


11-1-1978

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### Recommended Citation

Mary Anne Wood and W. Cole Durham Jr., *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 BYU L. Rev. 783 (1978).

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## Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship

Mary Anne Wood\* and W. Cole Durham, Jr.\*\*

The landmark holdings of the United States Supreme Court liberalizing access to abortion have placed special emphasis on the doctor's role in helping a woman decide whether or not to terminate her pregnancy. *Roe v. Wade*<sup>1</sup> envisioned the abortion decision as being made by the woman *in consultation with* her attending physician.<sup>2</sup> *Doe v. Bolton*<sup>3</sup> held that the interests in female autonomy and fetal life were adequately safeguarded by the woman's initial consultation with her physician, and that statutory provisions requiring independent medical review were unconstitutional.<sup>4</sup> Most recently, in *Colautti v. Franklin*,<sup>5</sup> the Court again emphasized "the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out."<sup>6</sup>

The emphasis on the doctor-patient relationship in these and other abortion cases<sup>7</sup> is no accident. The Supreme Court, like courts and legislatures in many other parts of the world during the 1970's, has been grappling with the problem of striking a more sensitive balance between female autonomy and fetal life than that achieved by restrictive nineteenth century abortion legislation.<sup>8</sup> By leaving the abortion decision to the expectant mother and her physician, the Court reasoned that it could eliminate restraints on abortion not rationally related to the mother's health or to legitimate state interests while interposing the re-

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1. 410 U.S. 113 (1973).

2. *Id.* at 153.

3. 410 U.S. 179 (1973).

4. *Id.* at 195-200.

5. 47 U.S.L.W. 4094 (U.S. Jan. 9, 1979).

6. *Id.* at 4096.

7. *Planned Parenthood v. Danforth*, 428 U.S. 52, 64, 71 (1976); *Connecticut v. Menillo*, 423 U.S. 9 (1975); *Doe v. Bolton*, 410 U.S. 179, 195-98 (1973).

8. See C. TIERZE & M. MURSTEIN, *INDUCED ABORTION: 1975 FACTBOOK 7* (Population Council Reports on Population/Family Planning No. 14, 2d ed. 1975).

strained and balanced judgment of the medical profession in the decisionmaking process. Chief Justice Burger's concurring opinion in *Roe v. Wade* and *Doe v. Bolton*<sup>9</sup> underscores the significance of the medical profession's role in this regard. He emphatically rejected the contention that the Court in *Roe* and *Doe* had legitimated abortion on demand, noting that such a view overlooks 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."<sup>10</sup>

The Court's conclusion that physicians are able to play a mediating role in preventing the woman's expanded autonomy from taking an undue toll in fetal life is based on a stereotyped picture of the doctor-patient relationship. The Court envisions the woman and her doctor counseling together to carefully consider the variety of factors relevant to her abortion decision—including possible medical complications, psychological harm, and potential impact on her life, family, and future.<sup>11</sup> After such consultation, the doctor exercises his best medical judgment about whether the abortion should be performed, and the woman presumably defers. This concept of the doctor-patient relationship recurs as a premise in subsequent Supreme Court decisions on abortion.<sup>12</sup>

Unfortunately, the vision conjured up by the Supreme Court is not the reality in today's abortion practice. At least six out of ten abortions performed in the United States are performed in freestanding abortion clinics.<sup>13</sup> Doctors in such clinics typically have a direct financial interest in seeing that abortions are performed as rapidly and efficiently as possible.<sup>14</sup> Frequently, the only time the doctor sees the patient is when she is on the operating table awaiting the procedure.<sup>15</sup>

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9. 410 U.S. 113, 207-08 (1973) (Burger, C.J., concurring).

10. *Id.* at 207-08.

11. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

12. See, e.g., *Colautti v. Franklin*, 47 U.S.L.W. 4094, 4096-97 (U.S. Jan. 9, 1979); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

13. Sullivan, Tietze, & Dryfoos, *Legal Abortion in the United States 1975-1976*, 9 *FAM. PLAN. PERSPECTIVES* 116, 127 (1977). The percentage of abortions performed in clinics may be even higher now, as the number of clinics is growing while the number of hospitals performing abortions is declining. *Id.* at 126-27.

14. See, e.g., Auerback, *Abortions: Now It's Big Business*, in *Hearing on S.J. Res. 119 and S.J. Res. 130 Before the Subcomm. on Constitutional Amendments of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess. 468 (1976); Connor, *Liberal Abortion Law Proves to Be a Bonanza for New York Doctors—Critics Hit "Profiteering," or Is It Free Enterprise? Referral Agencies Scored*, in *id.* at 470.

15. See Goldsmith, *Early Abortion in a Family Planning Clinic*, 6 *FAM. PLAN. PERSPECTIVES* 119 (1974); Klaus, *A Medical Cop-Out?*, 133 *AM. 68* (1975).

Even assuming there is some sort of doctor-patient consultation, much can and has been said in criticism of the Supreme Court's peculiar reliance on the doctor-patient relationship as an approach to resolving the abortion controversy. In light of the woman's freedom to select her own doctor, the protection this solution provides for developing life may be de minimus as a practical matter. Moreover, medical expertise does not carry with it moral authority, and therefore the justification for making the medical profession the ultimate arbiter of the abortion decision is difficult to see.<sup>16</sup> At least some women may mistake a doctor's judgment for moral approbation and derive unwarranted moral solace from a clinical opinion. In addition, allocation of a decisionmaking role to the doctor may reinforce a paternalistic doctor-patient relationship. Yet, barring a constitutional amendment, the Court's approach is here to stay.

The Court's careful insistence on doctor involvement in the abortion decisionmaking process can be taken in two ways. First, it can simply be dismissed as so much legal claptrap cluttering up a clear constitutional endorsement of unfettered female autonomy. This has been the dominant approach. If the significance of the Court's insistence on doctor involvement in the abortion choice is recognized at all, the tendency has been to render lip service to this aspect of the Court's decision, catalogue the failings of this approach, and then blithely assume that for all practical purposes, *Roe v. Wade* and its progeny repose the abortion choice entirely in the hands of the woman, at least during the first trimester.<sup>17</sup>

The aim of this Article is to suggest the plausibility and possible ramifications of a second approach—one that takes seriously the Court's insistence on doctor involvement in the abortion decisionmaking process. Despite its imperfections as a response to the abortion dilemma, the requirement of doctor involvement has the merit of holding open one of the few remaining legal channels through which sensitivity to the value of potential life may be manifested during the early stages of pregnancy. However cynical one may be about the efficacy of medical judgment as a safeguard for potential life and about the moral omniscience of the medical profession, one must remember that unfettered

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16. See Tribe, *The Supreme Court, 1972 Term—Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 37 (1973).

17. See, e.g., *Beal v. Doe*, 432 U.S. 438, 450-51 & note (1977) (Brennan, J., dissenting) (apparently interpreting the "joint autonomy" of physician and patient as right of individual women to be free from governmental intrusion in making reproductive choices); L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 933 (1978).

abortion on demand provides an even lower level of protection for the value of fetal life. And in fairness to the holdings in *Roe v. Wade* and its progeny, reliance on medical judgment may have reflected not so much a naive effort to submit an intractable moral problem to a scientific oracle as a practical determination that no other figure could be interposed in the abortion decision-making process with such minimal invasion of the woman's privacy right. After all, the Court may have reasoned, the doctor is someone the woman must approach about her decision in any event if she is to have a medically safe abortion, and injecting some concern for both maternal health and potential life at the stage of doctor-patient consultation can hardly be said to be an unreasonable intrusion into the woman's private life. Viewed in this light, the Court's reliance on the medical profession emerges as an insightful recognition of the need for a highly individualized evaluation of specific abortion decisions and as an approach that may be, at least in certain circumstances, extremely sensitive to the value of incipient life.

Since the Supreme Court apparently viewed the doctor-patient relationship as a way of injecting such sensitivity into the abortion choice, a question arises concerning the extent to which states can enact measures that seek to actualize the doctor-patient mythology on which *Roe* and its progeny have been premised. Analysis of this question will first require an examination of the critical components of the doctor-patient relationship as envisioned by the Supreme Court in its principal abortion decisions, and second, an assessment of a variety of measures aimed at shoring up the doctor-patient relationship in an effort to differentiate permissible "myth actualization" from impermissible state regulation of the abortion decision.

What emerges from this analysis is the recognition that, in a variety of contexts, a woman's autonomy with respect to the abortion choice is actually expanded rather than contracted by imposing a demand for stronger doctor-patient interaction. And, importantly, greater sensitivity for unborn life is often a concomitant of expanded autonomy. A woman's autonomy, after all, is protected not by ensuring her the ability to make any choice she wishes, but by protecting her right to make an informed, calm, and rational choice.<sup>18</sup> Thus, while a principal concern of this Arti-

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18. The classic formulation of the notion of autonomy as rational freedom is, of course, Kant's. See I. KANT, *GROUNDWORK OF THE METAPHYSIC OF MORALS* 98-100, 108, 114-16 (H. Paton trans. 1964). For a more current articulation of this Kantian idea, see J. RAWLS, *A THEORY OF JUSTICE* 515-16 (1971).

cle is to identify practical steps that can be taken to help stem the rising tide of fetal deaths within the framework of existing constitutional adjudication, the Article is not "antichoice" in its orientation. On the contrary, its aim is to show that a more careful appraisal of Supreme Court abortion decisions suggests at least some areas in which permissible state action may encourage greater sensitivity to fetal life in the very process of enhancing female autonomy.

## I. ABORTION CONSULTATION: THE SUPREME COURT'S VIEW OF THE DOCTOR-PATIENT RELATIONSHIP

### A. *Three Models of Doctor-Patient Privacy*

Despite the Supreme Court's recurrent emphasis on the significance of the doctor-patient relationship in the abortion context, actual indications of the views held by different Justices concerning the nature of the relationship are relatively sparse. For the most part, the Court has simply contented itself with language evoking vague images of sensitive individualized consultation, and differing ideas about doctor-patient interaction have been papered over in the process. Nonetheless, at least three distinguishable concepts of the relationship are discernible among Supreme Court Justices. These views are intimately linked to varying concepts of the constitutional right of privacy, and the full significance of the emerging view of the doctor-patient relationship cannot be appreciated until these privacy concepts are analyzed.

Scholars have long recognized that the constitutional right of privacy is a convenient label for a number of related but distinguishable rights and values.<sup>19</sup> Writing for the majority in *Whalen v. Roe*,<sup>20</sup> Justice Stevens identified two types of interests principally at issue where the doctor-patient relationship is involved: "One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions."<sup>21</sup> Particularly since *Roe*, the emphasis in this area has been on autonomy.<sup>22</sup> In *Carey v.*

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19. See, e.g., L. TRIBE, *supra* note 17, at 886-89; Gentry, *Redefining Privacy*, 12 HARV. C.R.-C.L.L. REV. 233 (1977); Reiman, *Privacy, Intimacy and Personhood*, 6 PHILOSOPHY & PUB. AFF. 26 (1976); Thomson, *The Right to Privacy*, 4 PHILOSOPHY & PUB. AFF. 295 (1975); Comment, *A Taxonomy of Privacy: Repose, Sanctuary, and Intimate Decision*, 64 CALIF. L. REV. 1447 (1976); Note, *Roe and Paris: Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161 (1974).

20. 429 U.S. 589 (1977).

21. *Id.* at 599-600 (footnotes omitted).

22. See, e.g., Note, *Roe and Paris: Does Privacy Have a Principle?*, 26 STAN. L. REV.

*Population Services International*,<sup>23</sup> the Court explicitly described the protections afforded by earlier privacy cases in terms of the value of individual autonomy.<sup>24</sup>

To speak of privacy in terms of autonomy, however, is to speak ambiguously, since the term "autonomy" can be understood in two significantly different ways. According to one view, autonomy can be understood as the right to unfettered self-determination—the right to set one's own course and make one's own choices regardless of the content of those choices, subject only to the obligation of according equal respect to the self-determination rights of others. This concept of autonomy has been identified in the works of John Stuart Mill<sup>25</sup> and has antecedents in the philosophy of Thomas Hobbes.<sup>26</sup> It lies at the foundation of much of modern libertarianism.<sup>27</sup> The opposing concept of autonomy stresses rational choice. As formulated by John Rawls, people are acting autonomously when "they are acting from principles that they would acknowledge under conditions that best express their nature as free and equal rational beings."<sup>28</sup> According to this view not every choice expresses a person's autonomy, but only those that are made in the absence of distorting factors that prevent the choice from reflecting a person's authentic individuality.

The distinction between these two concepts of autonomy is a profound one,<sup>29</sup> but the distinction can be described here only in rough, intuitive terms. The important point for present purposes is that much of the current controversy among Supreme

1161, 1166 (1974).

23. 431 U.S. 678 (1977).

24. *Id.* at 687.

25. See, e.g., H. AIKEN, *REASON AND CONDUCT: NEW BEARINGS IN MORAL PHILOSOPHY* 306-07 (1962); Dworkin, *Paternalism*, in *MORALITY AND THE LAW* 107, 117 (R. Wasserstrom ed. 1971). For supporting passages in Mill's own works, in *UTILITARIANISM, LIBERTY, AND REPRESENTATIVE GOVERNMENT* see J. MILL, *ON LIBERTY*, 65-77, 114-31 (1910). The precise nature of Mill's concept of liberty is not altogether clear. Rawls finds in Mill's defense of liberty an argument for the value of rational choice. J. RAWLS, *supra* note 18, at 209-10. To the extent this reading is accurate, Mill's notion of liberty conforms more closely to autonomy in the sense of rational choice than in the sense of sheer self-determination.

26. See T. HOBBS, *LEVIATHAN* 126-28 (C. Macpherson ed. 1968) (Hobbes defines deliberation as the alternation of appetites and aversions, and rejects the scholastic definition of deliberation as "Rational Appetite").

27. See, e.g., J. HOSPERS, *LIBERTARIANISM* 10, 49-60 (1971); A. RAND, *ATLAS SHRUGGED* (1957); M. ROTHBAND, *FOR A NEW LIBERTY* 104-30 (1973).

28. J. RAWLS, *supra* note 18, at 515.

29. In some senses, the distinction reflects one of the great divides in Western philosophy. See R. HARE, *FREEDOM AND REASON* 2-3 (1963). It lies at the root, for example, of Unger's contrast between moralities of reason and moralities of desire—a contrast designed to describe the two dominant styles of moral theory in the West. See R. UNGER, *KNOWLEDGE AND POLITICS* 49-51 (1975).

Court Justices as to the scope of the privacy right is rooted in an argument about which form of autonomy should ultimately prevail.

To summarize, then, there are at least three interests arguably safeguarded by the constitutional right of privacy: (1) avoiding disclosure of personal matters, (2) autonomy in the sense of unfettered self-determination, and (3) autonomy in the sense of rational choice. As one examines Supreme Court discussions of the doctor-patient relationship, one detects three corresponding models of that relationship.

The first model of the doctor-patient relationship could be characterized as the confidentiality model. It is clearly linked to the nondisclosure value. This model is perhaps best represented by Justice Douglas' concurring opinion in *Roe v. Wade* and *Doe v. Bolton*.<sup>30</sup> Although Justice Douglas alludes to a number of autonomy interests protected by the fourteenth amendment,<sup>31</sup> his central concern seems to be protecting the confidentiality of the doctor-patient relationship. "The right of privacy," he states, "has no more conspicuous place than in the physician-patient relationship, unless it be in the priest-penitent relationship."<sup>32</sup> Under this model, the woman's privacy right is invaded as soon as she is compelled to disclose intimate facts about her reproductive life to an outside doctor or, for that matter, to anyone she has not chosen to tell. According to Justice Douglas, such compulsory disclosure constitutes "a total destruction of the right of privacy between physician and patient and the intimacy of relation which that entails."<sup>33</sup> While this aspect of the privacy right is significant and may account in part for the prominence given the doctor-patient relationship in many of the abortion decisions, it is considerably less significant to privacy analysis than the autonomy concerns. The struggle over rival concepts of autonomy is the locus of much of the Court's current controversy concerning the scope of a woman's right to an abortion.

A second model of the doctor-patient relationship could be characterized as the medical expert model. Because of its linkage with the unfettered self-determination concept of autonomy, this model takes a rather narrow view of the doctor's role. The doctor is viewed as a medical specialist who appraises the woman of clinical facts bearing on her decision and then ultimately implements

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30. 410 U.S. at 209-21 (Douglas, J., concurring).

31. *Id.* at 211-15.

32. *Id.* at 219.

33. *Id.*



whatever course of action she selects. The doctor's posture is completely neutral and value free: the moral component of the abortion choice is left exclusively to the woman. This model of the doctor-patient relationship is most clearly articulated by Justice Brennan in *Carey v. Population Services International*.<sup>34</sup> Although the Court's concern in *Carey* is with the role of a physician in controlling a minor's access to contraceptives, and not in regulating the abortion decision, Justice Brennan's statements nevertheless shed considerable light on his view of the doctor-patient relationship. Commenting on *Doe v. Bolton*, he states that the Court there

doubted that physicians would allow their moral "predilections on extramarital sex" to interfere with their medical judgments concerning abortions. Here, however, no *medical* judgment is involved at all; the State purports to commission physicians to engage in *moral* counseling that can reflect little other than their private views on the morality of premarital sex among the young.<sup>35</sup>

He then suggests that the reason the doctor-patient relationship is emphasized in the abortion cases and not in the earlier contraceptive cases is that "the abortion decision necessarily involves a medical judgment, . . . while the decision to use a nonhazardous contraceptive does not."<sup>36</sup> Of course, Brennan's analysis of the difference between the abortion and contraceptive cases conveniently overlooks the fact that the latter do not involve the issue of unborn life—a probable reason for the emphasis on the doctor-patient relationship in the abortion cases. It seems clear, however, that Brennan's view of the doctor's role is a narrowly clinical one. The only reason the woman's privacy right does not exclude even her consulting physician from the abortion decision is that abortion, if nothing more, is still a medical procedure.

