clinics in the U.S., has left for-profit clinics with little choice but to hire low-paid, poorly educated workers “to do everything but the actual surgery.”⁹⁵ Their survival as businesses rests on high volume and low costs. Because of this competitive cost-cutting pressure, while all other medical costs have soared nearly 500 percent in the last twenty-five years, the cost of abortion has hardly changed at all. According to the *Times* article, “a

92. CRUTCHER, *supra* note 55, at 175.

93. BURKE & REARDON, *supra* note 1, at 221-229.

94. Gina Kolata, *As Abortion Rate Decreases, Clinics Compete for Patients*, N.Y. TIMES, Dec. 30, 2000, at A13.

95. *Id.*

\$300 abortion in 1972 would cost \$2,251 today.”⁹⁶ Some abortion providers admit they simply don’t have time for individual counseling.⁹⁷

Financial pressures not only discourage investment of the time and staff necessary to do proper individualized screening and counseling, but they may also foster a desire to “sell” this elective surgery to every customer who walks in the door.⁹⁸ In this regard, screening and counseling for risk factors might actually serve to reduce a clinic’s clientele and jeopardize its ability to survive as a business enterprise precisely because the proper identification of risks might cause some women to change their minds or even compel the counselor to recommend against abortion.

Even more troublesome than financial conflicts of interest is the fact that at least some abortion providers are ideologically committed to the use of abortion as a tool for social engineering. Whether they seek to use it to reduce welfare rolls, to eliminate the “unfit,” or to save the world from overpopulation, they envision abortion as serving some social good that is greater than the concerns of the individual patient. For example, Dr. Edward Allred, owner of the largest chain of abortion clinics in California, is a staunch advocate of abortion as a method of controlling the population of minority groups:

Population control is too important to be stopped by some right-wing pro-life types. Take the new influx of Hispanic immigrants.

96. *Id.*

97.

Most of us abortion providers don’t have time. Well at least at our clinic, we don’t specifically counsel every woman. I liked that—today’s term—‘consult with women’ as a part of getting them—as a part of the decision of making the abortion rather than counseling. So I used to be really pro-counseling but now I’m really changing my thinking in term—in that term. “Claudia” from WomenCare Clinic, Remarks at the National Abortion Federation, 16th Annual Meeting, San Diego, CA (Apr. 12-15, 1992) (transcript on file with the author). At the same conference another participant discussed the financial pressure on clinics to do “enough abortions” to be profitable:

And that we really are running a business and it was very difficult—and it still is very difficult for me when I say “Oh my God, we didn’t do enough abortions today! Aahh!” You know, we’re not gonna make our budget. . . . Cause when I tell my friends, they go, “What?! You didn’t do enough abortions? That’s disgusting!” But that is the bottom line with us, isn’t it?

Cheryl Schrepf, Remarks at the National Abortion Federation, 16th Annual Meeting, San Diego, CA (Apr. 12-15, 1992) (transcript on file with the author).

98. Zeckman & Warrick, *supra* note 55; see also REARDON, *supra* note 23, at 232-271.

Their lack of respect of democracy and social order is frightening. I hope I can do something to stem that tide; I'd set up a clinic in Mexico for free if I could. . . . When a sullen black woman . . . can decide to have a baby and get welfare and food stamps and become a burden to all of us, it's time to stop.⁹⁹

While most advocates of population control are more circumspect in their rhetoric and avoid Allred's racial stereotypes, the general view that easy access to abortion promotes population control interests is clearly widespread. For example, the largest abortion provider in the United States is the Planned Parenthood Federation of America (PPFA), for whom population control is the primary mission.¹⁰⁰ Much of the financial support given to Planned Parenthood to subsidize their abortion and contraception services is given precisely for the purpose of reducing birth rates, especially among the lowest income groups. The mission statements of many other family planning organizations also include goals pertaining to reducing population growth and welfare costs. At what point does the advancement of these goals interfere with the objective counseling of individual patients regarding each woman's own personal needs and desires?

In the not so recent past, PPFA officials have supported the right of governments to pursue population control even to the degree of employing forced abortion on women who become pregnant without government consent.¹⁰¹ More recently, PPFA's international affiliates

99. Anthony Perry, *Doctor's Abortion Business Is Lucrative*, THE SAN DIEGO UNION, Oct. 12, 1980, at A14.

100. See generally JACQUELINE KASUN, *THE WAR AGAINST POPULATION: THE ECONOMICS AND IDEOLOGY OF POPULATION CONTROL* (1988); GERMAINE GREER, *SEX AND DESTINY: THE POLITICS OF HUMAN FERTILITY* (1984); JULIAN L. SIMON, *THE ULTIMATE RESOURCE* (1981); ALLAN CHASE, *THE LEGACY OF MALTHUS: THE SOCIAL COSTS OF THE NEW SCIENTIFIC RACISM* (1977).

101. Planned Parenthood has frequently supported coercive population control. For example, at the White House Conference on Hunger in 1969, Dr. Alan Guttmacher of Planned Parenthood supported a proposal for a national plan that would require: "(1) *mandatory* abortion for any unmarried girl found to be within the first three months of pregnancy, and (2) *mandatory* sterilization of any such girl giving birth out of wedlock for a second time." Erma Craven, *Abortion, Poverty and Black Genocide: Gifts to the Poor?*, in *ABORTION AND SOCIAL JUSTICE* 231, 235 (Thomas W. Hilgers and Dennis J. Horan eds., 1972).

Similarly, Frederick Jaffe, Vice President of the Planned Parenthood/World Population and head of research for Alan Guttmacher, has argued for government population programs which would require "permits for children," "compulsory sterilization of all who have two children," "compulsory abortion," "encourage homosexuality," and "fertility control agents in water supply." Robin Elliott et al.,

have refused U.S. government funds that were tied to restrictions on their freedom to provide assistance to the Chinese government's "one child" program, in which unlawfully pregnant women have been "handcuffed, tied with ropes, or placed in pig's baskets" while awaiting their forced abortions.¹⁰² Still more recently, PPFA and Planned Parenthood of St. Louis have been the targets of a class action lawsuit which included the charge that there is "racial steering" of black women toward abortion.¹⁰³ The lead plaintiff in this case was a black mother of four who expressed reservations about undergoing an abortion at the time of counseling but was allegedly shuttled through the system with promises that someone further down the line would talk to her about her concerns.¹⁰⁴

Whenever abortion counselors have deeply rooted anti-natal attitudes, there is clearly the grave danger that these attitudes may influence the substance and tone of their counseling of women in general and of "less desirable" mothers in particular. When persons or organizations that are prepared to defend coercive population control programs are put into the position of counseling women who are considering an abortion, how can they not be inclined to encourage the abortion by concealing or understating the risks? Indeed, some population control advocates have frequently defended the use of dangerous or insufficiently tested birth control technologies on the grounds that injured women are a "secondary" concern when compared to "overpopulation."¹⁰⁵ If only eight percent, or even eighty

U.S. Population Growth and Family Planning: A Review of Literature, 2 FAM. PLAN. PERSP. vii, vii-ix (1970). Former Planned Parenthood president Faye Whittleton likewise promoted an us-against-them, rich-versus-poor mentality as motivation for population control at any price. SIMON, *supra* note 100, at 327.

102. Michale Vink, *Abortion and Birth Control in Canton, China*, WALL ST. J., Nov. 30, 1981 at 26. See generally STEPHEN W. MOSHER, *BROKEN EARTH: THE RURAL CHINESE* (1983).

103. Nicole Smith vs. Planned Parenthood of St Louis Region and Planned Parenthood of America, No. 4:01 cv 1574 (E.D. Mo. filed Oct. 1, 2001). Smith's attorneys subsequently dropped the class action suit and refiled the case as an individual claim Nicole Smith vs. Planned Parenthood of St Louis Region and Planned Parenthood Federation of America, No. 4:03 cv 01727 (E.D. Mo. filed Nov. 26, 2003). The case is still pending at the time of this writing.

104. See cases cited and accompanying text *supra* note 103.

105. In 1970, Planned Parenthood President Dr. Alan Guttmacher testified before a Senate subcommittee that the health dangers of the Pill are secondary to the social "dangers" of pregnancy and overpopulation. *Expert Declines 'Alarm' on Birth-Curb Pill*, N.Y. TIMES, Feb. 26, 1970, at 3.

percent, of women suffer minor to severe post-abortion trauma, some population controllers would deem this to be a small price to pay for the world peace, prosperity, and environmental purity to which they aspire.¹⁰⁶

Consider a more concrete example. Imagine that you are an abortion counselor and the patient sitting before you is a 24-year-old black woman who is on welfare, is a high school dropout, and already has three children. She appears to have some emotional problems and you suspect she may abuse her kids because you have already seen her snap angrily at the toddler she brought along. She explains that she is here to find out about an abortion, but she also says, right up front, "I'm not really for abortion. I'm a religious person. It's just not right, at least for a Christian. Besides, I've always loved holding my new little babies. But my fiancé, Benjamin, is insisting that I get rid of it. He's promised to marry me and let me have another someday. I've told him we should have this one, but my mother and friends agree with him. They say abortion would be best for everyone. And I'm not sure how I would handle it if Benjamin leaves me. A baby is a lot of work, you know, and I do have to take care of my other kids. What do you think?"

For many abortion counselors, it would not be easy to separate this woman's needs from their own values and world perspective.¹⁰⁷ It may

As another example, at a 1962 conference sponsored by the Population Council, the IUD was being promoted as the panacea for controlling the world's overpopulation. Arguing that the risks of IUD use were acceptable, Dr. J. Robert Willson of the University of Michigan School of Medicine defended its widespread promotion, saying: "If we look at this from an overall, long-range view. . . perhaps the individual patient is expendable in the general scheme of things, particularly if the infection she acquires is sterilizing but not lethal." ROBERT S. MENDELSON, *MALE PRACTICE: HOW DOCTORS MANIPULATE WOMEN* 120 (1981). Similarly, Dr. Ravenholt, head of AID's population control programs, defended the widespread promotion of Depo-Provera, despite initial negative results, on grounds that the ill-effects could not be fully ascertained until tested on tens of millions of women. Barbara Ehrenreich, *The Charge: Genocide, The Accused: The U.S. Government*, *MOTHER JONES*, Nov. 1979, at 30.

106. See, e.g., LAWRENCE LADER, *ABORTION II: MAKING THE REVOLUTION* 221-22 (1973); Garrett Hardin, *The Tragedy of the Commons*, 162 *SCIENCE* 1243, 1243-1248 (1968).

107. Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation*, in *A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION* 26 (Maureen Paul et al. eds., 1999). A list of ten patient attributes or behaviors that often trigger negative or critical judgments on the part of abortion clinic staff is listed. The authors advise abortion providers to guard against allowing these negative

be easy to conclude, based on their own prejudices and value judgments, that this woman is not a good mother, that she's just swelling the welfare rolls, that if the child is born it's likely to be abused and will probably end up in prison, or even that the world simply doesn't need another of this woman's children — she's already given us three.

Once thoughts like these intrude, some people might be inclined to encourage the woman to more carefully consider the advice of her friends and boyfriend. "Yes, another child would be quite a burden. Wouldn't it be better to wait to have another child until after you get married? Your little ones really need all your attention right now and another baby would just take away from what you can give to the children you already have. You can always have another baby later." Would these gentle suggestions roll off your tongue? If not, can you not easily imagine them rolling off the tongues of many people whom you know?

In fact, all these concerns about the welfare rolls, overpopulation, and even the future home environment of the child, if it is allowed to be born, are irrelevant to the physician's obligations to serve the woman's own personal well-being. The woman in our example clearly wants to give birth to her child. What she really wants is some support in resisting her boyfriend's pressure, and perhaps some help in convincing him that having a baby will work out just fine. It is also clear that she has many high-risk factors for suffering emotional problems from an abortion: moral beliefs against abortion, feeling pressured to abort, a maternal nature, prior children, and possibly prior or existing emotional problems. The only reason she is even considering the abortion is in the hope that her boyfriend will marry her. But that promise of marriage is one that an objective counselor would rightly call into question. The last thing this woman should do is abort solely for the sake of pleasing an uncommitted male partner.

Considering only this woman's own needs and desires, the only reasonable recommendation to give this woman would be to discourage her from aborting simply to please others (at her own expense) and to refer her to agencies that could provide her with emotional and financial assistance. Conversely, a recommendation for abortion can only be justified by importing into the recommendation beliefs about social policy, population control, or simply raw prejudice against this woman herself.

attitudes to be reflected in critical expressions, gestures or words that may "foster defensiveness, withdrawal, and mistrust."

The failure of abortion clinics to screen for risk factors, I would suggest, may be in part due to a widespread anti-natal attitude which views the unborn children of the women they serve as potential burdens on society. Many of these abortion providers may even realize that a large number of the women they treat are at a higher risk of suffering post-abortion problems, especially those women who are themselves least embraced by society because of their own mental or emotional limitations. Ideologically committed population controllers, however, might ask themselves which is worse: that these women may end up shedding a few tears in the middle of the night, or that our society should be forever burdened with their “unwanted” children, and grandchildren and great-grandchildren, for endless generations?

The issues of population control and social engineering illustrate another way in which abortion is fundamentally different from most other medical procedures. In most other cases, the patient’s and physician’s interests are more closely aligned. Both are looking for a cure. While the physicians often have a financial interest in the patient’s choice between appropriate options, this potential conflict is somewhat muted by long-term financial interests derived from healing the patient and thereby earning repeat business and referrals. In the case of abortion, however, the choice between birth and abortion has a social aspect (whether or not a new person shall enter into our society) that is not present in any other medical procedure (though it is indirectly present in decisions regarding sterilization and contraception, where similar conflicts of interest may arise). This social impact of individual abortion/birth choices introduces all the potential conflicts of interest described above. Such a social impact is not present in choices between, for example, antibiotics or any of thousands of other medical treatments. The importance placed by society on the social aspect of the abortion/birth decision is reflected in the fact that governments, foundations, and private agencies spend billions of dollars each year to curb population growth. It should therefore be no surprise to find that such passionately held views against “excess births” would directly or indirectly influence abortion counseling.

But the importation of any social engineering values into abortion counseling, whether conscious or unconscious, automatically introduces a potential conflict between serving the health needs of the individual patient and serving the social agenda of others. The well-being of patients may even be systematically threatened when beliefs, attitudes, and goals that prevail within the community of abortion providers results in a “professional persona” that exerts extraordinary

influence on patients in crisis situations, particularly since those in crisis are in a heightened state of psychological accessibility.¹⁰⁸ The physician is not being employed by the woman to solve world population problems, nor to protect her unborn child from being born to an “unfit” parent. There is no reasonable basis for assuming that a patient is entrusting these concerns to the physician’s discretion. Therefore, since a physician’s treatment recommendations should be “motivated only by the patient’s best therapeutic interests,”¹⁰⁹ the physician’s recommendation for or against the option of an induced abortion should exclude any of these extraneous social concerns. Abortion should only be recommended when there is evidence that the benefits to the woman herself outweigh the risks. Without adequate

108. CAPLAN, *supra* note 32, at 50-53. Following are Caplan’s observations regarding the benefits and dangers of a specialized “professional persona” when treating people in crisis situations that are particularly relevant to the issues at hand:

Each [care-giving] profession has a long history of development, during which certain problems of certain classes of citizens have been defined as its province of interest. . . . In each profession, this has gradually been *systematized into a defined professional subculture* which is handed on to neophytes through a systematic course of education and supervision. . . . Only rarely are questions of clients’ mental health or mental implications of professional procedure made the subject of explicit interest

CAPLAN *supra* note 32, at 50

Each of these professional people during his training and by virtue of his identification with his professional culture develops a ‘*professional persona*’—a set of characteristic ways of selecting and ordering his perceptions of his clients so that he focuses on certain aspects of their life situation. His perceptions are colored by a specific framework of reference which relates to his ability to deal with certain problems and not with others

CAPLAN *supra* note 32, at 51

We have seen that crisis involves a relatively short period of psychological disequilibrium Every crisis presents both an opportunity for psychological growth and *the danger of psychological deterioration* The outcome of the crisis depends on the resolution of a complex of conflicting forces during the period of disequilibrium. Some of the forces originate inside the individual... Some of the forces originate in his current environment, particularly changes in the intensity of the hazardous circumstances [involving some threat of loss] and the help or hindrance of other people, his family and friends, and *those formal and informal care-giving persons to whom he may turn.*”

CAPLAN, *supra* note 32, at 53 (emphasis added).

109. *Netanson v Kline*, 350 P.2d 1093, 1106 (Kan. 1960).

psychosocial screening, it is difficult to see how the physician can meet this obligation.

CAN WITHHOLDING RISK INFORMATION BENEFIT WOMEN?

Some have questioned the disclosure of information about the psychological risks of abortion on the basis that such information may increase patient anxiety and lower coping expectations, thereby increasing the risk of subsequent emotional maladjustment.¹¹⁰ In essence, these commentators raise the question of “therapeutic privilege,” the right of a physician to withhold information that in itself “poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.”¹¹¹ For example, tactlessly disclosing stressful information to a cardiac patient which might make the patient suffer a heart attack is clearly contraindicated.

The decision to withhold information is itself a medical decision, one that falls under the paternalistic model of decision-making. In making the decision to withhold the information, the physician is essentially accepting greater responsibility for the choice of the treatment that is being pursued. Even when a treatment is life-saving, however, the option of withholding potentially upsetting information from patients using this “therapeutic privilege” is very narrow.¹¹² In the case of an elective procedure, where by definition the patient may decline the proposed treatment without dire consequences,¹¹³ I would argue that the option of withholding information relevant to a patient’s decision simply does not exist. At the very least, since “no court has ever held a

110. Nancy F Russo & Kristin L. Zierk, *Abortion, Childbearing and Women’s Well-Being*, PROF. PSYCHOLOGY: RES. & PRAC., Aug. 1992, at 269, 271.

111. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

112.

The privilege [to withhold risk information which in itself would “present a threat to the patient’s well being”] does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

Id. at 789.

113. GEORGE J. ANNAS, *THE RIGHTS OF HOSPITAL PATIENTS: THE BASIC ACLU GUIDE TO A HOSPITAL PATIENT’S RIGHTS* 68 (1975).

doctor liable for . . . [providing] too much information,”¹¹⁴ it seems reasonable that physicians should err on the side of a full and expansive disclosure rather than risk the problems associated with a failure to disclose.

The application of these principles to the case of abortion is readily apparent. Since an elective abortion, by definition, never involves treatment for a life-threatening condition, the withholding of “upsetting” information is never justified. The right of women to be fully informed about the nature and risks of abortion is internationally acknowledged,¹¹⁵ since a decision to forego a previously desired elective abortion because of possible risks, even remote ones, is always reasonable, if not wise.¹¹⁶

Another variation on the “therapeutic privilege” defense is the claim that disturbing information about negative effects associated with abortion should not be given to women unless the causal connection has been firmly established. This argument is based on the distinction between statistical associations and underlying causation. Statistically significant associations between independent and dependent variables only support the conclusion that a hypothesis proposing a causal connection cannot be ruled out. But statistical associations, while

114. *Id.* at 92.

115.

The woman should be fully informed of the procedures to be performed, including anaesthesia. Their safety and their possible immediate and future side-effects and complications should be discussed It may be advantageous to allow, wherever possible, an interval of at least 24 hours to elapse between counselling and the performance of the abortion While counselling on contraception, the subject of repeat abortion and its undesirability should be discussed Pregnant adolescents seeking abortion require special care and attention during counselling.

IMAP Statement, supra note 47, at 1.

116.

The very foundation of the doctrine of informed consent is every man’s right to forego treatment or even cure if it entails what for him are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.

2 FOWLER V. HARPER & FLEMING JAMES, *THE LAW OF TORTS* § 17.1 (1st ed. 1956, Supp. 1968).

supportive of arguments for causation, are not direct proof of causation.

For example, consider Study A, which finds that children who grow up with nightlights in their rooms are more likely to have poor eyesight. This finding supports a biologically sound hypothesis that exposure to nightlights may damage children's eyesight. Two dozen other studies find similar results. But twelve years later, Study Z finally reveals that parents with poor eyesight are more likely to prefer and use nightlights in their children's rooms. Moreover, the analyses in Study Z show that when one statistically controls for the vision impairments of parents, the association between poor eyesight and nightlights completely disappears. This new finding prompts the authors of both Studies A through Z to conclude that association to nightlights found in Study A is most likely incidental, not causal.

This example illustrates why causation is often difficult to establish. Unlike research in physics and chemistry, it is extremely difficult, if not impossible, to measure and control all variables in the biological and sociological sciences, especially when using human subjects. As a result, there is almost always some level of uncertainty regarding causation because one can always speculate that some other factors may explain the association.

As a practical matter, the distinction between association and causation presents important ethical and legal questions regarding when people should be informed of potential risks. By definition, a statistical association to a negative outcome demonstrates that a potential risk exists. Until the association is proven to be incidental, the fact that the connection may be real means that the associated negative outcome may be causally connected to the independent variable.

Returning to the nightlight example, what should be done to protect consumers during the twelve years between Study A and Z? Should nightlights be recalled and banned from distribution? Should manufacturers print warnings on their packages notifying consumers of the results of Study A and the arguments for and against the hypothesis that the connection is causal? Should nothing be done? Should buyers of nightlights be left in the dark (pun intended) about Study A? If nothing is done, how much evidence (studies B through Y) must accumulate before people are warned or the potentially dangerous product is regulated?