This narrow view of the medical role dovetails naturally with a broad view of the nature of the abortion right. Dissenting in the *Maher* case, which was handed down two weeks after *Carey*, Brennan was sharply critical of the Court's holding that states funding normal childbirth need not fund nontherapeutic abortions. In his view, the prior cases had recognized "an area of

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34. 431 U.S. 678 (1977). Justice Brennan wrote the opinion for the Court in *Carey*. However, Part IV of his opinion was joined by only three other Justices. Justice White concurred in the result of that section of the opinion.

35. *Id.* at 699 n.24 (emphasis in original) (quoting *Doe v. Bolton*, 410 U.S. 179, 196 (1973)).

36. *Id.* at 699-700 n.25.

privacy invulnerable to the State's intrusion surround[ing] the decision of a pregnant woman whether or not to carry her pregnancy to term."<sup>37</sup> He viewed state measures that altered the incentive structure surrounding the abortion choice as "an obvious impairment of the fundamental right established by *Roe v. Wade*."<sup>38</sup> This uncompromising interpretation of the woman's right to an abortion shows Justice Brennan's commitment to the value of autonomy in the sense of unfettered self-determination. If the woman's right to self-determination is the ultimate value, the doctor's role is naturally constricted; he serves merely as the instrument of her will.

The third model of the doctor-patient relationship could be described as the medical counselor model. This is the model behind the Supreme Court's doctor-patient mythology, and it is founded on the rational choice concept of autonomy. Under this model, the consulting physician performs the tasks of the doctor as medical expert, but additionally assumes a larger interpersonal responsibility. The physician ensures that the woman is in a position not only to rationally assess the narrow medical issues, but also to evaluate carefully the nonmedical aspects of abortion. It is this highly personalized role the Court initially had in mind when it stressed that "medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient."<sup>39</sup>

Since medical considerations alone will rarely dictate the outcome of the abortion choice,<sup>40</sup> the Supreme Court's stress on the doctor-patient relationship is naturally interpreted as an implicit reference to the desirability of the medical counselor model. Indeed, a state may have a strong interest in encouraging relationships of the medical counselor rather than the medical expert variety. Given the state's legitimate (if noncompelling) interest in encouraging normal childbirth during the first two trimesters,<sup>41</sup> the state may be anxious to encourage a woman's full consideration of all factors that might lead her to continue her pregnancy. Although severe constraints have been imposed on the state's authority to restrict abortions, the state may nonetheless wish to maximize the probability that women will choose to continue

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37. *Maier v. Roe*, 432 U.S. 464, 484 (1977) (Brennan, J., dissenting).

38. *Id.* at 484-85.

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

40. See Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 *YALE L.J.* 920, 922 n.22 (1973) (quoting Stone, *Abortion and the Supreme Court*, *MOD. MED.*, April 30, 1973, at 32, 36).

41. *Beal v. Doe*, 432 U.S. 438, 446 (1977).

their pregnancies. Of course, the attending physician is not the only person capable of helping the woman fully to consider the alternatives to abortion.<sup>42</sup> But the Supreme Court's progressive insulation of the doctor-patient relationship has raised doubts concerning the appropriateness of legislation compelling consultation with other individuals.<sup>43</sup> Efforts to implement the medical counselor model may accordingly be the only remaining alternative for providing a woman with the information necessary to a rational abortion decision.

Even disregarding the concern for unborn life, the argument can be made that the concept of autonomy as rational choice should be preferred to that of autonomy as unfettered self-determination. The Supreme Court's careful refusal to establish a constitutional right to abortion on demand is undoubtedly the clearest indicator that the value of rational choice, rather than that of self-determination in itself, lies at the core of the constitutional right of privacy. Reinforcing this view is the Court's holding in *Planned Parenthood v. Danforth* that informed consent requirements are permissible because they help assure that the woman's abortion choice is "made with full knowledge of its nature and consequences."<sup>44</sup> The doctor-patient relationship falls within the penumbra of the privacy right because it maximizes the woman's rational choice autonomy. What the Court has sought to protect is not any decision the woman happens to make, regardless of the extent to which it is a reflection of emotional stress and possibly inadequate information. On the contrary, the Court has tried to promote careful decisions, conscientiously made after consideration of all the facts and alternatives.

There are, of course, problems with the notion of allowing the state to determine when an individual decision is sufficiently rational to be immune from state review.<sup>45</sup> This is unlikely to

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42. An appropriately trained social worker, for example, might be able to perform this service with greater competence and with lower fees.

43. See notes 87-89, 284-90 and accompanying text *infra*.

44. 428 U.S. 52, 67 (1976).

45. At bottom, the difficulty is the one common to so-called real-will theories. As Jeffrie Murphy phrases the objection, "Surely we want to avoid cramming indignities down the throats of people with the offhand observation that, no matter how much they scream, they are really rationally willing every bit of it. It would be particularly ironic for such arbitrary repression to come under the mask of respecting autonomy." Murphy, *Marxism and Retribution*, 2 *PHILOSOPHY & PUB. AFF.* 217, 230 (1973). For criticism of real-will theories, see I. BERLIN, *TWO CONCEPTS OF LIBERTY*, in *FOUR ESSAYS ON LIBERTY* (1969); Dworkin, *supra* note 25, at 119.

As both Murphy and Dworkin recognize, albeit for different reasons, state constraints that respect only rational choices, as opposed to arbitrary personal desires, may make sense under appropriate circumstances. See Dworkin, *supra* note 25, at 119-26; Murphy,

become a problem in the abortion setting, however, as constitutional norms preclude the creation of previability veto rights over the woman's ultimate choice.<sup>46</sup> Legislation designed to inform and sensitize without predetermining decisional outcomes can do nothing but expand female autonomy. Increased information may make the abortion choice more difficult, but this is not because the woman is being pressured to do something against her will. Rather, it is because the woman is led to feel the responsibility for her decision more keenly. Only those sympathetic to the arguments of Dostoyevsky's Grand Inquisitor<sup>47</sup> would perceive this burden as an incursion on autonomy. In any event, when one adds concern for unborn life into the equation, the argument in the abortion context for protecting the woman's autonomy in the sense of rational rather than arbitrary choice seems overpowering.

### B. *Components of the Doctor-Patient Relationship*

The foregoing analysis suggests that the rational choice version of autonomy and the associated medical counselor model of the doctor-patient relationship are emerging as dominant concepts in the Supreme Court's abortion cases. Assuming this analysis is accurate, it becomes vital to identify those features of the doctor-patient relationship that are either expressly considered or impliedly mandated by the Court's emerging view. Clearly, measures aimed at reinforcing these aspects of the doctor-patient relationship are the ones most likely to withstand constitutional scrutiny.

#### 1. *Screening*

One obvious component of the doctor-patient relationship contemplated by the Supreme Court is thorough patient screening.<sup>48</sup> The Court has always stressed that medical judgment should be "exercised in the light of all factors . . . relevant to the well-being of the patient."<sup>49</sup> The Court's willingness to sustain recordkeeping and reporting procedures in *Danforth*<sup>50</sup> and its at-

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*supra* at 238-43. So long as the state's efforts are limited to providing information to the woman considering abortion, and are not permitted to determine the result of the process, the dangers ascribed to more extreme real-will theories do not apply.

46. *Planned Parenthood v. Danforth*, 428 U.S. 52, 69, 74 (1976).

47. F. DOSTOYEVSKY, *THE BROTHERS KARAMAZOV* 292-314 (C. Garnett trans. 1950).

48. *See Doe v. Bolton*, 410 U.S. 179, 192 (1973). *See generally* Butler & Fujita, *Abortion Screening and Counseling: A Brief Guideline for Physicians*, 50 *POSTGRADUATE MED.* 208, 208 (1971).

49. *Doe v. Bolton*, 410 U.S. at 192.

50. *Planned Parenthood v. Danforth*, 428 U.S. 52, 79-81 (1976).

tention in *Doe v. Bolton* to the possibility that a physician might consult with another doctor in a "doubtful situation" or when the "medical decision is a delicate one"<sup>51</sup> provide additional evidence of the Court's concern for information that might be yielded by screening. The variety of factors to be considered by the doctor in the exercise of his or her medical judgment presupposes that the doctor will thoroughly assess the patient's individual needs.

The Court's concerns are linked to practical demands for thorough patient screening. Among other things, the fact of pregnancy itself needs to be established; the number of "abortions" which have been performed on nonpregnant women is extremely disconcerting.<sup>52</sup> More generally, a woman's overall health and medical history may have great impact on the relative safety of continued pregnancy or abortion.<sup>53</sup> Equally significant is the need to screen the patient to identify pertinent psychological and sociological characteristics. Recent studies indicate that many women contemplating abortion have apprehensions, unresolved conflicts, or feelings of ambivalence regarding abortion.<sup>54</sup> Women from strict religious or moral backgrounds or women with previous histories of emotional instability have a particularly great tendency to develop psychological complications following abortion.<sup>55</sup> If the doctor is to exercise his best medical judgment, he must have a thorough knowledge of the woman's psychological and emotional traits.

Family background must also be dealt with by both doctor and patient.<sup>56</sup> Both must evaluate the family's capacity to deal with the realities of pregnancy and additional offspring. The feelings of the woman's family and partner about abortion may have a profound impact on her own ability to deal with the abortion,<sup>57</sup> and this impact must therefore be considered.

51. 410 U.S. at 199.

52. "An estimated 20 to 30 percent of criminal abortions have been done on nonpregnant women." Butler & Fujita, *supra* note 48, at 208.

53. See, e.g., DEP'T OF MEDICINE & PUBLIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SERIES F, POPULATION REPORTS 69-70 (1976).

54. Bracken, *Psychosomatic Aspects of Abortion: Implications for Counseling*, 19 J. REPRODUCTIVE MED. 265 (1977); Nadelson, *Abortion Counselling: Focus on Adolescent Pregnancy*, 54 PEDIATRICS 765, 767 (1974); West & Walsh, *The Need for Pre-Abortion Counseling—Now More Than Ever*, 59 NEB. MED. J. 34 (1974).

55. See Belsey, Greer, Lal, Lewis, & Beard, *Predictive Factors in Emotional Response to Abortion: King's Termination Study—IV*, 11 Soc. Sci. & MED. 71, 80-81 (1977); Osofsky & Osofsky, *The Psychological Reaction of Patients to Legalized Abortion*, 42 AM. J. ORTHOPSYCH. 48, 58 (1972); West & Walsh, *supra* note 54, at 35.

56. See *Doe v. Bolton*, 410 U.S. 179, 192 (1973); Belsey, Greer, Lal, Lewis, & Beard, *supra* note 55, at 266.

57. Belsey, Greer, Lal, Lewis, & Beard, *supra* note 55, at 80-81; Bracken, *supra* note 54, at 266.

2. *Informing the patient as to the nature and consequences of the procedure*

Another component of the relationship contemplated by the Supreme Court is the responsibility of the doctor to inform the patient of the facts she needs to make her own decision. In *Danforth* the Supreme Court acknowledged that the decision to abort is a stressful one and that "it is desirable and imperative that it be made with full knowledge of its nature and consequences."<sup>58</sup> In so holding, the Supreme Court recognized that a woman's right to choose to have an abortion is an empty one if it is not accompanied by sufficient information to help her make that choice an intelligent and informed one. The doctor may be the only individual in a position to help protect the woman's autonomy in this manner, since he or she may be the only person who is both qualified to provide her the needed information and aware that she is contemplating an abortion.

The woman deciding whether or not to have an abortion vitally needs information in several particular areas. She needs to understand the facts of female reproduction and fetal development. These are critical to her understanding of the abortion procedure itself. Accurate understanding of fetal development may bear directly on whether a woman will choose to have an abortion and may also have a significant impact on her mental health after having one.<sup>59</sup> A woman may choose not to end a pregnancy if she learns that a fetus as few as eight weeks old is a minature human being rather than a blob of protoplasm,<sup>60</sup> or if she learns that the fetus she is carrying is just a few weeks from viability. Some women have reported experiencing severe mental distress as a result of learning the facts of fetal development after obtaining an abortion.<sup>61</sup>

As any other medical patient, a woman contemplating abortion needs information about the procedure to be performed on her and possible complications of that procedure.<sup>62</sup> A variety of

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58. 428 U.S. at 67.

59. See, e.g., 124 CONG. REC. § 2648, § 2649 (daily ed. Mar. 1, 1978) (testimony of Sen. Helms concerning § 2614); Letter from James E. Scoresby to Arizona House of Representatives in support of Arizona House bill 2193 (Mar. 25, 1978) (on file with the Brigham Young University Law Review).

60. *Life Before Birth* 10, reprinted from *LIFE*, Apr. 30, 1965 (Educational Reprint No. 27).

61. See authorities cited note 59 *supra*.

62. The need for medical patients to know about the treatment they are to receive is the basis for the tort concept of informed consent, which stems from the ancient law of battery. *Slater v. Baker*, 95 Eng. Rep. 860, 862 (K.B. 1767). The concept has developed to include disclosure of the nature of the procedure to be performed, and information

abortion procedures can be used at each stage of the pregnancy.<sup>63</sup> Women who are contemplating an abortion need to understand the procedure the doctor will employ. A woman who knows what to expect during the procedure will experience less anxiety.<sup>64</sup> In abortions during later stages of pregnancy, women should be informed of the possibility of the fetus being born alive. Women who have late abortions for reasons other than not wanting the child have a special interest in learning which procedure will most likely end the pregnancy without necessarily killing the fetus.

While it is relatively easy to provide a woman with a description of the abortion procedure, it is more difficult to give helpful

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concerning risks and alternatives to the procedure. Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PRR. L. REV. 137, 146-48 (1978). The cause of action for medical malpractice based on failure to obtain informed consent became commonly recognized as an action for negligence. Plant, *The Decline of "Informed Consent,"* 35 WASH. & LEE L. REV. 91, 92 (1978). Two different standards of care evolved. The earlier and currently majority view involves application of a "professional standard," requiring physicians to disclose the information that a "reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances" would disclose. *Natanson v. Kline*, 186 Kan. 393, 411, 350 P.2d 1093, 1107 (1960). Courts, however, have increasingly adopted a "full disclosure" standard, requiring the physician to disclose "all material risks inherent in the proposed treatment." Seidelson, *Medical Malpractice: Informed Consent Cases in "Full-Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 310 (1976). The standard is based on a patient's right to self-determination and is a standard "set by law for physicians rather than one which physicians may or may not impose upon themselves." *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). Theoretically, a standard "set by law" would diminish the need for expert testimony in informed consent litigation; however, that diminution may be insignificant if expert testimony is needed to "identify and elucidate for the factfinder the risks of therapy and the consequences of leaving existing maladies untreated." *Id.* at 791-92.

63. This is particularly true of abortions performed after the first trimester. Most abortions before 12 weeks' gestation are performed either by dilation and curettage or by vacuum aspiration. DEP'T OF MEDICINE & PUBLIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SERIES F, POPULATION REPORTS 10 (1973). In either case, the cervix is dilated and the contents of the uterus are either scraped or vacuumed out. In the first trimester of pregnancy, the obvious result will be destruction of the fetus. These methods may be used for periods up to 14 weeks of gestation. *Id.* at 28; C. TIETZE & M. MURSTEIN, *supra* note 8, at 44.

After the first trimester, abortions can be performed by saline amniocentesis, in which some of the amniotic fluid is removed from the uterus and replaced with a salt solution. Usually the fetus dies and labor begins. DEP'T OF MEDICINE & PUBLIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SERIES F, POPULATION REPORTS 68 (1975). Prostaglandin is also used to stimulate the onset of labor. Prostaglandin may be placed in the amniotic sac as in saline amniocentesis or it may be inserted vaginally. *Id.* at 72-76. Hysterotomy, another method of post-first-trimester abortion, is like a miniature caesarean section. An incision is made in the abdomen and the fetus is removed. *Id.* at 67. Rarely will the fetus survive an abortion performed by saline amniocentesis, but occasionally it does. *Id.* at 68. Prostaglandins or hysterotomy are somewhat more likely to produce a live fetus. *Id.* at 67, 76. There are numerous other methods of performing abortions that are not commonly used in the United States. *Id.* at 67.

64. Bracken, *supra* note 54, at 266; Nadelson, *supra* note 54, at 769.

information about abortion complications. The incidence and severity of possible complications varies with the procedure used, the stage of pregnancy, and the woman's overall health.<sup>65</sup> With the extent of today's research, however, it is surprisingly difficult to estimate the risk of complications in the abortion process. Although recent studies in the United States indicate that the risk of complications is decreasing as doctors develop greater experience in performing abortions,<sup>66</sup> the fact remains that we have a brief history in the United States of free access to abortion, and the studies that have been done are not extensive.<sup>67</sup> Moreover, it is difficult to counter the argument that since most abortions are performed in abortion clinics,<sup>68</sup> we may not be getting an accurate idea of the number of complications stemming from abortion. A woman who receives an abortion in a clinic may not return to that clinic if she is experiencing complications; she may be more likely to go to her family doctor or to the emergency room of a hospital. This difficulty is compounded by the fact that many women

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65. Generally, the possible physical complications of abortion include allergic response to anesthesia, excessive blood loss, hypertension, fever, infection, retained products of conception, cervical and uterine injuries, a possible tendency toward miscarriages or premature births in later pregnancies, and Rh immunization. DEP'T OF MEDICINE & PUBLIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SERIES F, POPULATION REPORTS 31-36 (1973). Post-first-trimester abortions include the possibility of more severe and perhaps life-threatening complications, especially in women with preexisting disorders such as sickle cell anemia, other moderate or severe anemia, cardiac or cardiovascular disorders, or renal disorders. DEP'T OF MEDICINE & PUBLIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SERIES F, POPULATION REPORTS 69-70 (1976). The incidence of morbidity and mortality stemming from abortion increases dramatically after the first trimester. *Id.* at 65.

In addition to these potential physical complications, there may be emotional or mental complications stemming from abortion, particularly for women who come from strict religious or moral backgrounds, Osofsky & Osofsky, *supra* note 55, at 58; West & Walsh, *supra* note 54, at 35, who already suffer from a degree of mental or emotional instability, Belsey, Greer, Lal, Lewis, & Beard, *supra* note 55, at 81, or who are under age 18, Bracken, Phil, Hachomovitch, & Grossman, *The Decision to Abort and Psychological Sequelae*, 158 J. NERVOUS & MENTAL DISEASE 154, 155 (1974); Goldsmith, Gabrielson, Gabrielson, Mathews, & Potts, *Teenagers, Sex, and Contraception*, 4 FAM. PLAN. PERSPECTIVES 32, 35 (1972); Nadelson, *supra* note 54, at 766.