These questions are central to the ongoing controversy over the statistical association between abortion and breast cancer. A meta-analysis of twenty-eight studies reveals that induced abortion is an

independent risk factor for subsequent breast cancer.¹¹⁷ But this risk is disputed by proponents of abortion who claim that causation cannot be established without more research. Both sides agree that changes in the breast during early pregnancy affect the risk of breast cancer and that full term deliveries, particularly at younger ages, have a protective effect against breast cancer. Abortion proponents insist, however, the evidence that abortion adds an additional independent risk is still inconclusive.¹¹⁸ They generally maintain that until a cause-effect relationship is firmly established, women should not be told of this disputed risk because, as phrased in one Planned Parenthood statement, it may cause “unwarranted fear.”¹¹⁹

The position of Planned Parenthood begs the question as to when fears are “unwarranted.” That a statistical association exists between induced abortion and breast cancer is beyond dispute. A plausible theory to explain a causal connection exists but has not been proven. The only way to completely prove a causal connection would require the impregnation of a random sample of women of whom half would be randomly selected for induced abortions and the others required to carry to term. Short of such a grossly unethical study, there will always be room for raising questions about possible confounding factors, other than abortion or birth of an unintended pregnancy, that may account for differences between the two groups of women. But since most effects in human biology and psychology are the result of the interaction of multiple causes, it is extremely difficult to rule out all possible alternative explanations. The fact that it took decades of research regarding smoking and lung cancer to rule out all the alternative explanations demonstrates that the skeptics can always create some room for doubt by appeals for ever higher standards of proof and more research.

Whether or not the observed statistical association between abortion and breast cancer is best explained by causal, related, or incidental factors may not be fully answered for decades, if ever. The only thing that can be positively known, at any particular time, is whether

117. Joel Brind et al., *Induced Abortion as an Independent Risk Factor for Breast Cancer: A Comprehensive Review and Meta-Analysis*, 50 J. EPIDEMIOLOGY AND COMMUNITY HEALTH 481, 481-496 (1996).

118. Tim Davidson, *Abortion and Breast Cancer: A Hard Decision Made Harder*, 2 THE LANCET ONCOLOGY 756-58 (2001).

119. “Since no reliable, accepted study shows a link between abortion and breast cancer this is not information that should be conveyed to clients. In fact, to do so would be irresponsible. Bogus medical arguments and flawed conclusions serve only to create unwarranted fear in women.” Planned Parenthood Public Statement (Nov. 1993), *cited in* SCOTT SOMERVILLE, CONNECTIONS 11 (1994).

research has demonstrated statistically significant associations between a treatment and negative outcomes. The relevant question here, then, is at what point do patients have a right to know about these statistically significant findings? I have no quarrel with doctors expressing their doubts that these findings will withstand future investigations. I do question, however, the right of doctors to withhold the evidence of risks from patients, especially in the case of an elective procedure. In the case of abortion, some doctors appear to be less concerned about screening women for known risk factors than they are about screening women from information that may raise concerns about abortion. Such a failure to screen for information reflects nothing less than a paternalistic decision that pregnant women are unable to weigh and judge information about risks for themselves. If their judgment is so poor that they are unable to judge the value and relevance of this information, why should we trust their judgment regarding whether or not they should abort? Or is that perhaps, in some cases, exactly the problem? As in the example of Barbara above, some abortion providers appear to believe that women inclined to give birth to their child in less than the most favorable conditions are not choosing wisely and therefore need to be paternalistically guided, or even bullied, into making the “right choice.” Among those inclined to believe that abortion is “the right choice” for their clients, the ability to withhold information that may provoke “unwarranted fears” is important if they are to better direct and control the choice of their clients.

Until a disputed risk is proven not to be a risk, it remains a potential risk. Yet all risks, whether proven by statistically validated measures or simply proposed on the basis of sound scientific theory, are simply potential risks.¹²⁰ If a negative outcome were a certainty, it would not be called a risk; it would be called a certainty. Uncertainty is fundamental to risk, and this uncertainty can take three forms: uncertainty regarding the percentage of patients who will experience the complication; uncertainty whether or not any particular patient will be one of the “unlucky few”; and uncertainty whether the complication is a direct result of the treatment, the result of a prior condition aggravated by the treatment, an indirect result of other complications of the treatment, or an incidental occurrence.

120. “The concept of risk generally embodies at least 2 distinct notions: first, an unwanted outcome, and second, some uncertainty about the occurrence of that outcome.” Sidney T. Bogardus et al., *Perils, Pitfalls, and Possibilities in Talking About Medical Risk*, 281 J. AMER. MED. ASS’N 1037, 1038 (1999); see also Richard Wilson & E.A.C. Crouch, *Risk Assessment and Comparisons: An Introduction*, 236 SCIENCE 267, 267, 268 (1987).

Most patients are capable of understanding not only the general concept of uncertainty but also these distinctions between the various types of uncertainty.¹²¹ Most also appreciate knowing about all risks and uncertainties.¹²² In the case of an experimental treatment, all three types of uncertainty are likely to exist in a high degree and it is precisely because of these uncertainties that patients are carefully cautioned about even the most theoretical of risks. Why should the standard for disclosure for an elective procedure be any less than the standard for an experimental procedure?

The primary benefit claimed for abortion is that it gives women a choice. It gives them the right to better control their destinies. But are they really given a choice if they are not given all the information they may find relevant to making that choice? Do they really control their own destinies when others decide for them what information should be withheld because it may cause them “undue fear?” Even if only one in twenty women considering abortion would consider the breast cancer association worth learning about and considering, should that one woman be denied that information for the sake of hastening the counseling process for the other nineteen? When physicians or counselors withhold information because they fear the information will lead to an “unreasonable” choice for childbirth, they are simply reflecting their own biases on the decision-making process — biases that infringe on the rights and autonomy of the patient and expose her to avoidable health risks.

The only objective standard for disclosure is to use the same standard used for reporting significant results in scientific journals, namely the ninety-five percent confidence limit, which equates to the probability statement: $P < 0.05$, meaning that there is only a five percent chance that the findings are due solely to chance.¹²³ Put another way, this means that the differences between groups are so great that it is likely that ninety-five out of one hundred similar studies would find similar results. This ninety-five percent confidence limit is the commonly accepted standard for identifying statistically significant results and would seem to be the most reasonable one to apply to screening and disclosure requirements. For example, if a study has shown that a history of prior depression is predictive of post-abortion

121. Dennis J. Mazur & David H. Hickam, *Patients' Preferences for Risk Disclosure and Role in Decision Making for Invasive Medical Procedures*, 12 J. GEN INTERNAL MED. 114, 114-17 (1997).

122. *Id.*

123. CHARLES H. BACKSTROM & GERALD HURSH-CESAR, SURVEY RESEARCH 355-358 (2nd ed. 1981).

suicide with a P-value (probability value) equal to 0.03, that means there is only a three percent chance that abortion counselors are raising a false alarm about a finding that was simply a statistical fluke.

If one envisions the distinction between statistical association and causation as analogous to the difference between circumstantial evidence and eyewitness evidence, then the ninety-five percent confidence limit serves a function that is analogous to a grand jury's function. Evidence of an association that exceeds this statistical limit verifies that there is enough statistical evidence to establish a prima facie case that should be presented to a trial jury, or in this analogy, the individual patient who must make the final judgment. Unlike a criminal case, however, conviction does not require proof beyond a reasonable doubt. Some patients may reject a proposed treatment based on very little "circumstantial" evidence that it is dangerous. That is the patient's prerogative, which is exactly why any statistically associated risk should be disclosed, especially with elective procedures.

Since statistical associations are not definitive proof of actual cause-effect correlations, however, it is quite appropriate for a physician to also provide his personal opinion, clearly qualified as such, that the disclosed statistically associated risk is most likely due to other confounding factors (as in the example of the nightlight). The duty to disclose risks does not encompass a duty to convince or to dissuade patients from believing that the negative outcome is likely or unlikely to occur. The purpose of disclosure is to ensure that patients have an opportunity to weigh in their own minds the risks and benefits of a procedure.¹²⁴ Only then will patients have enough knowledge to determine if they want to learn more about the nature and likelihood of risks and benefits, or if they feel informed enough to make their final decision.

WHAT ABOUT THE RISKS OF UNINTENDED BIRTH?

Some might reasonably wonder, however, if some women who are at risk of negative reactions to abortion might also be at greater risk of negative reactions if they carry their pregnancies to term. Indeed, it is not uncommon for researchers who advocate for abortion to dismiss their own findings regarding the adverse effects of abortion with the unsupported assertion that the negatively affected women would likely have fared equally as bad or worse if they had carried to term.¹²⁵ It is a notable fact that such assertions are almost always made without any

124. *Canterbury*, 464 F.2d at 789.

125. Major & Cozzarelli, *supra* note 14, at 121-142.

citation to actual research to support this view. When citations are offered, they are conspicuously limited to studies regarding the hardships of single parenthood or even to the troubles faced by children who are born into poverty or single parent households.¹²⁶ But all the studies cited compare the poor to the rich and the single to the married without any comparison between those who aborted and those who carried to term.¹²⁷

That poor and single mothers have a more difficult life is not doubted. The real question is whether poor and single women who have had abortions have a better life than similar women who carried to term. Unfortunately, there simply is not a substantial body of literature specifically comparing women who have had abortions to women who carry unintended pregnancies to term. While there are many studies examining these women as separate groups, few direct comparisons are available. Judging by the lack of citations, it does not appear that there are any studies that demonstrate significant or lasting benefits for women who have abortions compared to women who carry pregnancies to term.

Furthermore, at least to my knowledge, there is not a single study that has found that women who have multiple risk factors associated with negative post-abortion reactions are also at the same or higher risk for the same or worse negative reactions after childbirth. It is certainly reasonable to propose this hypothesis, but it is important to know that this is only a hypothesis that has yet to be supported by any statistically validated studies. Indeed, the evidence that is available would appear to mitigate against this hypothesis.

For example, an analysis of the National Longitudinal Study of Youth has revealed that women who subsequently married after aborting a first pregnancy were 138 percent more likely to be at risk of clinical depression compared to similar women who carried a first unintended pregnancy to term, even after controlling for age, income level, race, and, most importantly, a psychological measure taken prior to their first pregnancies.¹²⁸ Furthermore, examination of medical records for low-income women in California reveals that even after controlling for a history of prior psychological illness, women who

126. Nancy Felipe Russo et al., *U.S. Abortion in Context: Selected Characteristics and Motivations of Women Seeking Abortion*, 48 J. SOC. ISSUES 183, 187, 188 (1992).

127. *Id.*

128. David C. Reardon & Jesse R. Cogle, *Depression and unintended pregnancy in the National Longitudinal Survey of Youth: A Cohort Study*, 324 BRIT. MED. J. 151, 151-152 (2002).

have abortions are significantly more likely than women who carry to term to receive subsequent psychiatric care, both on an inpatient¹²⁹ and outpatient basis,¹³⁰ and are more likely to commit suicide.¹³¹ In the latter study, controlling for psychiatric history revealed that the difference in suicide rates between delivering and aborting women was highest among women with a history of psychiatric care.¹³² In other words, it appears that among women with prior psychological problems, childbirth decreases the risk of subsequent suicide while abortion increases the risk of suicide. This finding is consistent with other research on suicide that shows that pregnancy and childbirth reduce the risk of suicide.¹³³ It is also known that prior suicidal behavior is not predictive of abortion, nor does it explain the increased level of suicide attempts after an abortion.¹³⁴ In one study of women with a prior history of psychiatric problems, none of those who carried to term subsequently committed suicide over an eight-to-thirteen-year follow-up, while five percent of those who aborted subsequently committed suicide.¹³⁵ Through suicide notes and case studies, it is known that abortion-related grief, trauma, and/or guilt are contributing causes for at least some suicides.¹³⁶

While the above discussion is focused on a single major mental health problem, suicide, these findings consistently suggest that for women with prior psychological problems, childbirth is likely to reduce

129. Cogle et al., *supra* note 4, at 47.

130. Priscilla K. Coleman et al., *State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over five years*, 72 AM. J. ORTHOPSYCHIATRY 141, 141-52 (2002).

131. David C. Reardon et al., *Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95 SOUTHERN MED. J. 834, 834-841 (2002).

132. *Id.*

133. Louis Appleby, *Suicide During Pregnancy and in the First Postnatal Year*, 302 BRIT. MED. J. 137, 137-40 (1991).

134. Christopher M. Morgan et al., *Mental Health May Deteriorate as a Direct Effect of Induced Abortion*, 314 BRIT. MED. J. 902 (1997).

135. B. Jansson, *Mental Disorders After Abortion*, 41 ACTA PSYCHIATRICA SCANDINAVICA 87 (1965).

136. E. Joanne Angelo, *Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief*, 59 LINACRE QUARTERLY 69 (1992); see also Myre Sim & Robert Neisser, *Post-Abortive Psychoses*, in THE PSYCHOLOGICAL ASPECTS OF ABORTION (David Mall & Walter F. Watts eds., 1979); David A. Grimes, *Second-Trimester Abortions in the United States*, 16 FAM. PLAN. PERSP. 260 (1984). See generally ANNE SPECKHARD, *PSYCHO-SOCIAL STRESS FOLLOWING ABORTION* (1987); BURKE & REARDON, *supra* note 1.

the risk of subsequent suicide attempts, whereas abortion may aggravate that risk. A greater sense of family obligations and a fear of hurting one's children appear to account for fewer suicide attempts and suicidal thoughts.¹³⁷ The same connection to family may also help protect women from other mental health problems.

Obviously, comparing the lives of women who abort to those who carry unintended pregnancies to term is an extremely complex problem. It is even more difficult to prove causal relationships between abortion or childbirth and subsequent negative or positive effects. The previously discussed difficulty of proving causal relationships is only compounded further when one is comparing two different pregnancy outcomes and varying degrees of the intent to allow oneself to become pregnant and the desire and/or ambivalence about the abortion alternative.

But none of this really alters the fundamental argument of this paper. Even if it could be shown that women who are at higher risk for negative post-abortion reactions are at equal or higher risk of suffering negative consequences from childbirth, this would not remove the obligation of doctors to screen women for these risk factors and to inform them of their findings. Even if both options, abortion and childbirth, are laced with risks, this does not in any way reduce the woman's right to a full disclosure of risks or to a medical opinion that is properly formed after careful screening of her unique risk profile.

IDENTIFYING THE BENEFITS OF ABORTION

In forming a medical recommendation for abortion, physicians should not only be aware of predictive risk factors for physical or psychological sequelae, but they should also have a sound medical basis for determining in what circumstances an abortion is likely to be efficacious in producing the results women desire. If a woman has one or more risk factors related to serious complications, and there is no clear evidence that the benefits she is likely to obtain through the abortion will offset these risks, it is difficult to see how a physician can justify proceeding with what otherwise must be considered a risky or even contraindicated procedure.

Very little research has been done with regard to identifying situations or characteristics wherein abortion is most likely to improve a woman's life or well-being. There is even less, if any, research that

137. Marsha M. Linehan et al., *Reasons For Staying Alive When You Are Thinking About Killing Yourself: The Reasons For Living Inventory*, 51 J. CONSULTING & CLINICAL PSYCHOLOGY 276, 285 (1983).

has attempted to quantify such improvements. Instead, there is a widespread and untested presumption that if an abortion does not measurably hurt a woman's life, then it must benefit her life. But there is no logical basis for assuming that lack of harm correlates to positive benefit. One cannot rationally assume that if a woman suffers no physical or psychological injuries from an abortion, her life has been improved. Indeed, the only statistically validated study that has asked women to evaluate post-abortion benefits appears to contradict this assumption. In this two year follow-up survey, 438 women were asked to rate their agreement or disagreement with the statement, "I think the abortion has had a positive [good] effect on me," on a scale of 1 (strongly disagree) to 5 (strongly agree). The average response was a very neutral 3.1.¹³⁸ Examination of the distribution shows that most women clustered at the neutral (3) score, and that for every woman who strongly agreed there was a corresponding woman who strongly disagreed with the statement.

This finding is consistent with the results of a major national poll by the *Los Angeles Times*, indicating that fifty-six percent of women admitting to a past abortion reported a sense of guilt and twenty-six percent regretted choosing abortion.¹³⁹ As with similar studies, the number of women who admitted having an abortion was much less than half the actual abortion rate. Presumably, the rate of regret among concealers would be even higher as negative reactions are generally higher among this group.¹⁴⁰ Even if we assume this twenty-six percent figure to be roughly accurate, this rate of regret over a medical procedure is surely very high compared to most other medical treatments.

If it cannot be shown that abortion clearly benefits the lives of most patients, the issue of limiting the right of physicians to perform abortions will once again become a major public health issue. In such a circumstance, how will society weigh the pain and suffering of one group against the welfare and benefits of another group? For the sake of discussion, let us assume that twenty-five percent of abortion patients experience mostly negative effects and regret their decision, fifty percent have both negative and positive reactions, and twenty-five

138. Brenda Major et al., *Psychological Responses of Women Following First Trimester Abortion*, 57 ARCHIVES OF GENERAL PSYCHIATRY 777 (2000).

139. George Skelton, *Guilt Plagues Many Who Had Abortion*, L. A. TIMES, March 19, 1989, at 15.

140. Brenda Major & Richard H Gramzow, *Abortion as Stigma: Cognitive and Emotional Implications of Concealment*, 77 J. PERSONALITY & SOC. PSYCHOL. 735 (1999).

percent feel mostly satisfied with their decision. In such a case, how can we call America's abortion policy a "success" when only one in four patients feels mostly benefited by abortion? Is not their improved welfare offset by the number of women who deeply regret their abortions and have suffered great emotional pain for their ill-advised choice? And how will society factor in the mixed reactions of those who feel *both* loss and benefit? Assume that for every woman who is mostly helped by easy access to abortion, another woman is mostly hurt, two women experience both harm and benefit, and four human fetuses are aborted. By what measure can we honestly call this progress?

Clearly, those who support abortion as a necessary and efficacious treatment for problem pregnancies have a duty to protect women who are most likely to be injured by abortion and women who are being pressured into violating their consciences. In addition, the accessibility of abortion in the future may depend on the ability of abortion proponents to document characteristics and circumstances in which abortion is most probably beneficial to the lives of women. This challenge to abortion proponents has been well articulated by Philip Ney:

We should remember that in the science of medicine, the onus of proof lies with those who perform or support any medical or surgical procedure to show beyond reasonable doubt that the procedure is both safe and therapeutic. There are no proven psychiatric indications for abortion. The best evidence shows abortion is contraindicated in major psychiatric illness. There is no good evidence that abortion is therapeutic for any medical conditions with possible rare exceptions. In fact, there are no proven medical, psychological, or social benefits. . . . If abortion was a drug or any other surgical procedure about which so many doubts have been raised regarding its safety and therapeutic effectiveness, it would have been taken off the market long ago.¹⁴¹

In short, proper screening is necessary to achieve two ends: reducing negative outcomes, and increasing positive benefits. With regard to the latter end, since abortion is sought for a wide variety of reasons, it would seem essential to know in which cases abortion best fulfills the hopes and expectations of patients. Are women who seek abortions because of relationship problems likely to report that their relationships were improved, hindered, or unaffected? Are women

141. Philip G. Ney, *Some Real Issues Surrounding Abortion, or, the Current Practice of Abortion is Unscientific*, 4 J. CLINICAL ETHICS 179, 180 (1993).

who abort to protect their educational or career plans more likely to finish school or advance in their careers than women who carry to term and resume their education or career at a later date? Do women who abort in order to avoid embarrassing themselves or their families achieve higher levels of emotional security or family harmony?

Just as the risks of abortion vary by the characteristics of the individual, it is likely that research into any benefits that may be attached to abortion would also indicate that these benefits are most likely to be attained in certain situations or for women meeting certain physical and psychosocial criteria. In the absence of such research demonstrating in which types of cases abortion produces beneficial results, it is difficult to understand how physicians can fulfill their obligation to give women considering abortions sound medical advice, which is generally assumed to mean advice based on validated, scientific evidence.¹⁴² Until this research is done, proper screening for known and suspected risk factors is even more important to safeguard patients' health. In short, abortion without screening is the antithesis of medicine.

Those who promote abortion as a means of achieving social goals, such as reducing population growth, may feel frustrated by the argument that an appraisal of each woman's risks and benefits should determine when an abortion is recommended, discouraged, or even refused. Abortion on request, without regard to its long-term effects on women's lives, may indeed be preferable if one's goal is simply to reduce population growth. Abortion on request, as we have seen, is a double-edged sword. It can give women greater freedom to control their own bodies, but it can also be used by those who would pressure women into unwanted, unnecessary, or dangerous abortions.

Others may object to the idea that doctors should ever be allowed to refuse a woman an abortion that they believe is medically contraindicated. The woman, they might argue, is entitled to make her own decision without regard to a physician's recommendations. Even if it is an ill-advised decision, she has a right to make it and to suffer the consequences. But this argument, if taken to its logical end, would destroy all the ethical and legal obligations of physicians to their patients. If physicians retreat from their role of being responsible for their medical decisions, adopting the obedient posture of slaves or concentration camp guards who simply "follow orders," all semblances of medical ethics, as we understand it today, will be completely

142. David A. Grimes et al., *Teaching Critical Appraisal To Medical Students In Obstetrics And Gynecology*, 92 *OBSTETRICS & GYNECOLOGY* 877 (1998).

destroyed. The medical ethic “first, do no harm” should not be discarded simply because a woman is asking for an abortion.

Some have argued that women will suffer terrible injuries if they are denied abortion.¹⁴³ While these arguments are generally directed against state prohibitions of abortion, the same arguments would no doubt be levied against physicians who refused to perform abortions based on the opinion that the requested abortions may cause more harm than good. As suggested throughout this paper, I believe the claim that women will be harmed by denial of abortion, especially if they are at higher risk of adverse complications, is an ideological assertion that is not supported by any substantial research. Human beings are remarkably resilient in adjusting to the presence of their children. In fact, research has shown that women who have been denied abortion will frequently claim in retrospect that they never really wanted an abortion in the first place and that they are happy that their children were born.¹⁴⁴ It was perhaps for this very reason that Aleck Bourne (whose trial for an illegal abortion in 1938 sparked the trend toward the liberalization of abortion laws in Britain, if not the world) expressed his opposition to legalized abortion in a 1967 interview, saying, “Abortion on demand would be a calamity for womanhood. . . . I’ve had so many women coming to my surgery and pleading with me to end their pregnancies and being very upset when I have refused. But I have never known a woman who, when the baby was born, was not overjoyed that I had not killed it.”¹⁴⁵

In summary, it should never be presumed that abortion automatically confers benefit upon women. It certainly changes the courses of their lives, as does childbirth, but it has never been scientifically established when, if ever, the change is likely to be beneficial. Conversely, there are well-established risk factors that predict negative outcomes from abortion. Abortion is associated with

143. Nancy F. Russo et al., *U.S. Abortion in Context: Selected Characteristics and Motivations of Women Seeking Abortion*, 48 J. SOC. ISSUES 183 (1992).