66. C. TRETZE & M. MURSTEIN, *supra* note 8, at 52-53.

67. *Id.* at 51. Of course, we cannot afford to ignore the studies of complications of abortion conducted in other countries with longer histories of free access to abortion than our country. Hayasaka, Toda, Zimmerman, Ueno, & Ishizaki, *Japan's 22 Year Experience With a Liberal Abortion Law*, in *Hearing on S.J. Res. 119 and S.J. Res. 130 Before the Subcomm. on Constitutional Amendments of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess. 661, 667 (1976). The complications noted in these studies, such as sterility or increased premature births in later pregnancies, may not appear until years after the abortion or until the woman has had more than one abortion. *Id.*; Schwartz, *The Impact of Voluntary Abortion on American Obstetrics and Gynecology*, 42 MT. SINAI J. MED., N.Y. 468, 473 (1975).

68. See note 13 *supra*.



travel outside their own communities to obtain abortions, in part because those providing abortions are often concentrated in one or two metropolitan areas in a state,<sup>69</sup> and in part because women seeking abortions may wish to minimize the risk that anyone in their own community would learn about the abortion. Until effective followup methods are developed, it may be some time before accurate statistics on abortion complications are available.

Because of the difficulty of estimating the likelihood of abortion complications, some may argue that informing a woman in detail about a great variety of improbable but possible complications will not influence her decision whether or not to have an abortion, but may make her unnecessarily fearful about the procedure.<sup>70</sup> However, the trend is for patients to prefer greater specificity on the part of the physician in outlining the risks associated with a particular operation.<sup>71</sup> For example, a study of patient reactions to "straightforward and perhaps even harsh" information concerning the possible complications of angiography showed the information was welcomed by patients and did not appear to make them more fearful of the procedure.<sup>72</sup> There is no reason to think patient reaction in the abortion context would be appreciably different. Most women would prefer to make a decision autonomously—with complete information—rather than leave the decision to a paternalistic physician attempting to "protect" her from preoperation anxiety.

### 3. *Consideration of alternatives*

A woman's awareness of various possible answers to a problem pregnancy is also critical to her decisionmaking process. A frequently publicized HEW study concluded that there were no alternatives to abortion except suicide, motherhood, and madness.<sup>73</sup> Obviously such a cynical view will not be helpful to the woman facing a problem pregnancy. Women contemplating abortion for health reasons need information about other medical treatments that would permit them to maintain their health

69. Sullivan, Tietze, & Dryfoos, *supra* note 13, at 121, 124.

70. See, e.g., Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124, 132 n.28 (citing Fost, *A Surrogate System for Informed Consent*, 233 J.A.M.A. 800 (1975)).

71. See Alfidi, *Informed Consent: A Study of Patient Reaction*, 216 J.A.M.A. 1325 (1971).

72. *Id.*

73. O'Reilly, *Okay, Mr. Califano, Consider the Alternatives to Abortion . . .*, Ms., May 1978, at 74. The study referred to in this article has never been released, and Freedom of Information Act requests for information concerning the study have been, at least as of this printing, ignored.

while continuing their pregnancy to term.<sup>74</sup> Likewise, women contemplating abortion because of marital status, lack of financial resources, or inability to care for another child need information about available public and private assistance for the pregnant woman.<sup>75</sup> Women who have such information about alternatives will be capable of making more informed decisions.

#### 4. *Conscious exercise of medical judgment*

A somewhat less obvious but equally significant feature of the Supreme Court's idealization of the doctor-patient relationship is its emphasis on the conscious exercise of medical judgment in the abortion decisionmaking process. That the doctor is expected to take an active role in this process is apparent from a number of the Court's statements. After cataloguing the factors that may bear on the abortion decision, such as medically diagnosable harm, additional offspring, "distressful life and future," and psychological harm, the Court in *Roe* concludes: "All these are factors the woman and her responsible physician necessarily will consider in consultation."<sup>76</sup> In summarizing its holding regarding the first trimester of pregnancy, the Court goes so far as

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74. Physicians report that there are few medical indications for abortion: "[M]edical advances have made it possible for women with almost any kind of physical illness to survive pregnancy and childbirth . . . ." Schwartz, *Abortion on Request: The Psychiatric Indications*, in *ABORTION, SOCIETY, AND THE LAW* 139, 141 (D. Walbert & J. Butler eds. 1973). One physician discusses possible maternal health indications for abortion as including cardiovascular disease, ulcerative colitis, renal disease, neurological disease, tuberculosis, diabetes mellitus, and malignancy. He qualifies the discussion, however: "The paucity of recent papers in the medical literature recommending abortion for medical disease or even describing the effect of medical diseases on pregnancy . . . undoubtedly reflects the infrequency with which medical disease is now thought to indicate abortion." He concludes that proper management of all but the most severe conditions could allow a pregnancy to continue to term. Niswander, *Abortion Practices in the United States: A Medical Viewpoint*, in *ABORTION, SOCIETY, AND THE LAW* 199, 202-06 (D. Walbert & J. Butler eds. 1973).

75. Public assistance for abortion alternatives may presently be available on an individual basis in many states through a combination of various benefits from federally funded programs such as Medicaid, 42 U.S.C. §§ 1396-1396k (1976) (medical assistance payments for pregnancy, childbirth, and infant health care assistance); title XX of the Social Security Act, 42 U.S.C. §§ 1397-1397f (1976) (additional source of assistance for pregnancy-related expenses); and title V of the Social Security Act, 42 U.S.C. §§ 701-710 (1976) (pregnancy counseling, nutritional care, and child health care counseling), with state-funded adoption subsidy programs, see, e.g., Katz, *Subsidized Adoption in America*, 10 *FAM. L.Q.* 1 (1976).

Religious organizations often have established programs for financial support of "unwed mothers" or other women with unwanted pregnancies. See, e.g., Searle, *Adoption Program Aids Mother, Child* (1973) (pamphlet, available from the Church of Jesus Christ of Latter-day Saints, Social Services Dep't, Salt Lake City, Utah).

76. 410 U.S. 113, 153 (1973).

to state that "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."<sup>77</sup> The Court here depicts the ultimate abortion decision as one that is made not by the consenting woman, but by her doctor. This view is further reinforced by the Court's statement that during the first trimester "the abortion decision in all its aspects is inherently, and primarily, a medical decision, and *basic responsibility for it must rest with the physician*. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available."<sup>78</sup> This language appears to confer authority on the physician under appropriate circumstances to refuse a woman's request for an abortion if he does not believe the circumstances warrant one,<sup>79</sup> and to countenance legal and professional sanctions—even in the first trimester—for abuse of the "responsibility" of exercising such judgment. As a practical matter, the restraining force of a physician's refusal is minimal because of the probability in contemporary American society that a woman who desires an abortion can find another physician who views her situation differently and who is willing to perform an abortion at her request.<sup>80</sup> Nonetheless, the language is significant in evidencing the Supreme Court's view that the consulting physician is to play a major role in making the abortion decision.

As noted at the outset,<sup>81</sup> the Court's insistence on the conscious exercise of medical judgment in the abortion decisionmaking process is rooted in a concern to achieve some sensitivity in

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77. *Id.* at 164.

78. *Id.* at 166 (emphasis added). Justice Blackmun's opinion fails to indicate what his reference to the "usual remedies" implied. He was possibly thinking of malpractice actions as well as formal professional disciplinary proceedings and informal sanctions such as loss of the professional regard of one's peers. If the judicial remedies he contemplated were limited to malpractice, one could infer—contrary to what we are arguing—that the scope of the medical judgment he envisioned was narrowly limited to matters of medical or surgical technique. This narrow clinical conception of medical judgment, however, seems inconsistent with the larger and more personal consultative role assigned to the doctor in other parts of the opinion.

79. *Planned Parenthood v. Danforth*, 428 U.S. 52, 71 (1976). *But cf.* Note, *The Abortion Alternative and the Patient's Right to Know*, 1978 WASH. U.L.Q. 167, 184 [hereinafter cited as *Abortion Alternative*].

80. One of the glaring inconsistencies of Justice Blackmun's opinions for the Court in *Roe* and *Doe* is that they recognize the "emotional nature of the abortion controversy" and "the vigorous opposing views, even among physicians . . . that the subject inspires," *Roe v. Wade*, 410 U.S. at 116, and yet the opinions assume in a number of passages that the doctor-patient relationship will play a significant role in protecting potential life. *See, e.g., Doe v. Bolton*, 410 U.S. at 197. As long as the patient is free to select a doctor with pro-abortion views, the influence of the medical profession in inhibiting unnecessary abortions will obviously be weak.

81. *See* notes 8-12 and accompanying text *supra*.

balancing interests between female autonomy and fetal life. The Court apparently reasoned that this end could best be obtained by relying on the judgment of the consulting physician. He or she would presumably be in a position to evaluate the woman's physical, emotional, psychological, and familial needs, and at the same time would be able to give due weight to the value of incipient life in reaching the abortion decision. Viewed with the benefit of hindsight afforded by *Beal v. Doe*<sup>82</sup> and *Maher v. Roe*,<sup>83</sup> with their recognition of strong and legitimate state interests in fetal life throughout pregnancy,<sup>84</sup> the Court's holding in *Roe* may be interpreted as a determination that during the first trimester sufficient protection of the relevant state interests is afforded by consultation with the physician.<sup>85</sup> Accordingly, the Court's conclusion seems merely to be that the state's interests in maternal health and potential life do not become sufficiently compelling to warrant overriding the decision reached by the woman and her doctor until later stages in pregnancy.

This conclusion does not imply that concern for fetal life is to be totally abandoned during the first trimester. On the contrary, the Court expressly recognized the significance of the doctor's role in protecting the value of potential life in *Doe v. Bolton*. There, in the course of invalidating first trimester hospital committee review procedures, the Court stated, "[w]ith regard to the protection of potential life, the medical judgment is already completed prior to the committee stage, and review by a committee once removed from diagnosis is basically redundant."<sup>86</sup> The Court's insistence on the involvement of the medical profession in first trimester abortion decisions thus reflects a considered judgment about how the countervailing interests in protecting incipient life and preserving a woman's autonomy can be reconciled during early stages of pregnancy. Reemphasizing the significance of the conscious exercise of medical judgment in abortion consultations may accordingly provide the foundation for a more sensitive interpretation of the Supreme Court's abortion decisions.

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82. 432 U.S. 438 (1977).

83. 432 U.S. 464 (1977). See notes 94-104 and accompanying text *infra*.

84. *Maher v. Roe*, 432 U.S. at 478; *Beal v. Doe*, 432 U.S. at 446.

85. Justice Powell's statement in *Maher* that the decision not to require state funding of nontherapeutic abortions "signals no retreat from *Roe* or the cases applying it," 432 U.S. at 475, takes on added significance in this context. It implies that earlier interpretations of *Roe*, which read too much into the Court's recognition of a woman's right to obtain an abortion and attached too little significance to its concern for potential life, were unfounded.

86. 410 U.S. 179, 197 (1973) (emphasis added).

### C. *The Current Constitutional Parameters*

In order to evaluate concrete proposals aimed at strengthening the doctor-patient relationship, an understanding of the precise constitutional limits on state action affecting the abortion decision is vital. The major impact of the Court's rulings, of course, has been to insulate the doctor-patient relationship from outside influences. Beginning with *Roe v. Wade*, the Court held that, at least during the first trimester, doctor and patient may make and implement the abortion choice "without regulation [or] . . . interference by the State."<sup>87</sup> *Doe v. Bolton* went a step further by invalidating a scheme that conditioned access to abortion on hospital committee approval or on concurrence by other medical professionals.<sup>88</sup> Finally, in *Planned Parenthood v. Danforth*,<sup>89</sup> the Court invalidated parental and spousal consent requirements, thus insulating the doctor-patient decisionmaking process from familial vetoes.

In general, then, the doctor-patient relationship is seen as a private affair that should not be subjected to interference from the state, the medical profession, or other interested parties in the absence of compelling state interests. A distressing side effect of this progressive insulation of the doctor-patient relationship in all too many cases is the increasing isolation of the pregnant woman from a number of the support systems that would normally assist her in making an extremely difficult decision. Given the Court's recognition of the stressful nature of the abortion choice,<sup>90</sup> one implication of the recent decisions is that a greater share of the emotional burden of making the abortion decision is concentrated exclusively in the doctor-patient relationship. This would appear to create a demand for heightened sensitivity on the part of the consulting physician.

Consistent with this demand for heightened sensitivity, and notwithstanding the strong language in *Roe* suggesting the absolute impermissibility of state regulation of the abortion choice during the first trimester,<sup>91</sup> the Supreme Court has subsequently made it clear that some minimal constraints on the doctor-patient relationship are appropriate from the time of conception.

87. 410 U.S. 113, 163 (1973).

88. 410 U.S. 179, 197-200 (1973).

89. 428 U.S. 52, 67-75 (1976).

90. *Id.* at 67.

91. 410 U.S. 113, 163 (1973). See *Friendship Medical Center, Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141 (7th Cir. 1974) (invalidating regulations establishing sanitation and equipment requirements for abortion facilities), *cert. denied*, 420 U.S. 997 (1975).

States may continue to require that abortions be performed only by licensed physicians and may subject persons performing abortions without such authority to criminal sanctions.<sup>92</sup> Moreover, the Supreme Court in *Planned Parenthood v. Danforth* specifically sustained statutory provisions establishing recordkeeping and reporting procedures and making the woman's informed consent a necessary precondition for a lawful abortion.<sup>93</sup>

The clearest articulation of the scope of permissible state action during the first trimester occurs in *Maher v. Roe*,<sup>94</sup> where the Court sustained a state regulation limiting Medicaid benefits for first trimester abortions to those that are "medically necessary." Commenting on prior privacy cases, the Court stated,

*Roe* did not declare an unqualified "constitutional right to an abortion" . . . . Rather, the right protects the woman from *unduly burdensome interference* with her freedom to decide whether to terminate her pregnancy. It implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.<sup>95</sup>

The criminal abortion statutes invalidated by *Roe* and the spousal and parental consent requirements struck down in *Danforth* were thus objectionable not merely because they constituted state regulation within a protected zone of privacy, but because they were "unduly burdensome interference" with the abortion *choice*. They constituted state-created obstacles to the effectuation of the abortion decision independently reached by a woman and her consulting physician.<sup>96</sup> The *Maher* Court acknowledged that a state's failure to fund nontherapeutic abortions might make it difficult or even impossible for indigent women to obtain abortions.<sup>97</sup> The Court reasoned, however, that this lack of access resulted not from affirmative state action but from the women's indigency, and that the state had no affirmative obligation to finance the termination of a potential human life.<sup>98</sup> The conclusion, then, was that states are free to influence

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

93. 428 U.S. 52, 66-67 (1976). See Section III *infra* (discussion of informed consent).

94. 432 U.S. 464 (1977).

95. *Id.* at 473-74 (emphasis added).

96. *Id.* at 473. Chief Justice Burger formulated this notion by stating that the "legislative determination [to finance certain childbirth expenses] places no state-created barrier to a woman's choice to procure an abortion . . . ." *Id.* at 481-82 (Burger, C.J., concurring).

97. *Id.* at 474.

98. *Id.* at 474, 479-80.

the abortion choice by shaping incentive structures to accord with legitimate state policies, even during the first trimester, so long as no affirmative state action unduly interferes with the decision to continue or terminate the pregnancy.<sup>99</sup>

In this Article, the concern is not so much with state action that alters the incentive structure surrounding the abortion choice as with state action designed simply to shore up the doctor-patient relationship and to make certain that a meaningful relationship emerges. But in both areas the question is much the same. At what point does permissible fostering of legitimate state interests blur over into impermissible regulation of the abortion choice? When do regulatory efforts become "unduly burdensome interference with [the woman's] freedom to decide whether or not to terminate her pregnancy?"<sup>100</sup> One of the central teachings of *Maher* is that wherever that line lies, it cannot be identified simply by drawing a magic circle around the woman and her doctor and proscribing any law whose influence reaches inside it. As one scholar has noted, one cannot simply view "the zone of privacy as a legal island of personal autonomy in the midst of a sea of public regulation and interaction," because that metaphor fails to clarify what constitutes an impermissible "coming ashore."<sup>101</sup> The virtue of the Court's analysis in *Maher* is that it recognizes that the issue is one of degree—one of assessing what constitutes an "unduly burdensome interference"—and that in the abortion context, this question cannot be answered without assessing the significance of the state's interest in potential life. While only compelling state interests justify state nullification of decisions reached by a woman and her doctor, the state has a "strong and legitimate interest in encouraging normal childbirth"<sup>102</sup> which "exists throughout the pregnancy."<sup>103</sup> If this significant, though not compelling, interest is sufficiently potent to warrant first-trimester regulations that provide strong incentives for a decision to continue a pregnancy, as *Maher* implies, then surely requirements designed merely to assure meaningful doctor-patient interaction (without proscribing the decisional outcome of such interaction) must also be permissible.<sup>104</sup>

99. *Id.* at 474-78 & nn.8-10.

100. *Id.* at 474.

101. Gentry, *supra* note 19, at 271.

102. *Beal v. Doe*, 432 U.S. 438, 446 (1977).

103. *Maher v. Roe*, 432 U.S. 464, 478 (1977).