144. See BORN UNWANTED: DEVELOPMENTAL EFFECTS OF DENIED ABORTION (H.P. David et al. eds., 1988). Research also shows that the affection women have for their children does not appreciably differ with regard to wantedness of the pregnancy or even if an abortion had been sought. P.Cameron et al., How much do mothers love their children? (May 12, 1972) (unpublished manuscript presented to Rocky Mountain Psychological Association, Albuquerque, N.M.), cited in P. Cameron & J.C. Tischener, *The Swedish ‘Children Born to Women Denied Abortion’ Study: A Radical Criticism*, 39 PSYCHOL. REP. 391 (1976).

145. Valentine Low, *The Rape that Really Changed Our Minds about Abortion*, in EVENING STANDARD (London), Feb. 28, 1992, at 20 (Interview with Aleck Bourne originally published in the LONDON EXPRESS).

subsequent increased rates of suicide,¹⁴⁶ substance abuse,¹⁴⁷ and psychiatric hospitalization.¹⁴⁸ While only a minority of women may suffer from these extreme reactions, they are not inconsequential.

The failure to screen women and inform them of known risk factors is an act of negligence. More worrisome still, in some cases, is that the failure to screen may be the result of a deliberate effort to promote financial or social interests that are in conflict with the well-being of the individual woman. Whatever the reason, women are ill-served by physicians and other abortion providers who fail to fulfill their ethical and legal duties in regard to pre-abortion screening and counseling.

LEGAL OBLIGATIONS REGARDING SCREENING AND DISCLOSURE¹⁴⁹

The duty to screen for risk factors arises primarily out of the physician's fiduciary responsibility to apply his best medical judgment to each woman's individual case.¹⁵⁰ The fact that a woman requests an elective abortion does not free the physician from this obligation. Indeed, the fact that the physician agrees to accept the woman as a patient establishes the ethical duty, and arguably the legal duty, to protect her from foreseeable injuries, and the proper exercise of this duty necessarily requires screening for known risk factors. In this

146. Gissler et al., *supra* note 7, at 1431; *see also* Christopher Morgan et al., *Mental Health May Deteriorate as a Direct Effect of Induced Abortion*, 314 BRIT. MED. J. 902 (1997).

147. David C. Reardon and Philip G. Ney, *Abortion and Subsequent Substance Abuse*, 26 AM. J. DRUG & ALCOHOL ABUSE 61, 61-75 (2000).

148. H. David et al., *Postpartum and Postabortion Psychotic Reactions*, 13 FAM. PLAN. PERSP. 88, 88-91 (1981); Cogle et al., *supra* note 4, at 47.

149. Assistance in the preparation of the legal analysis in this section was provided by Thomas W. Strahan, J.D.

150.

Virtually every course of medical action is associated with some adverse risk to the patient. Discussing these risks with patients is a fundamental duty of physicians both to fulfill a role as trusted adviser and to promote the ethical principle of autonomy (particularly as embodied in the doctrine of informed consent).

Sidney T. Bogardus et al., *Perils, Pitfalls, and Possibilities in Talking About Medical Risk*, J. 281 AM. MED. ASS'N 1037, 1037-1041 (1999). These authors would appear to agree with my premise in this section that the obligation to inform patients arises from two fundamental principles, (1) the requirement that the physician fulfills his obligation to provide the best advise to the patient, and (2) the need for patients to sufficiently informed enough about the basis for the medical recommendation that their consent, if given, is meaningful.

section, we will examine several legal theories that may be used to recover damages arising from negligent screening.

The duty of a medical doctor to screen for psychological risk factors may be found in the doctrine of informed consent. Specific informed consent requirements applicable to informed consent vary from state to state. Generally, every state has either case law or statutes requiring informed consent for medical procedures. In some states, such as Minnesota, there is a cause of action for negligent non-disclosure. Some states have also enacted statutes specifically requiring informed consent prior to abortion.

The necessity of informed consent prior to induced abortion was recognized by the U.S. Supreme Court. In *Planned Parenthood v. Danforth*, decided in 1976, the Court upheld a state statute requiring informed consent in the first trimester of pregnancy prior to abortion. The Court said, “The decision to abort is often a stressful one, and it is desirable and imperative that it be made with *full knowledge* of its nature and consequences.”¹⁵¹ Later, in *City Akron v. Akron Center for Reproductive Health*, the Court found that “the validity of an informed consent requirement rests on the State’s interest in protecting the health of the pregnant woman and thus the state legitimately may seek to ensure that it has been made in the light of all attendant circumstances — *psychological and emotional* as well as physical — that might be relevant to the well-being of the patient.”¹⁵²

Screening for the particular risk factors of each individual is required if individualized counseling of those considering abortion is to occur. The Supreme Court has recognized the need for individualized abortion counseling. In *Akron Center for Reproductive Health*, decided in 1983, the Court struck down a city ordinance related to informed consent on the grounds that the mandated disclosure did not provide sufficient leeway for individual differences and circumstances, stating, “[I]t remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending upon her particular circumstances.”¹⁵³ The American Psychological Association (APA) also takes the position that individualized counseling is required prior to an abortion. In an Amicus Brief filed in *Planned Parenthood v. Casey*, the APA stated, “Pregnant women approach the possibility of abortion with widely

151. 428 U.S. 52, 66 (1976) (emphasis added).

152. 462 U.S. 416, 443 (1983) (citing *Colautti v. Franklin*, 439 U.S. 379, 394 (1979)) (emphasis added).

153. 462 U.S. at 443; *see also Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 762 (1986).

varying backgrounds, attitudes, levels of knowledge and familial and social support systems. To be effective, the *content* of the counseling must be tailored to those individual differences and needs.”¹⁵⁴ The scope of the subjects to be included in abortion screening and counseling must be considered in a framework which utilizes the broad definition of health as set forth in *Doe v. Bolton*, where the U.S. Supreme Court stated that “medical judgment may be exercised in the light of all factors - physical, *emotional, psychological*, familial, and the woman’s age - relevant to [her] well-being”¹⁵⁵ Since risks may vary substantially with respect to individual risk factors, it is clearly impossible for a physician to provide an adequate disclosure of risks without conducting a prior screening for all the risk factors that have been identified in statistically validated studies. Only after proper screening can the attending physician explain the risks that are most relevant to an individual given her specific history and circumstance.

Various theories have been utilized by the courts in an attempt to define and apply the duty of disclosure by the medical doctor to the patient prior to performing a medical procedure. Among the various possibilities is a duty of disclosure measured by the patient’s need to know the material information in order to accept or reject a proposed treatment. This approach to disclosure was adopted in the landmark cases of *Cobbs v. Grant*¹⁵⁶ and *Canterbury v. Spence*,¹⁵⁷ both decided in 1972, whose concepts, at least in part, have since been adopted in the state court decisions of many states.. In *Canterbury*, the court stated that this disclosure requirement springs from three axiomatic considerations:

[E]very human being of adult years . . . has a right to determine what shall be done with his own body . . . [;] [t]rue consent to what happens to one’s self is the informed exercise of a choice, and that entails . . . an opportunity to evaluate knowledgeably the options available and the risks attendant upon each . . . [;] (and that) [t]he average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look to for enlightenment with which to reach an intelligent decision.¹⁵⁸

154. Brief of Amicus Curiae American Psychological Association at 24, *Planned Parenthood S.E. Pa. v. Casey*, 947 U.S. 682 (1991) (No.91-744 and 91-902).

155. *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

156. *Cobbs v. Grant*, 502 P.2d 1, 9-10 (Cal. 1972).

157. *Canterbury*, 464 F.2d at 780; Laurent B. Frantz, Annotation, *Physicians Duty to Inform of Risks*, 88 A.L.R 3d 1008 (2004).

158. *Canterbury*, 464 F.2d at 780.

Because of respect for the patient's right of self-determination, the standard is set by law rather than the community of physicians regulating themselves.¹⁵⁹

In the abortion context, the duty of disclosure is measured by the pregnant woman's need for information that is material in order to decide whether or not to undergo the abortion because the right to abortion is based on the right of the woman to self-determination.¹⁶⁰ Moreover, as the Supreme Court has declared in the context of its constitutional rulings on abortion that women have a right to "full knowledge" of the risks associated with abortion,¹⁶¹ it is arguable that a patient-centered right to full disclosure supercedes any state rule that might otherwise allow a lower standard of disclosure, such as the community standard defined by abortion practitioners.¹⁶²

Among the abortion-related cases where negligent counseling or non-disclosure claims have been raised, a Louisiana court held in *Reynier v. Delta Women's Clinic, Inc.*¹⁶³ that an abortion facility was not liable on a theory of lack of informed consent where there was no showing that the pregnant woman would not have obtained the abortion if the risk were known.¹⁶⁴ In this case, a woman suffered excessive bleeding from a perforated uterus that required a hysterectomy.¹⁶⁵ The woman was given certain follow-up instructions that included what to do if there was excessive bleeding following her abortion.¹⁶⁶ The woman claimed that the instructions gave misleading information regarding going on a trip and when to contact the doctor.¹⁶⁷ Although there was evidence that the instructions were poorly written, the court held that there was not a causal connection shown between the misleading information and the injury.¹⁶⁸ Further, although the doctor must reveal all risks that would reasonably tend to affect the patient's decision, the patient must show that she was in fact

159. *Id.* at 784.

160. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67 (1976).

161. *Id.*

162. Joseph W. Stuart, *Abortion and Informed Consent: A Cause of Action*, 14 OHIO N.U. L. REV. 1, 8 (1987). This opinion is not held, however, in a more recent review: *contra* Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639, 667 (1996).

163. *Reynier v. Delta Women's Clinic, Inc.*, 359 So. 2d 733 (La. Ct. App. 1978).

164. *Id.* at 738.

165. *Id.* at 736-37.

166. *Id.* at 734-35.

167. *Id.* at 736-37.