104. A narrower interpretation of *Maher* that might preclude this conclusion could be developed on the basis of *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977), which was decided just two weeks before *Maher*. In *Carey*, the Court invalidated a New York statute regulating the sale and distribution of nonprescription contraceptives, holding

## II. ENSURING CONSULTATION OCCURS: INSTITUTIONAL APPROACHES

The first part of this Article has suggested that Supreme Court cases dealing with abortion, while drastically limiting the range of permissible state regulation of the abortion choice, have not altogether precluded state action that encourages heightened sensitivity to the value of unborn life. We have argued that although there is much that can be said in criticism of the Supreme Court's attempt to resolve the abortion dilemma by insisting on doctor involvement in the abortion decisionmaking process, the residual merits of that approach in terms of maintaining some respect for the value of fetal life while maintaining sufficient flexibility for female autonomy have not been fully appreciated. Once one begins to recognize the doctor-patient relationship as a vehicle for enhancing the woman's rational autonomy and for imposing noncoercive constraints on the decision to terminate fetal life, it becomes obvious that there are a number of things a

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that no compelling state interest justified the regulations in question. The *Maher* majority was able to conclude that states need not fund nontherapeutic abortions by reasoning that a state's decision to withhold funds in this manner impinged on no fundamental interests that would require a compelling state interest test. Arguably, the only distinction between *Maher* and *Carey* with regard to the applicability of a compelling state interest test is that *Carey* involved affirmative state action. Justice Powell, writing for the *Maher* majority, indicated that *Maher* "signal[ed] no retreat from *Roe*," 432 U.S. at 475, and he stressed the distinction between direct burdens and nonproffered advantages. *See id.* at 475 n.9. If this analysis is accurate, any regulation imposed on the doctor-patient relationship during the first trimester other than legislative refusals to affirmatively support abortion decisions through funding or otherwise would require use of the compelling state interest test.

*Carey* and *Maher*, however, can be harmonized on a basis that gives broader scope to the "unduly burdensome interference" rationale of *Maher*. Part of the reason for the difference between the two cases was that the New York regulatory scheme in *Carey* was not well crafted to meet its apparent ends. As Justice Stevens stated regarding the legislation's prohibition of contraceptive sales to minors under age sixteen, "[i]t is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets." 431 U.S. at 715 (Stevens, J., concurring). Even Justice Powell, who maintained that the majority erred by invoking the compelling state interest test, concurred in the result on the ground that there were no state interests of sufficient magnitude to justify the regulations as drafted. *See id.* at 707-08 (Powell, J., concurring). More significantly, *Carey* merely held that the compelling state interest test comes into play when state regulations "burden an individual's right to decide to prevent contraception or terminate pregnancy by substantially limiting access to the means of effectuating that decision . . . ." *Id.* at 688 (emphasis added). *See id.* at 688 n.5. The regulations in question in *Carey* were characterized as imposing "a significant burden on the right of individuals to use contraceptives . . . ." *Id.* at 689 (emphasis added). This language recognizes the analysis in *Maher* that at the boundaries the question of invasion of privacy is inescapably a question of degree—a question of "unduly burdensome interference." *Carey* leaves open the possibility that various state measures—even some going beyond mere non-support—may be constitutionally permissible.



state can do to enhance the efficacy of the doctor-patient relationship in promoting these ends. Having explored in some detail the Court's view of a desirable doctor-patient relationship and having noted the Court's apparent willingness in recent cases to permit some degree of state activity aimed at encouraging normal child-birth, we are now in a position to analyze the constitutionality of a number of concrete approaches designed to ensure that the contemplated doctor-patient relationship actually materializes. In this Section we will examine clinic regulation and recordkeeping and reporting procedures as they relate to the consultation process. In Section III we will turn to informed consent requirements, and in Section IV we will focus on counseling schemes.

#### A. Regulation of Abortion Clinics

A reality serving to undermine the emergence of meaningful doctor-patient relationships is the fact that at present at least sixty percent of abortions occur in freestanding clinics.<sup>105</sup> While some of these facilities are equipped not only to terminate pregnancy but also to provide needed counseling and other forms of support,<sup>106</sup> the general procedure allows the woman minimal contact with the physician performing the abortion. Typically, the clinics are run by entrepreneurs and physicians on a profitmaking basis.<sup>107</sup> Maximizing clinic revenue demands minimizing the amount of time the doctor spends with each patient, thus creating strong disincentives for the development of meaningful doctor-patient relationships. Even if time is allocated to careful doctor-patient consultation, the financial incentives for the doctor are all on the side of encouraging the woman to go through with the abortion. This is not to imply that medical judgment will inevitably be distorted by concern to make one more fee. Still, financial considerations are a powerful influence threatening to bias the consulting physician in favor of the abortion decision and against concern for fetal life.<sup>108</sup> A doctor routinely performing

105. Sullivan, Tietze, & Dryfoos, *supra* note 13, at 127.

106. Burnhill, *Humane Abortion Services: A Revolution in Human Rights and the Delivery of a Medical Service*, 42 *MT. SINAI J. MED.*, N.Y. 431, 436 (1975).

107. *Id.* at 434-35. *But cf.* Schwartz, *supra* note 67, at 475 (arguing in an early article that profit margins were likely to decline as clinics proliferated).

108. Numerous studies have noted the impact of differential financial rewards on medical treatment decisions. *See, e.g.*, Schneyer, *supra* note 70, at 136-41 & nn.48-70 (and authorities cited therein). Studies have also shown that there are a variety of contexts where doctor specialization and the likelihood of a noncontiguous doctor-patient relationship tend to make the attitudes of colleagues more important than patient interest in shaping physician behavior. *See* E. FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* 199-206 (1970); Schneyer, *supra* note 70, at 137-38.

abortions in a clinic is apt to become desensitized to the magnitude of the abortion choice in the life of an individual woman.<sup>109</sup> Thus, even if such a doctor does take the time to counsel with his patient, he is unlikely to play a role conducive to the protection of fetal life in the woman's decisionmaking process.

Because of these considerations, some countries have enacted legislation either disallowing or strictly regulating the performance of abortions in freestanding clinics.<sup>110</sup> Under French law, for example, a voluntary termination of pregnancy may be performed only by a physician in a public hospital or in a private hospital meeting certain statutory requirements.<sup>111</sup> If the number of abortions performed in a private hospital exceeds one-quarter of all surgical and obstetrical operations performed in any given year, the hospital will be closed for one year. A repeat offense will entail final closure of the establishment.<sup>112</sup>

Obviously, this type of statute precludes the emergence of freestanding clinics operating as abortion mills. However, it is not really clear that it solves the key problems associated with clinics. Even in a private French hospital that observed the "one-quarter" limitation, it would be quite possible that a relatively small number of doctors would perform a high percentage of the hospital's abortions. The problem of desensitization that is encountered in an abortion clinic would likely be replicated among these doctors. Moreover, the financial incentives tending to create an institutional bias in favor of abortion do not arise solely in the clinic setting. Because the great majority of abortions can be performed using simple procedures and with relatively low overhead costs, it is likely that a hospital's abortion facilities will operate in the black and may even provide funds to help support research or other hospital programs. Subtle administrative pres-

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109. *But see* Marcin & Marcin, *The Physician's Decision-Making Role in Abortion Cases*, 1975 *JURIST* 66, 70-71 (describing experience of Dr. Bernard N. Nathanson, who was influential in persuading the New York State Assembly to liberalize abortion laws in that state and subsequently headed a major abortion clinic, but ultimately became convinced that human life exists in the womb); Nathanson, *Sounding Board: Deeper Into Abortion*, 291 *NEW ENGLAND J. MED.* 1189 (1974).

110. *See, e.g.*, The Criminal Law Consolidation Ordinance, 1876 to 1969, § 79A(3)(b) (Austl., Northern Territory) (legal abortions must be performed in hospitals), reprinted in 28 *WORLD HEALTH ORGANIZATION, INTERNATIONAL DIGEST OF HEALTH LEGISLATION* 428 (1977) [hereinafter cited as *WHO INT'L DIGEST*]; Act of June 13, 1975, Law No. 50, § 3 (Nor.) (abortions after twelfth week permitted only in hospitals; earlier abortions may be performed in other approved institutions), translated in 26 *WHO INT'L DIGEST* 595 (1975).

111. Act of Jan. 17, 1975, Law No. 75-17, art. L. 162-2 (Fr.) (concerning the voluntary termination of pregnancy), translated in 26 *WHO INT'L DIGEST*, *supra* note 110, at 352 (1975).

112. *Id.* art. L. 178-1.

tures may result in the creation of a pro-abortion setting equivalent to the one a doctor is likely to experience in the clinic setting. Despite these considerations, however, there is greater reason to expect medical consultation that is sensitive to the value of potential life in a multipurpose medical institution than in a clinic whose *raison d'être* is the performance of abortions. Among other things, a hospital staff is likely to have greater diversity of attitudes toward abortion than the staff of an abortion clinic, and collegial dynamics might help to reduce the predictable pro-abortion bias of the clinic setting.<sup>113</sup>

While interesting as an approach to limiting abortion procurement systems peculiarly likely to be insensitive to the value of potential life, the French approach would have only limited relevance to the contemporary American scene. *Doe v. Bolton* expressly rejected a statutory requirement that all abortions, including first trimester abortions, be performed in licensed and accredited hospitals.<sup>114</sup> Moreover, *Roe v. Wade* and *Doe v. Bolton* have been interpreted as placing severe limitations on appropriate regulation of abortion clinics. Thus, attempts by local governments to subject abortion clinics to restrictive zoning have been declared unconstitutional.<sup>115</sup> Similarly, blanket measures requiring that all abortions, including first trimester abortions, be performed in hospitals or equivalent facilities have been held unconstitutional.<sup>116</sup> Courts have also taken a dim view of schemes imposing regulatory burdens on abortion facilities that are not applicable to medical facilities in general.<sup>117</sup> The most noteworthy case in this area is *Friendship Medical Center, Ltd. v. Chicago Board of Health*.<sup>118</sup> In that case, the Seventh Circuit Court of Appeals struck down regulations promulgated by the Chicago Board of Health that required abortion clinics to keep various types of records, conduct specified tests, maintain equipment necessary to treat abortion complications, and in general, provide facilities that could render a high standard of abortion care.<sup>119</sup> Notwithstanding the fact the regulations were clearly

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113. Cf. Schneyer, *supra* note 70, at 137-38 (noting the impact of organizational dynamics and collegial pressure in biasing medical treatment decisions).

114. 410 U.S. 179, 193-95 (1973).

115. *Planned Parenthood v. Citizens for Community Action*, 558 F.2d 861 (8th Cir. 1977); *Framingham Clinic, Inc. v. Board of Selectmen*, \_\_\_ Mass. \_\_\_, 367 N.E.2d 606 (1977).

116. *Arnold v. Sendak*, 416 F. Supp. 22 (S.D. Ind.), *aff'd*, 429 U.S. 968 (1976).

117. See, e.g., *Word v. Poelker*, 495 F.2d 1349 (8th Cir. 1974); *Mobile Women's Medical Clinic, Inc. v. Board of Comm'rs*, 426 F. Supp. 331 (S.D. Ala. 1977); *Hallmark Clinic v. North Carolina Dep't of Human Resources*, 380 F. Supp. 1153 (E.D.N.C. 1974).

118. 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975).

119. See *id.* at 1144-45.

designed to protect maternal health, the court held that they were unconstitutional because the state did not have a compelling interest in promoting maternal health until the end of the first trimester.<sup>120</sup>

The result in *Friendship Medical Center* may be criticized on several grounds. Most obviously, even though first trimester abortions are relatively safe, they will clearly be even safer if performed in facilities equipped to handle foreseeable complications. As long as the regulations do not interfere with the right of the woman and her doctor to make and implement an informed abortion decision, such regulations should be allowed. This conclusion draws added support from subsequent Supreme Court case law suggesting that a state interest need not be compelling in order to justify state action that does not unduly burden the abortion decision. In the *Friendship Medical Center* case, the Seventh Circuit assumed that the mere presence of the woman's fundamental privacy right was sufficient to require a compelling state interest test in the area of clinic regulation.<sup>121</sup> The Supreme Court's subsequent decision in *Maher v. Roe*,<sup>122</sup> however, has made it clear that legislation designed to foster legitimate state interests is not constitutionally objectionable where it does not create "unduly burdensome interference with [the woman's] freedom to decide."<sup>123</sup> Thus, it would now appear that the state need not meet the compelling state interest test to justify regulations—even regulations that add an overlay of requirements applicable only to abortion facilities<sup>124</sup>—unless the regulations constitute an excessive restriction of female autonomy.

Of course, the tougher compelling state interest analysis is triggered by a relatively slight burden on a woman's autonomy. In *Carey v. Population Services International*,<sup>125</sup> a statute permitting only licensed pharmacists to distribute nonprescription contraceptives was held unduly burdensome because it "substantially limit[ed] access to the means of effectuating"

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120. *Id.* at 1150.

121. *See id.*

122. 432 U.S. 464 (1977).

123. *Id.* at 474.

124. The "differential regulatory overlay" argument derives much, if not all, of its force from the assumption that any differential treatment in the abortion area can only be justified by a compelling state interest. *See generally* *Friendship Medical Center, Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141, 1152-53 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975). Justice Powell's conclusion in *Maher* that a state scheme that funded therapeutic but not nontherapeutic abortions could be sustained "under the less demanding test of rationality," 432 U.S. at 478, undercuts this assumption.

125. 431 U.S. 678 (1977).

reproductive choices.<sup>126</sup> Therefore, to the extent clinic regulations have the effect of significantly curtailing the availability of abortion facilities, such regulations will be subject to the compelling state interest analysis applied by the Seventh Circuit in *Friendship Medical Center*. But where their effect is merely to establish a minimum threshold for the quality of abortion facilities, regulations rationally related to maternal health should be permissible.

A number of states have passed legislation requiring that abortions after the first trimester be performed in hospitals.<sup>127</sup> The Court in *Doe v. Bolton* alluded to the possibility that after the first trimester the state might "adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the state seeks to accomplish."<sup>128</sup> The Court indicated that the state would be required to make a fairly strong showing that the standards were necessitated by medical considerations if such regulations were to be justified on the basis of the state's compelling interest in maternal health.<sup>129</sup> The dicta in *Doe v. Bolton* militate against the constitutionality of a statutory provision precluding clinics with sophisticated medical technology from performing second trimester abortions. Nonetheless, a plausible argument can be made that the added medical risks inherent in abortions during the later states of pregnancy, together with the Supreme Court's concern for a sensitive doctor-patient relationship, would constitutionally validate a statute requiring that abortions be performed in hospitals after the first trimester.

### B. Recordkeeping and Reporting Requirements

The permissibility of limited recordkeeping and reporting requirements is one of the few clear exceptions to the constitutional prohibition against regulation of first trimester abortions. The Supreme Court sustained such requirements in *Planned Parenthood v. Danforth*,<sup>130</sup> but made it clear that the exception was a narrow one. Recordkeeping and reporting requirements during the first trimester were characterized as "perhaps approaching

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126. *Id.* at 688.

127. See, e.g., IDAHO CODE § 18-608(2) (Supp. 1978); Illinois Abortion Law of 1975, § 4, ILL. ANN. STAT. ch. 38, § 81-24 (Smith-Hurd 1977); IND. CODE ANN. § 35-1-58.5-2(b)(2) (Burns 1975); KY. REV. STAT. § 311.760(2) (1977); MINN. STAT. ANN. § 145.412(2) (West Supp. 1979); MONT. REV. CODES ANN. § 94-5-618(b) (1977).

128. 410 U.S. 179, 194-95 (1973).

129. *Id.* at 195.

130. 428 U.S. 52, 79-81 (1976).

impermissible limits."<sup>131</sup> The Court warned against efforts to exploit the exception by indirectly imposing, "through the sheer burden of recordkeeping detail,"<sup>132</sup> constraints that the Court had previously held to be unconstitutional. Significantly, as in *Maher* a year later, the ultimate issue was perceived to be whether the requirements in question constituted an "unduly burdensome interference"<sup>133</sup> with the woman's abortion decision. The Court further limited its holding by stressing that the Missouri statute provided that the information gathered "shall be confidential and shall be used only for statistical purposes."<sup>134</sup> Finally, the Court noted the importance of a rational relationship between the information requested and a legitimate state interest.

In *Danforth*, the Court rationalized its acceptance of Missouri's recordkeeping requirements by recognizing the state's valid interest in maternal health.<sup>135</sup> Because *Roe v. Wade* had held that this interest did not become compelling until the second trimester, and because *Danforth* sanctioned first trimester recordkeeping requirements, one commentator has discerned in *Danforth* signs of a "circumspect retreat" from the no-regulation stance of *Roe*.<sup>136</sup> However, in light of the Court's subsequent assertion in *Maher* that validation of some measures affecting first trimester abortion choices "signals no retreat from *Roe*,"<sup>137</sup> it seems more accurate to state that *Roe* was not as rigidly antiregulation as initially supposed. In any event, it is clear the state has "strong and legitimate"<sup>138</sup> interests in protecting female autonomy and potential life as well as maternal health. All these interests can be furthered by reasonable recordkeeping and reporting requirements.

In the long run, such requirements should yield significant data facilitating medical judgments, thereby contributing to maternal health.<sup>139</sup> However, the immediate impact of recordkeeping and reporting requirements is to require a minimal level of interaction between the doctor and the patient. This increases the woman's autonomy by expanding the informational base upon which the abortion decision ultimately rests and may well alert the woman to facts that would lead her to continue her

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131. *Id.* at 81.

132. *Id.*

133. *Maher v. Roe*, 432 U.S. 464, 474 (1977).

134. 428 U.S. at 79, 87.

135. *Id.* at 80-81.

136. 1976 B.Y.U. L. REV. 977, 997.

137. 432 U.S. at 473-75.

138. *Maher v. Roe*, 432 U.S. at 478; *Beal v. Doe*, 432 U.S. at 446.

139. *Planned Parenthood v. Danforth*, 428 U.S. at 79-81.

pregnancy. Because several legitimate state interests support recordkeeping requirements,<sup>140</sup> there appears to be no reason why informational requests could not be tailored to further other of these interests in addition to the interest in maternal health. Thus, *Danforth* should not be read as holding that recordkeeping and reporting procedures are permissible *only* if they are rationally related to the state's maternal health interests.

As noted, the immediate effect of recordkeeping requirements is to reinforce one of the major features of the Supreme Court's view of the doctor-patient relationship: the screening function.<sup>141</sup> Essentially, recordkeeping requirements promote the interests in female autonomy and fetal life by insisting that a thorough patient history be obtained. That such requirements should turn out to be constitutional is not surprising, considering the Supreme Court's insistence in all its major abortion cases on doctor involvement in the abortion decision. Because the taking of a medical history is an important aspect of the doctor-patient relationship mandated by the Court, and because no incremental invasion of the woman's privacy occurs if the doctor is simply required to report some of the data gleaned in the process, no constitutional infraction occurs so long as confidentiality is adequately safeguarded.