168. *Reynier*, 359 So.2d at 736-37.

uninformed of the risk and that a disclosure of the risk to her would have resulted in a decision against surgery.¹⁶⁹ Because the patient had not done so, she failed to recover based on a theory of lack of informed consent.¹⁷⁰

In *Baker v. Gordon*,¹⁷¹ a Missouri case decided in 1988, a patient brought a malpractice action against a medical doctor based upon the doctor's negligent recommendation for an abortion.¹⁷² The medical doctor had performed a pap smear which suggested the possible presence of malignant cells.¹⁷³ The medical doctor told the patient, who was pregnant, that the cells were on the verge of becoming invasive cancer.¹⁷⁴ The doctor claimed that if the baby were carried to term there could be a chance of the cells becoming invasive, and for this reason an abortion should be performed as soon as possible.¹⁷⁵ Based upon the doctor's advice and recommendation, the patient had an abortion.¹⁷⁶ Another pap smear done at the time of the abortion, however, was normal.¹⁷⁷ The patient testified that, based upon communications with the doctor, she felt obligated to have an abortion.¹⁷⁸ She also testified that she would not have had the abortion if the doctor had not recommended it.¹⁷⁹ In addition, she testified to a variety of emotional problems following the abortion as well as hospitalization for post-partum depression following the birth of a subsequent child.¹⁸⁰ She had not consulted either a licensed psychologist or psychiatrist.¹⁸¹ The court did not apply a patient-centered standard based upon whether or not the information was material to her decision. Instead, the court found that the patient had failed to show that the care provided to her by the physician was of a lesser standard than the level of care used by other doctors in similar situations.¹⁸²

169. *Id.* at 737-738.

170. *Id.* at 738.

171. *Baker v. Gordon*, 759 S.W.2d 87 (Mo. Ct. App. 1988).

172. *Id.* at 88-89.

173. *Id.*

174. *Id.* at 89.

175. *Id.*

176. *Baker*, 759 S.W.2d at 89.

177. *Id.* at 90.

178. *Id.* at 89.

179. *Id.*

180. *Id.* at 90.

181. *Baker*, 759 S.W.2d at 90.

182. *Id.* at 94.

Recovery for negligent infliction of emotional distress, in the context of induced abortion in the absence of physical injury, has been allowed where the physician has delivered negligent counseling or diagnosis.¹⁸³ The leading case is *Martinez v. Long Island Jewish Hillside Medical Center*.¹⁸⁴ In this case, a pregnant woman had been misinformed by her obstetrician that “massive doses” of a steroid she had taken would cause her unborn child severe brain damage, that the child would be unable to breathe without machines, and would have to be permanently institutionalized.¹⁸⁵ Despite the patient’s strong religious beliefs that abortion was a sin, she was ultimately persuaded to undergo an abortion.¹⁸⁶ Subsequently, it was determined that, in fact, she had taken a much lower drug dosage that was not likely to have harmed the unborn child.¹⁸⁷ The woman suffered severe mental anguish and depression and recovered for emotional injuries based upon the medical malpractice of the facility.¹⁸⁸ The court held that where there was a special likelihood of genuine and serious emotional distress, the consequences were foreseeable that it would have a serious psychological impact on the woman.¹⁸⁹ It further held that the serious psychological effects were the direct result of the medical center’s breach of a duty owed directly to the patient when they gave her erroneous advice on which she affirmatively acted in deciding to have the abortion.¹⁹⁰

There appears to be a trend away from requiring a manifest physical injury in order to recover for emotional distress and pain and suffering. States such as New York¹⁹¹ and California¹⁹² do not require physical

183. *Martinez v. Long Island Jewish Hillside Medical Center*, 512 N.E.2d 538-39 (N.Y. 1987), *aff’d* 519 N.Y.S.2d 53 (N.Y.App.Div. 1987).

184. *Id.*

185. *Id.* at 538.

186. *Id.*

187. *Id.*

188. *Martinez*, 512 N.E.2d at 538.

189. *Id.* at 539.

190. *Id.*

191. *Id.* (holding no physical injury is required where there was a special likelihood of genuine and serious emotional distress); *see also* *Ferrara v. Bernstein*, 613 N.E.2d 542, 543 (N.Y. 1993) (noting that where plaintiff’s pain emanated from negligent abortion services, specifically the failure to notify her of her incomplete abortion and the failure to secure her prompt return to the facility, there may be recovery for a claim of negligent infliction of emotional distress).

192. *Palm v. United States*, 835 F.Supp. 512, 519 (N.D. Cal 1993) (*citing In re Air Crash Disaster Near Cerritos, Cal.*, Aug. 31, 1986, 973 F.2d 1490, 1493 (9th Cir. 1992) (noting that California recognizes a claim for negligent infliction of

injury in order to recover for negligent infliction of emotional distress. A North Carolina court held that severe abdominal pain is considered a foreseeable physical injury justifying a conclusion that defendant's negligent conduct was the proximate cause of the mental anguish,¹⁹³ and a Kentucky court held that exposure to x-rays is a sufficient manifest physical injury to recover for mental suffering.¹⁹⁴ In Alabama, an action can be brought if there is a breach of an implied contract or consensual relationship that causes emotional distress.¹⁹⁵ An Iowa court held that medical professionals have a duty to provide ordinary care to avoid causing emotional harm to patients.¹⁹⁶

Negligent counseling has been held to be actionable in the context of abortion.¹⁹⁷ In *Johnson v. United States*,¹⁹⁸ a suit was allowed under the Federal Tort Claims Act where a female member of the U.S. Army donated blood at a military hospital blood drive.¹⁹⁹ She was informed that she had HIV and that the baby she was carrying would be born with AIDS.²⁰⁰ Based on that information, she had an abortion.²⁰¹ A later test showed she did not have HIV.²⁰² She was permitted to sue based upon a theory of negligent advice.²⁰³ In *Cole v. Delaware League for Planned Parenthood*,²⁰⁴ the plaintiff, a minor, claimed that she was rendered sterile as a result of an abortion at the defendant's facility.²⁰⁵ The plaintiff argued that the defendant's employee, who was neither a nurse nor a physician, gratuitously assumed a fiduciary duty to counsel the plaintiff.²⁰⁶ The employee was alleged to have breached that duty

emotional distress under circumstances where a person is in the path of negligent conduct and reasonably fears for his safety); *see also* *Jacoves v. United Merch. Corp.* 11, Cal. Rptr. 2d 468, 480 (Cal. Ct. App. 1992).

193. *Ledford v. Martin*, 359 S.E.2d 505, 507 (N.C. Ct. App. 1987).

194. *Deutsch v. Shein*, 597 S.W.2d 141, 146 (Ky. 1980).

195. *Taylor v. Baptist Medical Center*, 400 So.2d 369, 374 (Ala. 1981).

196. *Oswald v. LeGrand*, 453 N.W.2d 634, 639 (Iowa 1990).

197. *Johnson v. United States*, 810 F. Supp. 7 (D. D.C. 1993) (rejecting *Feres* doctrine by allowing plaintiff, a member of the military, to sue for negligent advice).

198. *Id.*

199. *Id.*

200. *Id.* at 8.

201. *Id.*

202. *Johnson*, 810 F. Supp. at 8.

203. *Id.* at 9.

204. 530 A.2d 1119 (Del. 1987).

205. *Id.* at 1120.

206. *Id.* at 1121.

by failing to inform the plaintiff of alternatives to abortion, risks of abortion, biological information regarding the development of the unborn child, and possible long term complications.²⁰⁷ The case was remanded to the trial court to determine whether the case had been brought before the expiration of the applicable statute of limitations.²⁰⁸

Other abortion-related cases have allowed recovery for negligent diagnosis that sets in motion a chain of circumstances resulting in abortion. An example is *Deutsch v. Shein*,²⁰⁹ a Kentucky case where the plaintiff decided to terminate her pregnancy by abortion after a medical doctor exposed her to diagnostic x-rays while she was pregnant and without testing her for pregnancy beforehand.²¹⁰ Prior to deciding to have an abortion, the plaintiff had seen various articles which stated that x-rays administered to a pregnant woman could injure the fetus.²¹¹ She also consulted a pediatrician who stated that abortion was “medically indicated” but refused to advise her as to whether or not to have an abortion.²¹² The plaintiff also discussed the situation with her family and priest.²¹³ The Kentucky Supreme Court held that the act of exposing the woman to x-rays was a sufficient physical contact to support a claim for mental suffering.²¹⁴ The case was remanded to the trial court for a retrial on the issue of damages for physical and mental pain and suffering.²¹⁵

Repeatedly urging that a woman obtain an unnecessary abortion has been held to be actionable as intentional infliction of emotional distress.²¹⁶ In *Wall v. Pecaro*,²¹⁷ a pregnant woman sought treatment from a medical doctor regarding a tumorous growth in her mouth.²¹⁸ According to the complaint, the medical doctor urgently and repeatedly recommended not only the surgical removal of some of the internal structure and tissues in the patient’s head, but also the abortion of her five-and-a-half month old unborn child.²¹⁹ The doctor

207. *Id.*

208. *Id.* at 1126.

209. 597 S.W.2d 141 (Ky. 1980).

210. *Id.* at 43.

211. *Id.*

212. *Id.*

213. *Id.*

214. *Deutsch*, 597 S.W.2d at 146.

215. *Id.* at 147.

216. *Wall v. Pecaro*, 561 N.E.2d 1084, 1088 (Ill. App. Ct. 1991).

217. *Id.* at 1085.

218. *Id.*

219. *Id.*

allegedly told the woman several times even after the termination of their medical relationship that if she failed to undergo these procedures, her cancer would spread rapidly.²²⁰ An appellate court in Illinois held that she had stated a cause of action for intentional infliction of emotional distress, although yet unproven, and remanded the case to the trial court.²²¹

Analysis of prior law indicates that there are a number of possible legal theories which could allow recovery for psychological injuries associated with an abortion following a failure to screen for known risk factors prior to a woman undergoing an abortion. These include violation of informed consent for failing to provide material information necessary to make an informed decision, negligent counseling or negligent non-disclosure, negligent advice, breach of an implied contract or consensual relationship, and negligent or intentional infliction of emotional distress.

The physician's duty to carefully consider requests for abortion is further complicated by the fact that several jurisdictions have recognized that once a physician establishes a doctor-patient relationship with a pregnant woman, he also enters into an independent doctor-patient relationship with her unborn child, at least "to the extent a pregnant woman desires to continue her pregnancy and deliver a healthy baby at its conclusion."²²² As we have seen, many

220. *Id.*

221. *Wall*, 561 N.E.2d at 1089.

222. *Nold v. Binyon*, 31 P. 3d 274, 286 (Kan. 2001). A more complete quote from this decision is worthy of consideration:

To the extent a pregnant woman desires to continue her pregnancy and deliver a healthy baby at its conclusion, her interest in receiving adequate health care is inevitably intertwined with any interest or potential interest of her fetus. In such a situation, the patient cannot be separated from her pregnancy nor her pregnancy from herself. We need not look beyond this incomparable relationship that is the genesis of the human condition. The mother who wishes to carry her pregnancy to term looks to her physician to guide her through her pregnancy, with the ultimate goal of the delivery of a healthy infant. Childbirth involves a universally recognized unique relationship between mother and child. Other jurisdictions have recognized the relationship between a physician and a pregnant patient and her fetus.