As more states pass recordkeeping and reporting requirements, difficult line-drawing problems are bound to arise in determining (1) whether the confidentiality of the data gathered is sufficiently protected, (2) whether the information requested is unnecessarily intrusive, and (3) whether the requirements taken as a whole are overly burdensome. In order to analyze these issues, it is useful to consider in detail the types of requirements and informational requests apt to be encountered. In this regard, it will be useful to refer occasionally to a recently enacted Louisiana statute<sup>142</sup> that, because of its comprehensiveness, raises most of the issues likely to arise.

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140. Such alternative interests are not limited to those noted in the text. In *Whalen v. Roe*, 429 U.S. 589 (1977), the Supreme Court sustained a recordkeeping and reporting scheme pursuant to which all those distributing or obtaining dangerous drugs by prescription, as well as those prescribing such drugs, were reported to the state health department. The Court held that, in view of excellent confidentiality precautions, the privacy rights of those challenging the statute were not violated and the overall scheme was constitutional, since it was rationally related to the state's legitimate interest in regulating traffic in dangerous drugs.

141. See notes 48-57 and accompanying text *supra*.

142. Act of July 10, 1978, Act No. 435, sec. 1, §§ 1299.35.1-.18, 1978 La. Sess. Law Serv. 836 (West)(to be codified as LA. REV. STAT. ANN. §§ 40:1299.35.1-.18 (West)).

A. An individual abortion report for each abortion performed or induced

### 1. Confidentiality

The Louisiana statute deals with the confidentiality issue by requiring that the report "shall be confidential and shall not contain the name of the woman."<sup>143</sup> However, the patient is assigned a number which is included in the report,<sup>144</sup> and a copy of the abortion report is ultimately made a part of the medical record of the patient at the facility or hospital in which the abortion was performed.<sup>145</sup>

One of the primary objections to a reporting requirement that does not adequately safeguard confidentiality is that the patient may be deterred from seeking an abortion if she fears other people may hear about the abortion. Thus, at least one court has invalidated recording and reporting provisions that

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upon a woman shall be completed by her attending physician. The report shall be confidential and shall not contain the name of the woman. This report shall include: (1) Patient number, (2) Name and address of the abortion facility or hospital, (3) Date of abortion, (4) Zip code or residence of pregnant woman, (5) Age of pregnant woman, (6) Race, (7) Marital status, (8) Number of previous pregnancies, (9) Educational background, (10) Number of living children, (11) Number of previous induced abortions, (12) Date of last induced abortion, (13) Date of last live birth, (14) Method of contraception at time of conception, (15) Date of beginning of last menstrual period, (16) Medical condition of woman at time of abortion, (17) Rh type of pregnant woman, (18) Type of abortion procedure, (19) Complications by type, (20) Type of procedure done after the abortion, (21) Type of family planning recommended, (22) Type of additional counseling given, (23) Signature of attending physician, (24) The certifications provided for in this Chapter.

B. An individual complication report for any post-abortion care performed upon a woman shall be completed by the physician providing such post-abortion care. The report shall include: (1) The date of the abortion. (2) The name and address of the abortion facility or hospital where the abortion was performed. (3) The nature of the abortion complication diagnosed or treated.

C. All abortion reports shall be signed by the attending physician and submitted to the Department of Health and Human Resources within thirty days after the date of the abortion. All complication reports shall be signed by the physician providing the post-abortion care and submitted to the Department of Health and Human Resources within thirty days after the date of the completion of the post-abortion care.

D. A copy of the abortion report shall be made a part of the medical record of the patient of the facility or hospital in which the abortion was performed.

E. The Department of Health and Human Resources shall be responsible for collecting all abortion reports and complication reports and collating and evaluating all data gathered therefrom and shall annually publish a statistical report based on such data from abortions performed in the previous calendar year.

*Id.* § 1299.35.10.

143. *Id.* § 1299.35.10(A).

144. *Id.* § 1299.35.10(A)(1).

145. *Id.* § 1299.35.10(D).



called for the identification of the woman by name.<sup>146</sup> At the same time, an important benefit of reporting requirements is the information such reports could yield about risks to maternal health as a result of repeat abortions. If the information is gathered in a way that preserves the complete anonymity of the woman, longitudinal studies that would identify repeat abortion situations would be impossible.

The Louisiana approach to this dilemma is somewhat of a compromise. The woman's name does not appear on the report, but a patient number is assigned that makes it possible to identify repeat abortions if a second abortion is performed in the same institution. A problem with the Louisiana approach is that no provision is made for statewide standardization of patient numbers, thereby preventing meaningful longitudinal studies based on these reports. The legislature was no doubt reluctant to assign women universal abortion numbers permanently linked to their names or social security numbers because of the Orwellian aura of such a procedure and because it might ultimately make easier the disclosure of the name behind the number.

## 2. Intrusiveness

Much of the information requested under the Louisiana statute is unexceptionable from the perspective of relative intrusiveness. Patient number, age, name of facility where abortion is performed, date of abortion, and the zip code of the pregnant woman<sup>147</sup> are noncontroversial matters that would be expected to be included in virtually any recordkeeping procedure.

Other noncontroversial information that can reasonably be requested is information having a clear bearing on the medical advisability of abortion in the woman's situation, information that would indicate special medical techniques that might need to be applied, or information that would record medical complications involved in a particular abortion.<sup>148</sup> As a general rule, information that would normally be requested in the course of obtaining a woman's medical history should be subject to reasonable reporting requirements. The request for this information involves no invasion of the woman's privacy beyond that which

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146. *Schulman v. New York City Health & Hosp. Corp.*, 38 N.Y.2d 234, 240, 255-56, 342 N.E.2d 501, 504, 513-14, 379 N.Y.S.2d 702, 706, 718-19 (1975).

147. Nondisclosure of exact address information may of course be significant to preserving confidentiality.

148. See, e.g., Act of July 10, 1978, Act No. 435, sec. 1, § 1299.35.10(A)(8), (11), (13), (15), (20), 1978 La. Sess. Law Serv. 836 (West) (to be codified as LA. REV. STAT. ANN. § 40:1299.35.10(A)(8), (11), (13), (15), (20)(West)) (quoted in note 142 *supra*).

would be necessary in any event were she to obtain an abortion. These reporting requirements do not in any way operate to dictate the outcome of the abortion decision in a particular case.

Other more controversial information relates to the social and educational background of the woman.<sup>149</sup> Arguably, information of this nature is less relevant to the exercise of a doctor's medical judgment. Data such as race, marital status, and number of living children are less directly related to the exercise of a physician's judgment than the number of previous pregnancies, the number of previous abortions, date of the last menstrual period, and the like. A woman's background, however, and the circumstances under which she lives may have a significant bearing on the potential impact of the abortion choice on her mental health.<sup>150</sup> Thus, a sensitive physician will be concerned about the woman's background and environment in order to better assess the wisdom of abortion in her particular circumstances and in order to better assess the types of followup assistance or support she may need. This information would also be useful in statistical studies aimed at identifying the demographic characteristics of women seeking abortions. Although the potential for excessive reporting requirements may be of some concern, such requirements should be permissible as long as the information requested is relevant to the doctor's exercise of sensitive and informed judgment about the wisdom of an abortion in light of the totality of the woman's circumstances.

A final category of information relates to the method of contraception, if any, at the time of conception and the type of family planning recommended subsequent to an abortion.<sup>151</sup> This type of reporting requirement appears to be aimed primarily at minimizing the number of repeat abortions. Assuming that contraception is less risky than abortion, ensuring that a woman has adequate information about available contraceptives is obviously related to a legitimate interest in her long-range health.

Although it is not immediately clear how contraception information bears on the abortion actually being performed, such information may be useful in determining the extent to which the availability of abortion impacts on the use of contraceptives. So long as such information imposes no constraints on the ultimate decision reached by the woman and her consulting physician, a

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149. See, e.g., *id.* § 1299.35.10(A)(6), (7), (9), (10).

150. See notes 240, 264-66 and accompanying text *infra*.

151. See, e.g., Act of July 10, 1978, Act No. 435, sec. 1, § 1299.35.10(A) (14), (21), 1978 La. Sess. Law Serv. 836 (West)(to be codified as LA. REV. STAT. ANN. § 40:1299.35.10(A)(14), (21)(West)) (quoted in note 142 *supra*).

reporting procedure that helps identify the need for contraception procedures that could possibly avoid repeat abortions would seem to be permissible.

### 3. *Burdensomeness*

There is no easy way to assess whether specific reporting and recordkeeping legislation is overly burdensome. No readily identifiable standard is available on the basis of which one may discriminate between legislation demanding too much and legislation imposing only a reasonable burden. The *Danforth* decision itself provides little guidance. The statute involved in *Danforth* called for the preparation of reporting forms by the Missouri Division of Health, but because the Court gave no indication of what was on such forms (presumably because the constitutionality of the statute was challenged before the forms were prepared), there is no way to gauge the burdensomeness of the reporting requirements approved in *Danforth*. While certain factors bearing on the burdensomeness issue come to mind—the length of the report required, the extent to which the reporting procedures call for information beyond a normal medical history, the likelihood that the burden of preparing the report itself would bias a doctor's judgment as to the appropriateness of an abortion—the burdensomeness issue is one that must ultimately be decided on a case-by-case basis. The Louisiana statute is quite rigorous in its reporting requirements, but arguably is not *overly* burdensome.

It is still too early to predict with precision how extensive a recordkeeping and reporting requirement is permissible under *Danforth*. However, the allowance of the reporting requirement in *Danforth* is additional evidence of the Supreme Court's concern for the existence of a meaningful doctor-patient relationship in the abortion context. Hopefully, the information *Danforth* allows to be gathered will be put to meaningful use. As indicated earlier, there is language in *Danforth* praising the Missouri statute on the ground that the data gathered would be used "only for statistical purposes."<sup>152</sup> This "statistical purpose" restriction should be construed broadly to allow meaningful analysis of the data gathered so that medical knowledge may be advanced and society placed in a better position to grapple with the problem of abortion.

One of the more interesting statutory recordkeeping provisions in Europe is one that has been adopted in Czechoslovakia. Not only does Czechoslovakian law require the collection of sta-

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152. 428 U.S. at 79, 81.

tistical abortion data, the law also demands that district and regional abortion commissions use the data in analyzing on an annual basis the factors that cause women to seek abortions. It is hoped the reports will place various governmental agencies in a better position to take practical steps toward eliminating at least some of the factors leading women to seek abortions.<sup>153</sup> A statutory provision of this nature would appear to be wholly consistent with both *Roe* and *Danforth* and would help to heighten sensitivity to the value of unborn life. A recordkeeping and reporting procedure akin to the Czechoslovakian statute would thus provide another avenue for improving, within the constitutional framework delineated by the Supreme Court, both the meaningfulness of doctor-patient interaction and the sensitivity of the abortion decisionmaking process to the interest in fetal life.

### III. INFORMED CONSENT REQUIREMENTS

#### A. *Types of Informed Consent Provisions*

For the most part, *Planned Parenthood v. Danforth*<sup>154</sup> will be remembered as a decision that narrowed the range of permissible state intervention in the abortion decision. The Court's acceptance of recordkeeping and reporting procedures is like a quiet backwater in a more dominant current, paralleled in direction only by its decision to sustain Missouri's informed consent statute. But reverse currents should not be ignored. The recognition by the *Danforth* Court of the appropriateness of informed consent requirements is particularly significant.

Statutes and case law requiring a woman's consent prior to the performance of an abortion constitute an important regulation of the doctor-patient relationship and one clearly aimed at protecting the woman's autonomy. Several states have passed informed consent legislation,<sup>155</sup> and the conventional common law notion that consent is a prerequisite to nonliability for battery would presumably apply elsewhere.<sup>156</sup> Focusing on informed consent statutes, considerable variation is discernible among state

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153. Order of May 16, 1973, No. 71, § 13 (Czech.), translated in 25 WHO INT'L DIGEST, *supra* note 110, at 75 (1974).

154. 428 U.S. 52 (1976).

155. IDAHO CODE §§ 18-608 to -609 (Supp. 1978); Illinois Abortion Law of 1975, ILL. ANN. STAT. ch. 38, § 81-23(2) (Smith-Hurd 1977); KY. REV. STAT. §§ 311.730, .740 (1977); MASS. GEN. LAWS ANN. ch. 112, § 12Q (West Supp. 1978-1979); MINN. STAT. ANN. § 145.412 (West Supp. 1978); MO. ANN. STAT. § 188.020 (Vernon Supp. 1978); MONT. REV. CODES ANN. §§ 94-5-615 to -616 (1977); N.D. CENT. CODE §§ 14-02.1-02 to -03 (Supp. 1977); 35 PA. CONS. STAT. ANN. §§ 6602-6603 (Purdon 1977); UTAH CODE ANN. § 76-7-305 (1978).

156. See W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18 (4th ed. 1971).

provisions. Some demand only a general expression of consent, while others specify in detail what information a woman must be given before she can effectively give her informed consent.

General informed consent provisions are well illustrated by the Missouri provision sustained in *Danforth*. That provision requires that prior to submitting to an abortion a woman must certify in writing that she consents to it and that her consent is informed, freely given, and not the result of coercion.<sup>157</sup> Many states have enacted only the barest of consent requirements, doing little if anything beyond codifying common law rules.<sup>158</sup> At this end of the continuum, regulation of the doctor-patient relationship diminishes to the vanishing point and the statutes merely operate to protect a woman from undergoing an abortion against her will.

More detailed informed consent provisions tend to resemble the statute adopted in Utah. Under its provisions, consent must be given in writing, and no consent is considered voluntary and informed unless the attending physician has informed the prospective abortion patient of a variety of matters that could bear upon her decision. Specifically, the woman must be given the names and addresses of two Utah adoption agencies, told of the availability of their services, and informed of the possibility of nonagency adoption. She must be apprised of the details of development of unborn children. The particulars of the abortion procedure and the nature of postoperative recovery must be described to her, along with any foreseeable complications and risks. Further, the doctor must discuss with her any additional factors that he or she deems relevant to the woman's informed consent.<sup>159</sup>

Other detailed informed consent provisions vary slightly in the types of information required to be given. Most detailed provisions require that the woman be informed concerning fetal development, the nature of the procedure and possible complications, and alternatives to abortion. The most detailed informed consent statute adopted to date is a recently enacted Louisiana

157. MO. ANN. STAT. § 188.020 (Vernon Supp. 1978). Massachusetts also has a general statute of this type. MASS GEN. LAWS ANN. ch. 112, § 12Q (West Supp. 1978-1979).

158. ARK. STAT. ANN. § 41-2555 (1977); IND. CODE ANN. § 35-1-58.5-2 (Burns 1975); IOWA CODE ANN. § 707.8 (West 1978); NEV. REV. STAT. § 442.250 (1977); N.Y. PENAL LAW § 125.05 (McKinney 1975); OR. REV. STAT. § 435.435 (1977); S.C. CODE § 44-41-20 (1977); S.D. COMPILED LAWS ANN. § 34-23A-7 (1977); TENN. CODE ANN. § 39-301 (1975); VA. CODE § 18.2-76 (1975); WASH. REV. CODE § 9.02.070 (1977).

159. UTAH CODE ANN. § 76-7-305 (1978). The Idaho, Illinois, Kentucky, Minnesota, Montana, North Dakota, and Pennsylvania statutes also give some description of what constitutes informed consent or mandate some counseling. See note 155 *supra*.

provision.<sup>160</sup> It requires the doctor to tell the woman that she is pregnant, indicate how many weeks her pregnancy has progressed, inform her that "the unborn child is a human life from the moment of conception," and describe "the anatomical and physiological characteristics of the particular unborn child." The doctor must also inform the woman that the "unborn child may be viable" if it is more than twenty-two weeks in gestation and that abortion can result in serious complications that are spelled out in the statute. Finally, the woman must be told about public and private agencies from which she can receive family planning information and from which she may obtain assistance during pregnancy and after birth if she decides not to have an abortion.<sup>161</sup>

The emergence of informed consent statutes in the abortion area is part of a broader development in tort law. Modern informed consent law as it has emerged over the past twenty years<sup>162</sup> is a synthesis of battery notions of consent and negligence concepts of reasonable disclosure.<sup>163</sup> The area is complex and, to be candid, somewhat of a morass.<sup>164</sup> For our purposes, however, a few general comments will suffice. Behind questions about how much information a doctor must give his patient to avoid malpractice liability lie much deeper concerns over state and doctor paternalism, as well as protection of the woman's autonomy.<sup>165</sup> As one contrasts the general and specific informed consent statutes, for example, it seems evident that the reason for the more detailed disclosure requirements in the latter is to provide stronger assurances that the patient will receive the information needed for an autonomous decision. The general statutes leave more room for

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160. Act of July 10, 1978, Act No. 435, sec. 1, § 1299.35.6, 1978 La. Sess. Law Serv. 836 (West) (to be codified as LA. REV. STAT. ANN. § 40:1299.35.6 (West)).

161. *Id.*

162. Contemporary informed consent law is often traced to two sources: Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1975), and McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 392 (1957). See, e.g., Plante, *An Analysis of Informed Consent*, 36 FORDHAM L. REV. 639, 651 (1968); *Abortion Alternative*, *supra* note 79, at 175 n.54.

163. Katz, *supra* note 62, at 143; *Abortion Alternative*, *supra* note 79, at 175.

164. An extensive body of literature dealing with this issue has been produced. See, e.g., Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758 (1970); Katz, *supra* note 62; Plante, *supra* note 162; Schneyer, *supra* note 70; Seidelson, *supra* note 62; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628 (1970); Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOKLYN L. REV. 241, 259 (1978); Note, *Advice and Consent in Medicine: A Look at the Doctrine of Informed Consent*, 16 N.Y.L.F. 863 (1970); Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970); *Abortion Alternative*, *supra* note 79.

165. For an excellent discussion of informed consent law in terms of the tension between doctor paternalism and patient autonomy, see Katz, *supra* note 62.

doctor paternalism by giving the doctor more leeway to decide whether or not the patient needs particular information. At the same time, it seems clear that the more specific statutes involve a heavier dose of state paternalism. Detailed statutes reflect a legislative judgment that the doctor and patient are not capable of resolving on their own the extent to which disclosure occurs or decisionmaking is left with the doctor. One is reminded of Rousseau's remark about being "forced to be free."<sup>166</sup> The state adopts a paternalistic posture toward the doctor-patient relationship in order to protect the woman's autonomy from doctor paternalism.

Whatever the paradoxes in this situation, there is no doubt that the theory behind the emerging pattern of informed consent statutes is to assure the patient greater autonomy in the making of treatment decisions. As a practical matter, doctor paternalism poses a greater threat to patient autonomy than state paternalism in this context, since the state merely mandates disclosure, whereas a variety of influences predispose doctors toward minimizing the time they spend educating patients.<sup>167</sup> Thus, doctor paternalism is much more likely to remain invisible until it is too late for effective exercise of patient autonomy. Moreover, the realities of the abortion situation tend to promote reticence on the part of the woman and close off normal channels of communication and support, so that the woman's decision is all too often made hurriedly without full consideration of its ramifications.<sup>168</sup>

Part of what is going on in the informed consent area reflects a practical concern to circumvent the "conspiracy of doctor silence" in order to make it easier for malpractice cases to get to the jury.<sup>169</sup> Moreover, there is abundant evidence that informed consent provisions seldom lead to as much patient autonomy in practice as the underlying theory would suggest.<sup>170</sup> All that is important for our purposes, however, is that informed consent statutes, even if only minimally effective in attaining their theoretical ends, are at least conducive to expanding in some degree the autonomy of a woman faced with an abortion decision. If the

166. J. ROUSSEAU, *THE SOCIAL CONTRACT* 18 (G. Cole trans. 1950).

167. See, e.g., Katz, *supra* note 62, at 148 (speaking of strong doctor beliefs that patients are not intellectually or emotionally equipped to make difficult treatment decisions and of the "deeply ingrained Hippocratic tradition against disclosure"). See generally Schneyer, *supra* note 70.

168. See *Planned Parenthood Ass'n v. Fitzpatrick*, 401 F. Supp. 554, 587 (E.D. Pa. 1975) (Adams, J., concurring and dissenting), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

169. See, e.g., J. WALT & F. INBAU, *MEDICAL JURISPRUDENCE* 75 (1971); Schneyer, *supra* note 70, at 155 & n.135; *Abortion Alternative*, *supra* note 79, at 179.

170. See Katz, *supra* note 62, at 164-74.

autonomy of the woman is the primary value behind her privacy right, it is difficult to see how informed consent statutes, which increase her autonomy, can be deemed to intrude on a woman's privacy right.

### B. *Constitutionality of Informed Consent Provisions*

Although not explicit in the Court's analysis in *Danforth*, the foregoing reasoning is reflected in its result. The appellants in *Danforth* challenged Missouri's general informed consent provision on the grounds that it imposed an impermissible extra layer of regulation on the abortion decision in violation of earlier abortion decisions,<sup>171</sup> and was vague and overbroad.<sup>172</sup> The Supreme Court, in upholding the consent provision, reasoned that the decision to have an abortion "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences."<sup>173</sup> Justice Stewart underscored the permissibility of informed consent statutes in his concurring opinion by stressing that the Court's holding in *Roe v. Wade* "was not intended to preclude the State from enacting a provision aimed at ensuring that the abortion decision is made in a knowing, intelligent, and voluntary fashion."<sup>174</sup> The Court dispensed with the vagueness argument in a footnote, holding that the arguably vague term "informed" simply meant "the giving of information to the patient as to just what would be done and as to its consequences."<sup>175</sup> To give the term a more extensive meaning, the Court indicated, might "confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession."<sup>176</sup>

Because *Danforth* involved a very general informed consent statute, the precise scope of its holding with regard to more detailed and arguably more intrusive consent requirements remains somewhat unclear. For the most part, the more detailed informed consent statutes reviewed since *Danforth* have withstood judicial scrutiny. In *Hodgson v. Lawson*<sup>177</sup> the Eighth Circuit sustained a Minnesota statute that made it "unlawful to perform an abortion without first obtaining the consent of the woman . . . after a full

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171. 428 U.S. at 65-66 (citing *Roe v. Wade*, 410 U.S. 113, 164-65 (1973); *Doe v. Bolton*, 410 U.S. 179, 195-200 (1973)).

172. *Id.* at 66.

173. *Id.* at 67.

174. *Id.* at 90 (Stewart, J., concurring).

175. *Id.* at 67 n.8.

176. *Id.*

177. 542 F.2d 1350 (8th Cir. 1976).



explanation of the abortion procedure and its effect."<sup>178</sup> Similarly, in *Wolfe v. Schroering*,<sup>179</sup> the Sixth Circuit upheld a Kentucky informed consent provision that requires physicians to "inform the expectant mother of the reasonably possible physical and mental consequences of the performance of the abortion or the nonperformance of the abortion."<sup>180</sup> Still more specific was the Pennsylvania statute sustained by a three-judge court in *Planned Parenthood Association v. Fitzpatrick*.<sup>181</sup> That provision requires informed consent except where abortion is immediately necessary to save the life of the mother, and defines "informed consent" as

a written statement, voluntarily entered into by the person upon whom an abortion is to be performed, whereby she specifically consents thereto. Such consent shall be deemed to be an informed consent only if it affirmatively appears in the written statement signed by the person upon whom the abortion is to be performed that she has been advised (i) that there may be detrimental physical and psychological effects which are not foreseeable [sic], (ii) of possible alternatives to abortion, including childbirth and adoption, and (iii) of the medical procedures to be used. Such statement shall be signed by the physician or by a counselor authorized by him and shall also be made orally in readily understandable terms insofar as practicable.<sup>182</sup>

Significantly, the Supreme Court summarily affirmed *Fitzpatrick*,<sup>183</sup> citing *Danforth*. The Court's statements in other contexts regarding the binding character of summary affirmances have been less than a model of consistency,<sup>184</sup> but in light of dictum in *Hicks v. Miranda*<sup>185</sup> that such affirmances constitute adjudication on the merits, the Court's affirmance of *Fitzpatrick* would appear to control lower court adjudication in this area unless and until the Court revises its position—at least with regard to informed consent statutes no more detailed than Pennsylvania's.

The only post-*Danforth* case to invalidate an informed consent statute is *Wynn v. Scott*.<sup>186</sup> In that case, a three-judge court

178. *Id.* at 1355-56 (quoting MINN. STAT. ANN. § 145.412(1)(4)(West Supp. 1978)).

179. 541 F.2d 523 (6th Cir. 1976).

180. *Id.* at 526 (quoting KY. REV. STAT. § 311.730 (1977)).

181. 401 F. Supp. 554, 583 (E.D. Pa. 1975), *aff'd sub nom.* Franklin v. Fitzpatrick, 428 U.S. 901 (1976).

182. 35 PA. CONS. STAT. ANN. § 6602 (Purdon 1977).

183. Franklin v. Fitzpatrick, 428 U.S. 901 (1976).

184. See generally R. STERN & E. GRESSMAN, SUPREME COURT PRACTICE 321-25 (5th ed. 1978).

185. 422 U.S. 332, 343-45 (1975). See also Mandel v. Bradley, 432 U.S. 173 (1977).

186. 449 F. Supp. 1302 (N.D. Ill. 1978). An appeal from the decision in *Wynn* was

sustained those portions of an Illinois statute modeled on the provision sustained in *Danforth*. However, the court struck down two further provisions that specified that no consent would be informed unless the woman was instructed regarding

- (a) The physical competency of the fetus at the time the abortion is to be performed, such as, but not limited to, what the fetus looks like, the fetus' ability to move, swallow, and its physical characteristics; (b) The general dangers of abortion, including, but not limited to, the possibility of subsequent sterility, premature birth, liveborn fetus and other dangers . . . .<sup>187</sup>

Conscious of the Supreme Court's affirmance of *Fitzpatrick*, the court avoided premising its conclusion on an analysis of the impact of these provisions on the doctor-patient decisionmaking process. Instead, the court reasoned that the provisions were objectionable because they were "both overly vague and overly specific."<sup>188</sup> They were overly vague because the descriptions of specific facts the woman must be told were prefaced with the phrases "such as, but not limited to" and "including, but not limited to." Thus doctors were purportedly not given "fair warning of what is required."<sup>189</sup> On the other hand, the provisions were supposedly too specific in that the physician was required to inform the woman of dangers that might not be applicable in her situation (*e.g.*, the possibility of live birth in the case of a woman seeking a first trimester abortion).<sup>190</sup>

While these arguments have some force and indicate a need for careful drafting, differentiating the provisions in *Wynn* from those sustained in *Fitzpatrick* on the basis of vagueness or overspecificity is difficult. If anything, the *Wynn* statute is less vague because its drafters included specific instances of the types of information required, whereas the *Fitzpatrick* statute merely provides a general description of such information.<sup>191</sup> The overspecif-

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filed with the Supreme Court but dismissed for lack of jurisdiction. *Carey v. Wynn*, 99 S. Ct. 49 (1978). The dismissal did not go to the merits and merely indicated that the appeal from the declaratory judgment issued by the three-judge court in *Wynn* should have been to the court of appeals. *Id.* at 50.

187. Illinois Abortion Law of 1975, § 3(2)(a), (b), ILL. ANN. STAT. ch. 38, § 81-23(a), (b) (Smith-Hurd 1977).

188. 449 F. Supp. at 1317.

189. *Id.*

190. *Id.*

191. The authors of the Model Penal Code pursued a similar gambit in trying to circumvent void-for-vagueness problems in drafting their loitering statute. See MODEL PENAL CODE § 250.6 (Proposed Final Draft, 1962). *Cf.* *People v. Berck*, 32 N.Y.2d 567, 300 N.E.2d 411, 347 N.Y.S.2d 33 (1973) (holding statute with general description of loitering void for vagueness, but intimating that a statute following the approach of MODEL PENAL CODE § 250.6 would be constitutional).

icity problem is also exaggerated. As the *Fitzpatrick* court noted, if some of the information the doctor is required to give the woman is inapplicable in the particular case, nothing prevents the doctor from telling her so after complying with the statute.<sup>192</sup> The *Wynn* court's response appears to be<sup>193</sup> that it was precisely this type of contradictory verbal gymnastics that Justice Blackmun intended to rule out when he warned in *Danforth* against informed consent statutes that "confine the attending physician in an undesired and uncomfortable straitjacket."<sup>194</sup> While this argument is not without plausibility, it would make better sense to construe the straitjacket metaphor more loosely to comport with *Maher's* emphasis on "unduly burdensome interference" with the abortion decisionmaking process.<sup>195</sup> Informed consent provisions that call for an occasional qualifying remark or equivalent adaptation would not be objectionable under this analysis. Only provisions that are so detailed, unrealistic, or distorted that they impede rather than facilitate meaningful doctor-patient interaction would be prohibited. Inasmuch as the effect of informed consent is generally to expand the woman's autonomy, states should be granted wide latitude in framing such provisions. Consent requirements that are not drafted so as to dictate medical judgment or foreclose treatment options should be allowed.

Justice Blackmun's straitjacket metaphor and the concomitant definition of "informed consent" as merely "the giving of information to the patient as to just what would be done and as to its consequences"<sup>196</sup> could be taken to support only the constitutionality of "general" consent provisions. But such an interpretation would be exceedingly insensitive to the informational needs of a woman faced with an abortion decision. A narrow reading of Justice Blackmun's definition would limit the doctor's responsibility to informing the patient of the selected abortion method and of the fact that as a result of this procedure she would no longer be pregnant. Such a reading would ignore a woman's frequent need for much more detailed information about the nature of the procedure, its risks, and alternatives.<sup>197</sup> Moreover, general provisions do very little to protect the woman from the possible bias of her physician. If the doctor is strongly pro-abortion, or has a financial interest in the potential abortion, he

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192. 401 F. Supp. at 587-88.

193. See 449 F. Supp. at 1316-17.

194. *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 n.8 (1976).

195. *Maher v. Roe*, 432 U.S. 464, 473-74 (1977).

196. *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 n.8 (1976).

197. See notes 58-64 and accompanying text *supra*.

or she may too easily conclude that the decision is not a critical one to the woman and that she needs very limited information before making the decision.<sup>198</sup>

Finally, general statutes may ignore the woman's need for information about the facts of fetal development. If the doctor is not specifically required to provide this information, he may be able to meet his statutory obligation by describing the procedure as if nothing more were at stake than the removal of a benign growth. Yet information about fetal development may be more significant than anything else in shaping the woman's decision. It may have a crucial bearing on her postabortion mental health.<sup>199</sup> And, leaving aside issues of maternal health, the state has a strong and legitimate interest in being certain that all parties to the abortion decision clearly understand that the destruction of unborn human life will occur in the process.<sup>200</sup>

Detailed informed consent provisions come closer than general statutes to ensuring that each woman contemplating abortion has the information she needs to make an informed decision. In comparison to general statutes they do a better job of putting the doctor on notice of his responsibility to give the patient relevant information in each of the critical areas: nature and risks of the procedure, facts of reproduction and fetal development, and abortion alternatives.<sup>201</sup> This is not to say that there are no problems with the detailed provisions. Compliance with such statutes is more likely to degenerate into "disengaged monologues"<sup>202</sup> or *Miranda*-style warnings than is compliance with a general statute. Moreover, while doctors are generally well qualified to provide medical information, they may not be fully aware of the nonmedical information relevant to abortion alternatives. States requiring doctors to provide such information<sup>203</sup> might follow the lead of some European countries<sup>204</sup> and equip doctors with information packets that they can give to their patients. Such packets should include addresses and phone numbers of public and private agencies that provide assistance to women with problem

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198. See notes 107-09 and accompanying text *supra*.

199. See note 61 and accompanying text *supra*.

200. See *Maher v. Roe*, 432 U.S. 464, 478 (1977); *Beal v. Doe*, 432 U.S. 438, 446 (1977).

See also notes 102-04 and accompanying text *supra*.

201. See notes 58-75 and accompanying text *supra*.

202. See *Katz*, *supra* note 62, at 147.

203. See, e.g., Act of July 10, 1978, Act No. 435, sec. 1, § 1299.35.6(B)(7), 1978 La. Sess. Law Serv. 836 (West)(to be codified as LA. REV. STAT. ANN. § 40:1299.35.6(B)(7) (West)).

204. See, e.g., Act of Jan. 17, 1975, Law No. 75-17, art. L. 162-3(2) (Fr.), translated in 26 WHO INT'L DIGEST, *supra* note 110, at 352 (1975).

pregnancies, as well as any additional information deemed useful. A doctor should not, however, be able to comply with an informed consent statute merely by handing a woman an information packet. That would reduce what is at worst a ritual warning to a silent (and totally inadequate) litany.

### C. *Waiting Period Requirements*

For informed consent provisions to be maximally effective, the required information ought to be provided well in advance of the abortion procedure. The twenty-four-hour period prior to the performance of an abortion is a period of great ambivalence and distress.<sup>205</sup> Giving the woman information and counseling at that point will probably not aid in her decisionmaking process and may even produce a great deal of anxiety.<sup>206</sup> Several European countries<sup>207</sup> and some states<sup>208</sup> have responded to this problem by requiring that the woman receive counseling or informed consent information anywhere from a day to a week before the abortion. Since the twenty-four-hour period prior to the abortion is such a critical time, it would be best if the informing and counseling were completed at least twenty-four hours before the abortion decision is firmly made. In the designated waiting period, the woman will have sufficient time to weigh the information she has received, make her decision, and give her informed consent to any procedure she chooses. The delay can thus make a substantial contribution to expanding her rational autonomy.<sup>209</sup> And, in most instances, a waiting period from one day to several days is not long enough to impact on the safety of the procedure or the type of procedure that could be used to perform an abortion.<sup>210</sup> Of course, in emergency or life-threatening situations, the imposition of a waiting period may be unreasonable or medically unsafe.

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205. Nadelson, *supra* note 54, at 768.

206. *See id.*

207. *See, e.g.*, Act of Jan. 17, 1975, Law No. 75-17, art. L. 162-5 (Fr.) (one week), translated in 26 WHO INT'L DIGEST, *supra* note 110, at 351, 353 (1975); STRAFGESETZBUCH [StGB] § 218b (1) (W. Ger.) (three days), translated in 27 WHO INT'L DIGEST, *supra* note 110, at 564 (1976).

208. *See, e.g.*, KY. REV. STAT. § 436.023 (1977) (24 hours); Act of July 10, 1978, Act No. 435, sec. 1, § 1299.35.7, 1978 La. Sess. Law Serv. 836 (West) (to be codified as LA. REV. STAT. ANN. § 40:1299.35.7 (West)).

209. *See* Dworkin, *supra* note 25, at 123-24.

210. Physicians are unable to determine the length of gestation in any one pregnancy with sufficient accuracy to enable a 24-hour period to serve as a transition between trimesters or to affect a judgment of fetal nonviability. *Wolfe v. Schroering*, 541 F.2d 523, 526 (6th Cir. 1976).

Currently, informed consent statutes in eight states provide for exceptions to normal consent requirements in life-threatening situations.<sup>211</sup> Such exceptions should be built into all informed consent statutes and should apply to waiting period requirements.

The constitutionality of a waiting period provision poses slightly different issues than that of informed consent provisions in general, but the result should be the same. In *Wolfe v. Schroering*,<sup>212</sup> the only case to consider a waiting period requirement to date, the Sixth Circuit sustained the validity of a twenty-four-hour provision.<sup>213</sup> The court reasoned that a one-day delay would not result in a transition from one trimester to the next, and did not "significantly" burden the abortion process.<sup>214</sup> Since the Supreme Court has concluded states may require informed consent even during the first trimester,<sup>215</sup> and has allowed state action not constituting "unduly burdensome interference" with the abortion decision,<sup>216</sup> short waiting periods should be constitutional. After all, reasonable waiting periods are tolerated in a number of other areas, even when they limit the exercise of fundamental rights. Most states require some waiting period between the application for a marriage license and the marriage.<sup>217</sup> Similarly, voters may be required to register prior to the date of an election.<sup>218</sup> After the first trimester, the woman's need for information to assist in the making of a rational abortion choice and the often stressful results of withholding such information until the time of the procedure are sufficiently related to the state's then-compelling interest in maternal health to justify a reasonable waiting period requirement.