See *Hughson v. St. Francis Hosp.*, 459 N.Y.S.2d 814, 816 (1983) (finding "[I]t is now beyond dispute that in the case of negligence resulting in prenatal injuries, both the mother and the child in utero may each be directly injured and are each owed a duty, independent of the other"); *Wheeler v. Yettie Kersting Memorial Hosp.*, 866 S.W.2d 32, 44 n.16 (Tex. App. 1993) ("[N]oting that the scope of the

women requesting abortions actually desire to carry their pregnancies to term. If any such desire does exist, it would seem that the physician would then have a duty, to both the woman and her unborn child, to concentrate his efforts on making it easier for her to deliver a healthy child. Screening a woman to identify any explicit, or even unstated, desire to carry her pregnancy to term is therefore necessary not only to identify an important risk factor for subsequent dissatisfaction and mental health problems but also to determine the extent, if any, of the physician's doctor-patient relationship with the unborn child. For the sake of retaining the focus of this section on the obligations of the physician to the woman herself, however, the implications of this line of reasoning are relegated to a footnote.²²³

duty owed by a treating physician to a pregnant woman extends to the fetus and includes a duty to avoid injury to the fetus and the emotional distress that would result to the mother from such an injury.”).

See generally Burgess v. Superior Court, 831 P. 2d 1197 (Ca. 1992).

223. If we accept the Kansas Supreme Court's view that this duty to the unborn patient varies with the intent of the pregnant mother, how might this duty be affected by her ambivalence? Does the physician's duty to the child fade on and off with every wave of sentiment? Or is the doctor-patient relationship with the unborn child created as soon as the woman expresses any desire (intent) to carry the child to term? If the latter is true, then the doctor's obligation to the unborn child, which is brought into existence by the woman's desire for the child, even if ambivalent and fleeting, would obligate the doctor to refrain from recommending abortion since it is an option that is guaranteed to be fatal for at least one of his patients.

I would argue for the latter view because the medical precept “first, do no harm” would suggest that the physician should not interfere in a woman's ambivalence in such a way as would tilt her toward choosing an abortion, which would be fatal to his second patient, the unborn child. In addition, I believe that physicians, and the law, should have a preference for life. Even if abortion is made legal as an option, it should not be promoted. Therefore, under the logic of the Kansas Supreme Court ruling, I would argue that until a woman clearly, and independently from the physician, declares her intent to abort, and the physician has confirmed that this declaration is made without any uncertainty or reservation, the physician is obligated to be an advocate for options that will not harm the second patient, the unborn child. Only after her intent to abort is unambiguous and clear might the physician be freed from his doctor-patient relationship with the unborn child. Even at this point, however, the doctor is clearly not free of any legal obligations that may preclude the abortion. Screening of the woman may reveal risk factors that make abortion contraindicated. Informed consent obligations may also result in a reversal of the woman's intent, or at least her certainty of intent, and therefore give rise to a restoration of the physician's obligation to be an advocate for the unborn child.

CONSTITUTIONAL QUESTIONS REGARDING THE ABORTION LIBERTY
VS THE DUTY TO SCREEN

Numerous battles have been waged in American courts to define the degree to which states may regulate abortion. The central issues at hand are the State's interest in protecting the health of women and potential human lives versus the liberty of doctors to practice medicine according to their best medical judgment²²⁴ and the liberty of women to control their reproductive lives.²²⁵

In this paper, however, I have raised issues that have not been addressed by the Supreme Court which may have a direct bearing on the availability of abortion. These issues raise new questions regarding State intervention requiring screening for risk factors in the interest of protecting women's health. In this section, I will attempt to address some of the issues that are most likely to be raised.

First, for the most zealous defenders of abortion, the idea that doctors may have a right, or even a duty, to refuse to perform a contraindicated abortion may seem to conflict with a woman's "fundamental right to abortion." But as noted previously, the Supreme Court has repeatedly rejected an "absolute right" to abortion precisely because it is a medical procedure and involves certain health

This reasoning would also call into question the practice of genetic screening of unborn children when there is no known treatment for the defects for which tests are ordered. Pregnancies that are aborted due to suspected fetal anomalies are always cases where a doctor-patient relationship with the unborn child has been established. In most cases, the woman is clearly intending to bring the child to term. For a physician to recommend such tests when the only "treatment" is abortion is contrary to the interests of the second patient, the child. Furthermore, even if routine tests, such as sonograms, showed that the child had a likely defect, the physician's independent obligation to the unborn child would preclude him from recommending abortion. Indeed, I would argue that the doctor's duty to care for the unborn child would require him to counsel against abortion, at least until such time as the woman, independent of his influence, had determined that it was no longer her intent to carry the child to term.

224. "The [*Roe v. Wade*] 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." *Roe*, 410 U.S. at 165-166.

225. "The Court's holdings in *Roe . . .* and *Doe v. Bolton . . .* require that a State not create an absolute barrier to a woman's decision to have an abortion." *Maher v. Roe*, 432 U.S. 464, 481 (1977) (Burger, C.J., concurring). The concept of abortion as a woman's liberty is most thoroughly discussed in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

risks.²²⁶ More importantly, constitutional liberties may restrict the ability of the State to regulate abortion, but they do not impose a duty on a physician to provide a contraindicated procedure which would violate his best medical judgment, conscience, or both. It is inconceivable that the Supreme Court would mandate that physicians have a duty to perform dangerous abortions on women simply because women request them. By imposing the subservient model of medical decision-making on physicians,²²⁷ even in regard to just this one “treatment,” the Court would be laying a constitutional basis for physicians to be “subservient” in regard to all “treatment” demands. Conversely, it seems unlikely that the Court would entertain an argument from abortion providers that they have a constitutionally protected right to provide contraindicated abortions—particularly without informing the woman of her heightened risks.

The issue of risk factors does not provide a direct means for the State to limit women’s access to abortion. The evaluation of risk factors and determination that an abortion for a particular woman is contraindicated is a medical task. It does seem reasonable, however, that the State might require physicians to screen for psychological risk factors because of the State’s interest in protecting women’s health.²²⁸ The goal of protecting women from psychological injuries resulting from abortion is heightened by the fact that many women seek abortion primarily in the hope of obtaining psychological benefits. In that regard, the psychological outcome may be the most pertinent to women. In short, if abortion is sought and recommended for psychosocial reasons, it seems obvious that screening should encompass a psychosocial risk/benefit analysis.

The determination of how many risk factors must be present before an abortion is contraindicated is a question of medical judgment. Additional research and expert consensus might be able to establish

226. “Some *amici* argue that the woman’s right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.” *Roe*, 410 U.S. at 153. “The privacy right involved, therefore, cannot be said to be absolute The Court has refused to recognize an unlimited right of this kind in the past.” *Roe*, 410 U.S. at 154. “Even an adult woman’s right to an abortion is not unqualified.” *Matheson*, 450 U.S. at 419 (Powell, J., and Stewart, J., concurring); see *Danforth*, 428 U.S. at 60; see *Casey*, 505 U.S. at 709.

227. Morss, *A Fourth Model*, *supra* note 84.

228. *Roe*, 410 U.S. at 162. “We repeat, however, that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the State or a nonresident who seeks medical consultation and treatment there”

some objective standard for determining when identified risk factors merely identify heightened risks versus a contraindication for abortion. However, without such a consensus, which does not currently exist, any attempt by a State to define precisely when an abortion is “contraindicated” would almost certainly be rejected by the courts as interference in the rights of physicians to use their own best medical judgment.

State mandates requiring screening may also be problematic if they include legal sanctions against the physician. At the very least, the threats of fines, loss of license, or even criminal penalties provide a basis for legal challenges on the part of physicians against the State. Interference by the State would be minimized if the State limited itself to defining the appropriate standard of care, at least in regard to screening, in a statute. The only enforcement mechanism of such a statute would be through civil liability, but it would have the effect of giving physicians adequate notice of the screening standard that would be applied in civil cases, and give plaintiffs the benefit of not having to prove what the standard of care should be. Such legislation has been introduced in Mississippi.²²⁹ While the bill died in committee, it is

229. The Mississippi Protection from High Risk and Coercive Abortion Act defines a requirement for screening as follows:

Except in the case of a medical emergency, in addition to whatever requirements exist under the common or statutory law of this state consent to abortion is informed, voluntary and free from negligent and unnecessary exposure to risks if and only if all of the following are true:

(a) Before the physician recommends or performs an abortion, a qualified person has evaluated the woman to identify the presence of any known or suspected risk factors and informed her and the physician, in writing, of the results of this evaluation. This screening for risk factors shall normally include, but not be limited to, the following: gonorrhea or chlamydia infection; a family history of breast cancer; prior history of gestational trophoblastic tumor; history of caesarean section; a history of prior abortion; adolescence; feelings of being pressured to have the abortion; feelings of emotional attachment to the unborn child; a history of prior psychological illness or emotional instability; lack of support from the partner or parents; moral or religious convictions against abortion; a second or third-trimester pregnancy; low expectations of coping well.

(b) In the event that any risk factors were identified, the patient has been fully informed by a qualified person which risk factors exist, why these risk factors may lead to adverse reactions, and a detailed explanation of what adverse reactions may occur. This explanation shall include quantifiable risk rates whenever relevant data exists in

likely to resurface in the same or similar forms in Mississippi and other states. While the Mississippi bill would have defined inadequate screening to be an act of negligence, Missouri recently passed an amendment to its Woman's Right to Know law that would require screening and counseling regarding risk factors as a part of the required informed consent process.²³⁰ By relying purely on civil

the detail that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(c) In the event that any risk factors were identified, the qualified person who has provided the screening and counseling provided a written statement to the patient and the physician certifying, to the best of the qualified person's knowledge, that the patient fully understands and appreciates the significance of the risk factors discussed and her increased exposure to the related adverse reactions.

The risk factors and related reactions shall be listed in this certificate.

H.R. 1513, 2000 Reg. Sess. (Ms. 2000).

Additional sections of the bill require malpractice insurance, extend the statute of limitations, and make other provisions governing civil remedies.. To avoid conflict with existing informed consent statutes, the introductory paragraph of this model language could be amended to state: "Except in the case of a medical emergency, in addition to whatever requirements exist under the common or statutory law of this state, it is an act of medical negligence to perform an abortion unless all the following are true."

230. See MO. REV. STAT. §188.039 (2003).

2. Except in the case of medical emergency, no person shall perform or induce an abortion unless at least twenty-four hours prior thereto, a treating physician has conferred with the patient and *discussed with her the indicators and contra-indicators, and risk factors, including any physical, psychological, or situational factors for the proposed procedure and the use of medications, including but not limited to mifepristone, in light of her medical history and medical condition.* For an abortion performed or an abortion induced by a drug or drugs, such conference shall take place at least twenty-four hours prior to the writing or communication of the first prescription for such drug or drugs in connection with inducing an abortion. Only one such conference shall be required for each abortion.

3. The patient shall be evaluated by a treating physician during the conference for indicators and contraindicators, risk factors, including any physical, psychological, or situational factors which would predispose the patient to or increase the risk of experiencing one or more adverse physical, emotional, or other health reactions to the proposed procedure or drug or drugs in

liability as the enforcement mechanism, states may effectively protect the health interests of women without raising any constitutional issues regarding state regulation of abortion.²³¹ While abortion providers who neglect to do proper screening would technically be free to do so, civil liability would provide a powerful incentive for proper screening and better informed medical recommendations. The effect of proper liability would be to draw the standard of care used in practice more closely to the high standard that is proposed in theory.