#### D. Enforcing Informed Consent Provisions

A final point needs to be made about enforcing compliance with informed consent statutes. While most members of the medical profession would no doubt comply with such statutes in good faith, there is always the possibility that any given physician

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211. IDAHO CODE § 18-609 (Supp. 1978); KY. REV. STAT. § 436.010 (1977); MASS. GEN. LAWS ANN. ch. 112, § 12Q (West Supp. 1978-1979); MINN. STAT. ANN. § 145.412 (West Supp. 1978); MONT. REV. CODES ANN. § 94-5-616 (1977); N.D. CENT. CODE § 14-02.1-03 (Supp. 1977); 35 PA. CONS. STAT. ANN. § 6603 (Purdon 1977); UTAH CODE ANN. § 76-7-315 (1978).

212. 541 F.2d 523 (6th Cir. 1976).

213. *Id.* at 526.

214. *Id.*

215. *Planned Parenthood v. Danforth*, 428 U.S. 52, 66-67 (1976).

216. *Maher v. Roe*, 432 U.S. 464, 474 (1977).

217. H. CLARK, *LAW OF DOMESTIC RELATIONS* 38 (1968).

218. *See Burns v. Fortson*, 410 U.S. 686 (1973); *Marston v. Lewis*, 410 U.S. 679 (1973).

might treat such obligations cavalierly. Thus, most informed consent statutes make failure to comply a misdemeanor.<sup>219</sup> Although criminal sanctions may be important as a last resort, prosecutors are likely to proceed against doctors only rarely, with the result that such sanctions would be underenforced. Moreover, it is primarily the criminal dimension of informed consent statutes that gives rise to the void-for-vagueness problem discussed in connection with the *Wynn* case above;<sup>220</sup> the vagueness doctrine is normally inapplicable in civil contexts.<sup>221</sup> For these reasons, states may wish to pay greater attention to civil remedies that would provide compliance incentives.

In most states, the impact on civil litigation of noncompliance with informed consent provisions is solely a matter of case law. Illinois appears to be the only state that has established by statute the civil consequences of noncompliance. Illinois' informed consent statute provides that "[a]ny intentional violation of this section shall be admissible in a civil suit as prima facie evidence of the physician's failure to obtain an informed consent."<sup>222</sup> In the absence of similarly specific legislation, courts may hold that noncompliance with an informed consent statute invokes the doctrine of "negligence per se."<sup>223</sup> The resulting reallocation of the burden of proof may encourage doctors to comply with the statute. However, application of the negligence per se doctrine will have widely differing results in different jurisdic-

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219. Illinois Abortion Law of 1975, § 3(2), ILL. ANN. STAT. ch. 38, § 81-23 (Smith-Hurd 1977); MO. ANN. STAT. § 188.075 (Vernon Supp. 1978); MONT. REV. CODES ANN. § 94-5-616(5) (1977); 35 PA. CONS. STAT. ANN. § 6603(e) (Purdon 1977); UTAH CODE ANN. § 76-7-314(3) (1978). Minnesota makes failure to comply a felony. MINN. STAT. ANN. § 145.412 subd. 4 (West Supp. 1978). Kentucky and Massachusetts impose fines of up to \$1,000 and \$2,000 respectively. Kentucky also imposes a penalty of one year in prison. KY. REV. STAT. § 311.990(13) (1977); MASS. GEN. LAWS ANN. ch. 112, § 12T (West Supp. 1978-1979). Missouri provides for revocation of the physician's professional license as well as a misdemeanor conviction. MO. ANN. STAT. § 188.065 (Vernon Supp. 1978).

220. See notes 186-95 and accompanying text *supra*.

221. See generally Note, *Vagueness Doctrine in the Federal Courts: A Focus on the Military, Prison, and Campus Contexts*, 26 STAN. L. REV. 855, 855 n.1 (1974); Note, *The Void-for-Vagueness Doctrine in the Supreme Court*, 109 U. PA. L. REV. 67, 69 n.16 (1960). In recent years, there has been some extension of the vagueness doctrine to civil statutes, but this has been true primarily in areas where civil remedies are closely analogous in their impact to criminal sanctions. See Note, *Vagueness Doctrine in the Federal Courts: A Focus on the Military, Prison, and Campus Contexts*, 26 STAN. L. REV. 855, 862 & n.32 (1974). Where the civil statute merely involves shifting the burden of proof in ordinary civil litigation, as suggested in the text, vagueness concerns would be unlikely to arise.

222. Illinois Abortion Law of 1975, § 3(2), ILL. ANN. STAT. ch. 38, § 81-23 (Smith-Hurd 1977). The Missouri statute provides that nothing contained therein will exempt any person from civil liability for negligent acts. MO. ANN. STAT. § 188.085 (Vernon Supp. 1978).

223. W. PROSSER, *supra* note 156, § 36, at 200-02.

tions;<sup>224</sup> in at least some, the practical impact on potential physician liability will be de minimus.

Because of the amorphous and unsettled state of case law governing the civil significance of informed consent requirements and the doctrine of negligence per se, greater clarity could be achieved for all affected parties if legislatures would follow Illinois' lead and incorporate clear statements of the civil consequences of noncompliance into informed consent statutes. Such statements could track the language of the Illinois statute and make noncompliance with an informed consent statute prima facie evidence of failure to obtain informed consent. Legislatures could establish rebuttable or irrebuttable presumptions of malpractice. They could also establish presumptions that would operate to benefit physicians.

Doctors might welcome informed consent provisions requiring that detailed written consent be given. Such provisions would help insulate them against charges of inadequate disclosure by providing written evidentiary documents that would avoid the necessity of relying on vague or contradictory recollections of a particular discussion crucial to a malpractice case.<sup>225</sup> Doctors may also appreciate legislative guidelines concerning the proper medical standard for informed consent because abortion has greater emotional and moral overtones than most medical procedures involved in malpractice cases. The standards normally applicable in other malpractice cases may be meaningless if abortion malpractice trials degenerate into microcosmic showdowns between pro-abortion and anti-abortion forces, as has happened in a number of recent abortion-related cases.<sup>226</sup>

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224. The possible effects on civil litigation of violating a state statute have been described as follows:

- (1) Such conduct is conclusively negligence as a matter of law;
- (2) Such conduct is presumed to be negligence as a matter of law until evidence is received tending to show that the violation was excusable under the circumstances;
- (3) Such conduct is prima facie evidence of negligence, so that from the violation alone the jury may infer that the person was negligent;
- (4) Such conduct is evidence of negligence which the jury may consider, but is not, standing alone, sufficient to support a finding of negligence; or
- (5) The conduct may, in itself, constitute negligence or may be evidence of it, but the fact is wholly irrelevant that a statute . . . was violated in the process.

Comment, *Contributory Negligence in Five Midwestern States—Some Barriers for Plaintiff to Hurdle in Auto Accident Cases*, 1954 WIS. L. REV. 95, 116. The author implies that the first and fifth options are rarely the rule and warns that the standard may differ depending on which statute has been violated. *Id.* at 116-17.

225. Note, *Who's Afraid of Informed Consent? An Affirmative Approach to the Medical Malpractice Crisis*, 44 BROOKLYN L. REV. 241, 259-62 (1978).

226. See, e.g., *Commonwealth v. Edelin*, \_\_\_ Mass. \_\_\_, 359 N.E.2d 4 (1976); *The*



Overall, then, there is much to be said for detailed informed consent statutes that include provisions governing civil liability for noncompliance. Such provisions help ensure a meaningful doctor-patient interaction that will permit maximum autonomy to the woman faced with an abortion decision.

#### IV. COUNSELING

##### A. *The Appropriateness of Counseling Requirements*

While informed consent statutes can make a substantial contribution to meaningful doctor-patient interaction, there is something awkward, something unmistakably wooden about the informed consent approach. It is as if the law were being used to bludgeon a human relationship into existence. The needed interpersonal dynamics are too rich to be captured in the dead language of a statute and too dependent on natural fellow feeling to be coerced. These considerations suggest that skillful counseling is the ideal approach to assuring that the woman receives the information and help she needs in determining whether or not to obtain an abortion. Indeed, as one contemplates the Supreme Court's emphasis on the "consulting physician,"<sup>227</sup> it seems clear that counseling is precisely what the Supreme Court had in mind. In the Court's mythology of the doctor-patient relationship, the woman reaches the decision whether or not to terminate her pregnancy only after careful and sensitive consultation with a medical expert who is aware not only of her physical situation, but of her emotional, psychological, and familial needs as well.<sup>228</sup>

Counseling transcends other approaches to assisting the woman precisely because its aim is not merely to provide her with information, but also to help her make an extremely personal decision in a sensitive and personal manner. But the same highly personal dimension of counseling that gives it its flexibility and appeal may constitute the primary obstacle to implementing abortion-counseling schemes in the United States. Counseling is so inherently personal that by its very nature it eludes easy and mechanical management. The resulting uncertainties about the precise impact of counseling on the abortion decisionmaking process exacerbate the constitutional questions surrounding the per-

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*Trial of Dr. Waddill*, NEWSWEEK, Apr. 3, 1978, at 35; *The Ordeal of a Divided Jury*, TIME, May 22, 1978, at 24.

227. See, e.g., *Colautti v. Franklin*, 47 U.S.L.W. 4094, 4096-97 (U.S. Jan. 9, 1979); *Roe v. Wade*, 410 U.S. 113, 153, 163-64 (1973). See also notes 1-10 and accompanying text *supra*.

228. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

missibility of mandatory counseling schemes. Moreover, from a purely political perspective, however much competing pressure groups may favor counseling in principle, they may be reluctant to press for it in practice because there is no way for them to feel confident about the content of the counseling that would be rendered. As long as there are fears that it would be constitutionally impermissible or effectively impossible to control the orientation of counseling, pro-life groups will worry that counseling might tend to assuage guilt rather than deter abortions, and pro-choice groups will fear that counseling might degenerate into harassment of the woman seeking an abortion.<sup>229</sup> Legally mandated counseling has thus failed to emerge in the United States.

Yet the need for counseling is acute. There is a wealth of information attesting to the need for counseling in the abortion context.<sup>230</sup> As a consequence, many European countries that have recently liberalized their abortion laws have paid careful attention to integrating counseling into the abortion process.<sup>231</sup> In the United States, the need to assure that at least some counseling occurs within the confines of the doctor-patient relationship has been heightened in the aftermath of *Danforth*. Since *Danforth* may tend to isolate the woman making the abortion decision from typical sources of social and emotional support by denying her parents, spouse, or the father of the child a final say in the abortion choice, the woman may be in particularly great need of sensitive personal help from her doctor. Experience in Germany has suggested that counseling may be particularly significant for minors faced with the difficult abortion choice.<sup>232</sup> In post-*Danforth* America, therefore, counseling with the woman's consulting physician takes on added significance if the isolated woman's overall needs in the abortion context are to be met.<sup>233</sup> To the extent that political realities and apprehensions about constitutionality operate to preclude the emergence of counseling schemes, women in need of counseling are the ultimate losers.

The solution to this situation appears to lie in rethinking the

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229. See O'Reilly, *supra* note 73, at 74.

230. See, e.g., Bracken, *supra* note 54, at 265-66; Butler & Fujita, *supra* note 48, at 210-12; Kay & Thompson, *An Outcome Evaluation of Counseling Services Provided by Abortion Clinics*, 15 *MED. CARE* 858, 858-59 (1977); Margolis, *Some Thoughts on Medical Evaluation and Counseling of Applicants for Abortion*, 14 *CLINICAL OBSTETRICS & GYNECOLOGY* 1255, 1257 (1971); Nadelson, *supra* note 54, at 767-69; West & Walsh, *supra* note 54.

231. See notes 234-71 and accompanying text *infra*.

232. See Beulke, *Zur Reform des Schwangerschaftsabbruches durch das 15. Strafrechtsänderungsgesetz*, 1976 *ZEITSCHRIFT FÜR DAS GESAMTE FAMILIENRECHT* 596, 597.

233. See notes 87-90 and accompanying text *supra*.

implications of *Roe v. Wade* and its progeny. Once one begins analyzing the Supreme Court's abortion decisions as rooted in a concern for rational female autonomy, arguing for the permissibility of at least certain types of counseling schemes becomes easier. Before turning to the constitutional issues, however, it will be useful to consider three differing approaches to counseling that have been developed in Europe. This will provide a basis for a better understanding of the varying ways in which counseling can be integrated into an abortion scheme, and will make possible a more concrete analysis of the constitutional issues.

## B. European Counseling Schemes

### 1. Germany

In part because of the unique history of abortion reform efforts in Germany, counseling has assumed a particularly important role in the legislative scheme governing abortion there. The current abortion statute<sup>234</sup> was passed in response to the West German Constitutional Court's 1975 determination that a prior abortion liberalization scheme<sup>235</sup> was unconstitutional.<sup>236</sup> The law<sup>237</sup> provides that abortion constitutes a criminal offense except when performed by a physician, with the pregnant woman's consent, and within appropriate time limits<sup>238</sup> when a generalized "indication" of a need for the abortion is present. The generalized

234. StGB §§ 218-219 (W. Ger.), as amended by Das 15. Strafrechtsänderungsgesetz vom 18.5.1976, translated in 27 WHO INT'L DIGEST, *supra* note 110, at 562-65 (1976).

235. The text of the initial West German abortion legislation of 1974 is available in 25 WHO INT'L DIGEST, *supra* note 110, at 779-83 (1974).

236. Judgment of Feb. 25, 1975, BVerfGE, W. Ger., 39 Bundesverfassungsgericht [BVerfGE] 1 (1975). This judgment was also published in 2 EUROPÄISCHE GRUNDRECHTE ZEITSCHRIFT 126; 1975 JURISTENZEITUNG 205; 127 NEUE JURISTISCHE WOCHENSCHRIFT 574 (1975). English translations of the judgment were published in Jonas & Gorby, *West German Abortion Decision: A Contrast to Roe v. Wade*, 9 J. MAR. J. PRAC. & PROC. 605 (1976); E. JANN, *THE ABORTION DECISION OF FEBRUARY 25, 1975 OF THE FEDERAL CONSTITUTIONAL COURT, FEDERAL REPUBLIC OF GERMANY* (1975).

237. Specifically, StGB § 218a(1) (W. Ger.) provides that:

(1) The termination of pregnancy performed by a physician shall not be punishable . . . provided that:

. . . .  
2. according to medical findings, a pregnancy termination is indicated, taking account of the present and future living conditions of the pregnant woman, in order to avert a risk to the life or a risk of serious damage to the physical or mental state of health of the pregnant woman, and such risk cannot be averted by any other means that the woman can be expected to accept.

*Id.*, translated in 27 WHO INT'L DIGEST, *supra* note 110, at 563 (1976).

238. A pregnancy may only be terminated on the basis of the eugenic indication within the first 22 weeks following conception, or on the basis of the juridical or social indications within the first 12 weeks. *Id.* § 218a(3).

indication is present whenever, in light of the totality of the woman's circumstances, the woman cannot reasonably be expected to continue with the pregnancy because of grave risk to her physical or mental health.<sup>239</sup> The statute further establishes a presumption that the generalized indication is present if there is a compelling reason to assume that the child would be born with a severe birth defect (eugenic indication), if the pregnancy is the result of an unlawful act such as rape or incest (juridical indication), or if the general circumstances of the woman's life place her in such state of material necessity (*Notlage*) that she cannot fairly be expected to continue with the pregnancy (social indication).<sup>240</sup>

In addition to requiring that the presence of one of these indications be confirmed by a doctor other than the doctor that will perform the abortion,<sup>241</sup> the statute provides that anyone who performs an abortion on a woman who has not received counseling at least three days before the abortion from an individual or agency legally authorized to provide such counseling is subject to criminal sanctions.<sup>242</sup> The woman herself is not subject to punishment under this provision on the theory that she is more likely to seek counseling if she knows there is absolutely no legal risk associated with her doing so. A broad network of counseling centers has been established; as of the end of 1976, there were more than 600 centers where free abortion counseling could be obtained.<sup>243</sup> In addition, the statute provides that the counseling may be given by a doctor (other than the one performing the abortion) if he has appropriate qualifications to give the requisite counseling.<sup>244</sup> The wording of the statute makes it clear that the

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239. *Id.* § 218a(1)2.

240. *Id.* § 218a(2).

241. *Id.* § 219.

242. *Id.* § 218b (providing for imprisonment of up to one year and a criminal fine).

243. Franz, *Kosten der sozialen Beratung nach der Reform des § 218 StGB*, 29 NEUE JURISTISCHE WOCHENSCHRIFT 1085, 1086 (1977) (citing INFORMATIONEN DES BUNDESMINISTERIUMS FÜR JUGEND, FAMILIE UND GESUNDHEIT, ZUR PRAKTIZIERUNG DER NEUREGELUNG ÜBER DEN SCHWANGERSCHAFTSABBRUCH 3 (1976)).

244. See notes 250-54 and accompanying text *infra*. One of the difficult problems currently being faced in the course of implementing the new German abortion statute concerns the question of who pays for counseling services provided by the doctor instead of by one of the many free counseling centers. State insurance coverage may be construed as denying coverage for counseling provided by a doctor concerning the woman's social situation, and a growing number of doctors and health institutions are proceeding on the basis of this construction. See Franz, *supra* note 243, at 1087. However this problem is ultimately resolved in Germany, its existence points to an important practical issue that must ultimately be faced in the United States if more intensive counseling requirements are adopted here. Will insurance coverage and state or federal funding be available to

counseling must occur in person; counseling over the telephone for example would not suffice.<sup>245</sup>

Two phases or components of counseling are envisioned. The first, which must be obtained at least three days before the abortion is performed, is generally referred to as social counseling. The statute requires that the pregnant woman be apprised of the variety of public and private sources of aid available to assist her with both the continuation of her pregnancy and the alleviation of difficult circumstances that might accrue as a result of an additional child. While the statute itself does not specify any particular orientation for this counseling, it is quite clear from the background of the legislation that it is to be given a pro-life direction.<sup>246</sup>

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cover the cost of the increased expenditure of a doctor's time necessitated by more extensive counseling?