RECOMMENDATIONS

Physicians and mental health professionals who counsel women in crisis pregnancies should be familiar with the predictive risk factors reported in the literature. Women faced with crisis pregnancies have every reason to expect that professional counselors will be aware of this information whenever they engage in crisis pregnancy counseling. Therapists should be especially alert for patients who are seeking their therapist's "approval" of a decision to abort. Women who are morally conflicted over an abortion choice frequently turn to authority figures, such as therapists, school counselors, or religious figures. This need for approval may suggest a deeply rooted ambivalence. In such cases, the woman may be seeking either a "blessing" upon a decision to "bend" her moral beliefs or, conversely, encouragement to follow her "emotional" desire to protect the pregnancy despite all the "rational reasons" to abort. To provide such a "blessing" without screening for known risk factors may make the therapist liable for negligent advice. Physicians who recommend or perform abortions without prior adequate screening are particularly negligent.

either the short or long term as compared with women who do not possess such risk factors.

4. At the end of the conference, and if the woman chooses to proceed with the abortion, a treating physician shall sign and shall cause the patient to sign a written statement that the woman gave her informed consent freely and without coercion *after the physician had discussed with her the indicators and contraindicators, and risk factors, including any physical, psychological, or situational factors.* All such executed statements shall be maintained as part of the patient's medical file, subject to the confidentiality laws and rules of this state.

(Emphasis added).

231. *Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001).

Attorneys representing women who have suffered injuries related to an abortion should examine causes of action not only related to informed consent but also negligent screening and the failure to form and provide an informed medical recommendation. Exploration of these issues will reveal, at least in some cases, that the attending physician was treating the woman as a customer rather than a client and thereby failed to comply with even his most fundamental obligations to protect her well-being.

The health of women would be better protected by the passage of statutes that would clarify the standard of care applicable in cases of abortion. Such statutes should include a provision defining the failure to screen women for risk factors that are significantly associated with negative reactions after abortion as an act of negligence. As psychological injuries associated with abortion may impede an injured woman's ability to bring a lawsuit within the normal period allowed by law, consideration should be given to extending the statute of limitations for abortion-related injuries to some reasonable period after a woman has recovered from those psychological injuries and is capable of effectively working with her counsel and enduring the emotional challenges of deposition and court-room testimony.

*Table 1. Percentages of women possessing identified risk factors and risk significantly associated with each risk factor as reported in a single study.**

Risk Factor	At three weeks post-abortion, women possessing the risk factor were at higher risk of more...	Percentage at Risk
Low Expectation of coping well	depression, negative mood (regret, sadness, guilt...), anticipated more severe negative reactions in future, more physical complaints	40%
Self Character Blame	depression, negative mood (regret, sadness, guilt...), anticipated more severe negative reactions in future, more physical complaints	47%
High Chance Blame	more negative mood (regret, sadness, guilt...)	52%
High Other Person Blame	anticipated more severe negative reactions in future	35%
High Situation Blame	Depression	50%
Greater intention to have become pregnant	Depression	12%
Higher evaluation of "this pregnancy as a meaningful experience."	physical complaints, and higher anticipation of more severe negative reactions in future	56%
Accompanied by Partner	depression, physical complaints	33%

*B. Major, P. Mueller, K. Hildebrandt, *Attributions, Expectations and Coping with Abortion*, 48 JOURNAL OF PERSONALITY AND SOCIAL PSYCHOLOGY, 585-599 (1985)

Table 2. Predisposing Risk Factors for Negative Psychological Reactions as Compiled by Three Authorities

<i>Planned Parenthood Federation of America</i> ²³²	<i>A Clinician's Guide to Medical and Surgical Abortion</i> ²³³	<i>Speckhard and Rue</i> ²³⁴
Adolescence		adolescence
emotional instability	existing or prior mental illness or disorder	prior emotional problems
	past childhood sexual abuse	unresolved traumatization
	unresolved past losses and perception of abortion as a loss	
	low self-esteem	low self-esteem
pressure or coercion to abort	perceived coercion	pressure or coercion to abort
lack of parental support	lack of emotional support and receiving criticism from significant people in their lives	lack of support from one's family of origin
lack of partner support		lack of relationship support and/or immature interpersonal relationships
unstable living conditions		
	commitment to the pregnancy	a maternal orientation

232. Planned Parenthood Federation of America, *Fact Sheet: The Emotional Effects of Induced Abortion* (PPFA Communications Division, FS-A4, revised 1993).

233. Anne Baker et al., *Informed Consent, Counseling, and Patient Preparation*, in *A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION*, Maureen Paul, et al., editors (1999).

234. Anne C. Speckhard & Vincent M. Rue, *Postabortion Syndrome: An Emerging Public Health Concern*, 48 J. SOC. ISSUES 95, 114 (1992)(citing Vincent M. Rue & Anne C. Speckhard, *Informed Consent and Abortion: Issues in Medicine and Counseling*, 6 MED. & MIND 75-94 (1992)).

<i>Planned Parenthood Federation of America</i>	<i>A Clinician's Guide to Medical and Surgical Abortion</i>	<i>Speckhard and Rue</i>
		prior children
diagnosis of a fetal malformation leading to abortion	diagnosis of a fetal malformation or other medical indication	diagnosis of a fetal malformation leading to abortion
late term abortion		late term abortion
		prior abortion
	significant ambivalence about decision	pre-abortion ambivalence
strong religious convictions against abortion	belief that fetus is the same as a 4-year-old and that abortion is murder	religious affiliation and religious conservatism
	guilt or shame prior to abortion	
low expectations for coping well after the abortion	expectations of depression, grief, guilt or regret after the abortion	
	usual coping style is repression or denial	
pregnancy as a result of failed contraception		
		biased pre-abortion counseling
	Experiencing social stigma and anti-abortion demonstrators	

Table 4: A model of the distribution of responsibility between a woman (W) and her doctor (D) in the five steps required to make a decision regarding the best course of treatment of an unintended pregnancy, and the relative amount of information necessary for disclosure, according to each of the four models of medical decision-making.

	Paternalistic Model	Shared Model	Informed Model	Subservient Model
Diagnosis of Problem	D	D	D	W
Knowledge of Treatment Risks and Benefits	D	D	D	W
Determination of Appropriate Treatment Options	D	D	D	W
Disclosure of Information About Treatment Options' Risks and Benefits	D	D	D	W
Final Selection of Treatment	D	W&D	W	W
Amount of Information Necessary to Disclose	Little	Enough	All	Little or none

APPENDIX

Table 3: Outline of Risk Factors Predictive of Greater Post-abortion Psychological Sequelae with Citations to Authorities

(Key for all citations: Normal type = Literature Review or Committee Reports; *Italicized* = *Clinical Experience, Soft Data, Expert Opinion*; **Bold - Statistically Validated Study.**)

* The citations in this table do not conform to bluebook rules.

I. CONFLICTED DECISION

A. Difficulty making the decision, ambivalence, unresolved doubts 1, 2, **3**, **10**, 13, **14**, 18, 23, **25**, **29**, **34**, 37, **38**, **40**, **46**, **49**, **52**, 53, 55, **56**, **57**, 61

1. Moral beliefs against abortion ⁶¹

a. Religious or conservative values 1, 2, **5**, 23, **34**, **39**, **40**, **48**, **49**, 54, **56**, **58**, **59**

b. Negative attitudes toward abortion 1, **8**, 27, **57**

c. Feelings of shame or social stigma attached to abortion 2, 61

d. Strong concerns about secrecy 50

2. Conflicting maternal desires 1, **29**, **30**, **33**, **34**, **46**, **51**

a. Originally wanted or planned pregnancy 1, 13, 23, 27, **29**, 53, **57**, **59**, 61

b. Abortion of wanted child due to fetal abnormalities **3**, **7**, 13, 18, **19**, 20, **26**, 27, **28**, 41, 61

c. Therapeutic abortion of wanted pregnancy due to maternal health risk **3**, 13, 15, 18, 20, **26**, 27, 37, 42, **49**, 54, 55, 61

d. Strong maternal orientation **34**, **48**

e. Being married 1, **10**

f. Prior children **25**, 48, 54, **58**, **60**

g. Failure to take contraceptive precautions, which may indicate an ambivalent desire to become pregnant **6**

h. Delay in seeking an abortion 1, 2, **26**

3. Second or third trimester abortion 1, 20, **26**, 27, **39**, 42, **49**

- 4. Low coping expectancy 1, 27, **29, 30**
- B. Feels pressured or coerced 13, 16, 18, 27, **34, 43, 45, 48, 49, 53, 51, 52, 55, 61**
 - 1. Feels decision is not her own, or is “her only choice” **14, 18**
 - 2. Feels pressured to choose too quickly **17, 24**
- C. Decision is made with biased, inaccurate, or inadequate information **17, 48, 49**

II. PSYCHOLOGICAL OR DEVELOPMENTAL LIMITATIONS

- A. Adolescence, emotional immaturity 1, 4, **9, 11, 15, 16, 17, 27, 29, 32, 33, 42, 48, 50, 54**
- B. Prior emotional or psychiatric problems **3, 5, 6, 13, 15, 18, 20, 22, 23, 25, 26, 34, 37, 40, 42, 47, 51, 54, 57, 61, 63**
 - 1. Poor use of psychological coping mechanisms 2, **29, 34, 61**
 - 2. Prior low self-image **33, 34, 43, 48, 52, 61, 63**
 - 3. Poor work pattern or dissatisfied with job **6, 52**
 - 4. Prior unresolved trauma or unresolved grief **48, 51**
 - 5. A history of sexual abuse or sexual assault. **23, 31, 51, 61**
 - 6. Blames pregnancy on her own character flaws, rather than on chance, others, or on correctable mistakes in behavior **29, 30, 36**
 - 7. Avoidance and denial prior to abortion **12, 27**
 - 8. Unsatisfactory or mediocre marital adjustment **6**
 - 9. Past negative relationship with mother **5, 40**
- C. Lack of social support 1, **9, 27, 33, 46, 54, 55, 56, 58, 61, 62, 63**
 - 1. Few friends, unsatisfactory interpersonal relations **6, 52**
 - 2. Made decision alone, without assistance from partner **35**
 - 3. A poor or unstable relationship with male partner **6, 25, 34, 40, 43, 53**
 - 4. Single and nulliparous **9**
 - 5. Separated, divorced, or widowed **14, 62**
 - 6. Lack of support from parents and family 2, **8, 9, 18, 27, 29, 33, 35, 52, 56**
 - either to have baby or to have abortion

- 7. Lack of support from male partner 2, **6**, **8**, **9**, 18, **25**, 27, **29**, **33**, **34**, **35**, 42, **46**, **52**, 53
 - either to have baby or to have abortion
- 8. Accompanied to abortion by male partner 21, **30**
- 9. Living alone **56**
- 10. High alienation **63**
- D. Prior abortion(s) 13, 37, 43, 48, **52**, **58**
- E. Prior miscarriage **58**
- F. Less education **58**

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