245. See Beulke, *supra* note 232, at 600; Laufhütte & Wilkitzki, *Zur Reform der Strafvorschriften über den Schwangerschaftsabbruch*, 1976 JURISTENZEITUNG 329, 333.

246. The prior abortion legislation struck down by the constitutional court provided that there would be no criminal sanctions for a woman who obtained an abortion after receiving counseling during the first twelve weeks of pregnancy. See 25 WHO INT'L DIGEST, *supra* note 110, at 779-83 (1974). Advocates of the time-phase approach to regulating abortion during the early phase of pregnancy, which was incorporated in the prior law, had argued that developing life is better protected by individual counseling of the pregnant woman than by penal sanctions. Penal sanctions might deter a woman from seeking counseling for fear that she would reveal her pregnancy at the counseling stage and then be unable to obtain an abortion in the event the counseling did not indicate an abortion. See Judgment of Feb. 25, 1975, BVerfGE, W. Ger., 39 BVerfGE 1, 52 (1975); Jonas & Gorby, *supra* note 236, at 650. The court rejected this approach for two reasons. The major reason was that the time-phase approach, despite its counseling feature, legalized even nonindicated abortion during the first trimester. The court held that this was inconsistent with the state's obligation to protect incipient life under the German Constitution. 39 BVerfGE at 53-54; Jonas & Gorby, *supra* note 236, at 651-52. The second objection to the counseling scheme in the earlier legislation was that it appeared to require only that the woman be "instructed" (*unterrichtet*) concerning "the public and private assistance available for pregnant women, mothers, and the children, particularly concerning such assistance which alleviates the continuation of the pregnancy and the situation of the mother and child." 39 BVerfGE at 61; Jonas & Gorby, *supra* note 236, at 657-58. In the court's view, mere instruction was not enough. The court's criticism of the prior counseling scheme implied that, to be consonant with German constitutional requirements, the counseling must be directed toward persuading a woman to continue her pregnancy. See 39 BVerfGE at 61-62; Jonas & Gorby, *supra* note 236, at 657-58. Moreover, the court indicated that a counseling scheme equipped with the capacity to provide direct financial assistance in appropriate cases in addition to mere advice would be less objectionable in that such a scheme would be much more likely to play a determinative role in deterring abortions. See 39 BVerfGE at 61; Jonas & Gorby, *supra* note 236, at 657. Under the new statute, the term "*unterrichtet*" has been replaced with a much stronger term (*beraten*) which has a meaning somewhere between "counseled" and "admonished." Commentators have been alert to the difference, and it is well understood that the type of counseling now required must aim at protecting developing life. See, e.g., Beulke, *supra* note 232, at 600; Lackner, *Die Neuregelung des Schwangerschaftsabbruchs*, 28 NEUE JURISTISCHE WOCHENSCHRIFT 1233, 1239-40 (1976); Laufhütte & Wilkitzki, *supra* note 245, at 333.

The second aspect of the current German counseling scheme requires that the woman be counseled concerning the medically significant aspects of the procedure.<sup>247</sup> This counseling may or may not be provided by the same individual who provides the social counseling. Although the statute is unclear as to whether or not the social counseling must precede the medical counseling, this order would appear to make sense if the two are to be conducted separately.<sup>248</sup> Significantly, counseling is not required even under the new statute in situations where the reason for the abortion is a threat to the life or physical health of the mother.<sup>249</sup>

Assessing the qualifications of those rendering the counseling service is one of the difficult problems under the German scheme. The problem relates not to the qualifications of those working for government counseling centers, churches, or other such organizations that have historically played a significant role in abortion counseling,<sup>250</sup> but with the qualifications physicians must have in order to provide the required counseling. In its 1975 abortion decision, the constitutional court sharply questioned whether physicians could give competent social counseling.<sup>251</sup> Physicians, the court reasoned, are experts in medical matters, but cannot be expected to have expertise in the intricacies of German social welfare law (e.g., they may not be familiar with sources of rental assistance, income assistance, and other sources of state aid that may alleviate the problems leading a woman to seek an abortion).<sup>252</sup> A number of scholars have accordingly voiced doubts about whether the qualifications a doctor must have in order to provide counseling<sup>253</sup> are sufficient to meet the constitutional

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247. StGB § 218b(1)2 (W. Ger.), translated in 27 WHO INT'L DIGEST, *supra* note 110, at 564 (1976).

248. See Laufhütte & Wilkitzki, *supra* note 245, at 333.

249. StGB § 218b(3) (W. Ger.), translated in 27 WHO INT'L DIGEST, *supra* note 110, at 564 (1976).

250. Section 218b(2) specifies that "a counseling center recognized by an authority [*Behörde*] or corporation, institution, or foundation of public law" (authors' translation) may perform the statutory counseling. *Id.* § 218b(2)1. Since all major and most minor religious denominations are public law entities (*Körperschaften des Öffentlichen Rechts*), see generally Solte, *Die Organisationsstruktur der Kirchen und Religionsgemeinschaften*, in 1 HANDBUCH DES STAATSKIRCHENRECHTS DER BUNDESREPUBLIK DEUTSCHLAND 341 (E. Friesenhahn, U. Scheuner, & J. Listl eds. 1974), the foregoing provision makes it clear that these denominations may recognize and thereby authorize counseling centers. See Laufhütte & Wilkitzki, *supra* note 245, at 334 (noting that the legislative purpose for giving these various entities such authorizing power was to establish a broad network of counseling centers).

251. Judgment of Feb. 25, 1975, BVerfGE, W. Ger., 39 BVerfGE 1, 62-63 (1975); Jonas & Gorby, *supra* note 236, at 658-59.

252. 39 BVerfGE at 62-63, Jonas & Gorby, *supra* note 236, at 658-59.

253. Counseling may be provided by a physician if: (1) he is a member of a recognized

court's objections to doctor-provided counseling under the previous statutory scheme.<sup>254</sup> Similar concerns could obviously arise with regard to physician counseling in the United States.

One of the interesting points of the German counseling scheme is that its initial proponents under the prior law were convinced that counseling would be more efficacious in the context of a time-phase resolution to the abortion controversy, such as that adopted in the United States, than in the statutory indication solution ultimately adopted.<sup>255</sup> As noted above, they were convinced that more women would actually seek counseling if they viewed it as a ticket to a legal abortion rather than part of a larger state strategy explicitly aimed at deterring abortions. This is significant, because it suggests that the introduction of counseling requirements in the United States may be even more beneficial than counseling as it exists in Germany since the Supreme Court's rulings here have precluded the possibility of counseling schemes designed to impose substantive constraints on the woman's ultimate abortion choice during the first trimester of pregnancy.

## 2. France

Like Germany, France has recently liberalized its abortion laws and has also integrated a counseling scheme into this new legal framework. Under French law, a woman in "a situation of distress"<sup>256</sup> may make a request for the termination of her preg-

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counseling center; (2) he has been recognized as a counselor by a public law entity, *see* note 250, *supra*; or (3) he has obtained information regarding assistance available in individual cases by consulting with a staff member of an approved counseling center. StGB § 218b(2)2 (W. Ger.), translated in 27 WHO INT'L DIGEST, *supra* note 110, at 564 (1976). Understandably, the third method of qualification has attracted the most criticism because it is difficult to see how any physician can fail to meet its requirements.

254. *See, e.g.*, Beulke, *supra* note 232, at 601. *Cf.* Laufhütte & Wilkitzki, *supra* note 245, at 334-35 (arguing that the new rules do meet the constitutional court's objections concerning a physician's lack of qualification in the social counseling area if they are narrowly construed).

255. *See* Judgment of Feb. 25, 1975, BVerfGE, W. Ger., 39 BVerfGE 1, 52 (1975); Jonas & Gorby, *supra* note 236, at 650. *Cf.* Lackner, *supra* note 246, at 1240 (noting that a counseling scheme has a different significance in a statutory scheme that takes a time-phase approach to the problem than it has where the indication approach has been adopted).

256. Neither the text of the statute, Act of Jan. 17, 1975, Law No. 75-17, art. L. 162-1 to -14 (Fr.), translated in 26 WHO INT'L DIGEST, *supra* note 110, at 351-54 (1975), nor the decision of the French Constitutional Court sustaining the statute, Judgment of Jan. 15, 1975, Con. const., Fr., [1975] Juris-Classeur periodique, la semaine juridique [J.C.P.] II 18030, translated in A. VON MEHREN & J. GORDLEY, THE CIVIL LAW SYSTEM: AN INTRODUCTION TO THE COMPARATIVE STUDY OF LAW 337 (2d ed. 1977), articulates what constitutes a "situation of distress." Presumably, it would be a situation similar to one constituting a "social indication" in Germany.

nancy, and, provided she complies with the counseling requirements imposed by law, may obtain an abortion prior to the tenth week of pregnancy.<sup>257</sup>

The French counseling scheme involves two stages. The first is similar in many respects to detailed informed consent statutes in the United States. That is, a physician who has been approached by a woman seeking an abortion must inform her of the medical risks involved and must provide her with an information folder containing "(a) a list of the rights, forms of assistance, and benefits guaranteed by the law to families, mothers, including unmarried mothers, and their children, as well as the possibilities offered by child adoption; (b) a list of the names and addresses of [counseling institutions]."<sup>258</sup>

Once a woman has received this information she must receive counseling from an approved counseling institution.<sup>259</sup> The counseling involved must consist of a private interview during which the woman is to be provided with the assistance and advice appropriate to her situation and, importantly, with the necessary means to resolve the problems posed.<sup>260</sup> While it is not clear from the statute exactly how much the approved institutions are able to do in terms of providing direct financial assistance, it is clear that affirmative help is to be provided through the counseling system to help alleviate social or economic problems that may be leading the woman to seek a termination of her pregnancy.

Once the woman has received the requisite counseling, she is free to repeat her request for an abortion.<sup>261</sup> There must be at least one week between the time that the woman first requests an abortion and the time that a doctor receives confirmation from the woman that she still desires the abortion.<sup>262</sup> Assuming that the ten-week period from conception has not lapsed, the doctor is then free to perform the abortion himself or to provide the

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257. Act of Jan. 17, 1975, Law No. 75-17, art. L. 162-1 to -14 (Fr.), translated in 26 WHO INT'L DIGEST, *supra* note 110, at 351-54 (1975). A woman may also obtain an abortion "at any stage of gestation if two physicians certify . . . that the continuation of the pregnancy is seriously endangering the woman's health or that there is a strong possibility that the unborn child is suffering from a particularly serious disease or condition considered as incurable at the time of diagnosis." *Id.* art. L. 162-12. As in Germany, the counseling requirements are not triggered for therapeutic abortions. The French scheme differs in not requiring counseling for abortions indicated on eugenic grounds.

258. *Id.* art. L. 162-3(2)(a)-(b).

259. Article L. 162-4 provides that she must "consult a family information, counseling, or advisory establishment, a family planning or education centre, a social welfare service, or any other approved institution . . . ." *Id.* art. L. 162-4.

260. *Id.*

261. *Id.* art. L. 162-5.

262. *Id.*



woman with a document certifying that he has completed his portion of the counseling requirements so that the woman may apply to another physician for the abortion without having to repeat these steps.<sup>263</sup>

The counseling scheme in France thus appears to be similar in many respects to that in Germany. It is obviously designed to help provide the woman with information and resources that may alleviate the problems leading her to seek an abortion. The French scheme is more explicit than the German plan, however, in its recognition that the woman may choose to reject the advice received from the approved counseling centers and request an abortion. Once that decision has been reached, the position of the French statutory scheme seems to be that the state has done all it can to inform the woman of the value of the potential life at stake. The ultimate decision is then left to the individual woman. Under the German scheme, a woman who desires an abortion after counseling may not lawfully obtain one unless an abortion is indicated in her case.

### 3. *Iceland*

A rather different approach to counseling has been adopted in Iceland.<sup>264</sup> Under Icelandic law, a woman may obtain an abortion if the termination of pregnancy is called for as a result of medical, eugenic, juridical, or social indications. The circumstances giving rise to the social indication are rather loosely drawn. The statute speaks in terms of "unsurmountable social circumstances,"<sup>265</sup> but examples of circumstances that will give rise to this situation include "the presence of young children" in the home and situations where a woman, apparently without regard to her economic circumstances, has given birth to several children at frequent intervals and only a short time has elapsed since the previous birth.<sup>266</sup>

Under the Icelandic statute everyone has a right to counseling,<sup>267</sup> but counseling is not mandatory except to the extent that a woman seeking an abortion "must have been informed of the risks associated with the procedure and have received information as to the social assistance which she is entitled to receive

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263. *Id.* art. L. 162-6.

264. Act of May 22, 1975 (Iceland), translated in 28 WHO INT'L DIGEST, *supra* note 110, at 614-16 (1977).

265. *Id.* § 9(1).

266. *Id.* § 9(1)(a)-(b).

267. *Id.* § 1.

from the community.”<sup>268</sup> In any event, “[a]ll counseling and information shall be given impartially.”<sup>269</sup> Thus, while individuals may receive basically the same counseling that would be available in France or Germany (*i.e.* medical assistance, pregnancy testing, interviews intended to provide advice and support, and social assistance),<sup>270</sup> the counseling is just as likely to be oriented toward providing support for a decision to terminate a pregnancy, as encouraging a woman to carry her pregnancy full term.<sup>271</sup> Counseling in Iceland is thus clearly nondirective in nature and is by no means mandatory.

### C. *Permissible Counseling Schemes in the United States*

The German, French, and Icelandic counseling schemes are indicative of a spectrum of possible approaches that might be considered in the United States, ranging from mandatory, oriented counseling at the one extreme to optional, nondirective counseling at the other. Before proceeding with the effort to analyze precisely where along this continuum the constitutional line between permissible and impermissible schemes lies, two preliminary points should be made.

First, there can be no doubt that a state may take steps to make counseling services along the lines of the Icelandic model available to women desiring them. As long as the woman is not required to submit to counseling in order to obtain an abortion, counseling services are merely one of a wide range of social services that the state may permissibly provide. Indeed, as long as the counseling is optional, there would appear to be no objection to counseling oriented toward encouraging normal childbirth. Of course, if it were widely known that the aim of state counselors was to dissuade women from obtaining an abortion, relatively few women seeking an abortion would choose to undergo such counseling. In an optional system, nondirective counseling would accordingly be much more likely not only to meet genuine counseling needs but also to reduce the number of abortions obtained. Greater attention should be paid to the potential value of voluntary counseling schemes both by those concerned with meeting the needs of women considering abortion and by those anxious to encourage greater sensitivity to the value of fetal life.

Second, while the German mandatory, oriented counseling

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268. *Id.* § 12.

269. *Id.*

270. *Id.* § 6.

271. *Id.* §§ 2, 6(5).

has a definite pro-life cast, it must be remembered that counseling with an opposite orientation is equally conceivable. In countries with severe population problems, for instance, it is easy to imagine the introduction of a counseling system with a definite pro-abortion slant. Both possibilities must be considered when one evaluates the constitutionality of mandatory, directive counseling.

The difficult constitutional issues with respect to counseling center on three questions. First, is a mandatory counseling scheme of any type permissible under *Roe v. Wade* and its progeny, particularly during the first trimester? Second, assuming that some mandatory counseling is permissible, to what extent can a state legislature insist that the counseling have a particular orientation? That is, may a system as rigorously pro-life as the German scheme be adopted or is the apparently nondirective form of counseling called for under the French scheme the most that can be required? Third, can counseling with anyone other than the woman's consulting physician be mandated? To simplify the analysis, it will be useful to proceed by analyzing the first two questions on the assumption that it is counseling by the attending physician that is in issue. Broader questions about the permissibility of mandatory third-party counseling can more easily be dealt with in conjunction with the third question.

With regard to the first question, the Supreme Court's allowance of mandatory informed consent provisions and mandatory recordkeeping and reporting procedures even during the first trimester,<sup>272</sup> taken together with the Supreme Court's heavy insistence on the significance of doctor-patient consultation in the abortion decision,<sup>273</sup> suggests that an appropriately limited counseling requirement may be permissible. As this Article has shown,<sup>274</sup> the crucial issue under current case law is whether a particular counseling scheme operates as an "unduly burdensome interference"<sup>275</sup> with the woman's abortion choice. As long as a scheme is carefully designed to avoid such interference, the strict "compelling state interest" test would not come into play, and the scheme's constitutionality would be evaluated in terms of the more flexible "rational basis" test.<sup>276</sup> Since a counseling scheme would further legitimate state interests in promoting female autonomy, protecting maternal health, and encouraging normal

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272. See notes 130-38, 154-58 and accompanying text *supra*.

273. See notes 1-12 and accompanying text *supra*.

274. See notes 100-04 and accompanying text *supra*.

275. *Maier v. Roe*, 432 U.S. 464, 474 (1977).

276. See notes 94-104 and accompanying text *supra*.

childbirth,<sup>277</sup> meeting this more relaxed standard would not be a problem.

With these principles in mind, there would appear to be no constitutional obstacle to a statute requiring a doctor to provide nondirective counseling to a patient seeking an abortion. In a sense, the informed consent statutes discussed in Section III are designed to promote indirectly that very result. They may be viewed (and utilized) as a means of assuring that some minimal quantum of counseling, whatever its content, has occurred. Surely that which can be done indirectly via informed consent statutes can be done directly with a counseling statute. A statute requiring a woman to spend fifteen to thirty minutes counseling with her physician before finalizing an abortion decision can scarcely be characterized as an "unduly burdensome interference" with the abortion decision. Such a statute merely assures materialization of the doctor-patient consultation that has been a keystone of the Supreme Court's abortion decisions from the beginning.

Any potential "harrassment" that a woman who is dead set on obtaining an abortion might perceive in the counseling requirement is a trivial burden for her to bear, particularly when compared with the enormity of the decision to snuff out unborn life. The harassment concern pales even further when one realizes that in the long run counseling actually facilitates the full, if sometimes painful, exercise of the woman's autonomy along lines consistent with her true interests and in ways that can alleviate abiding psychological conflicts and anguish.<sup>278</sup> A substantial number of states impose counseling requirements in connection with divorce proceedings,<sup>279</sup> even though fundamental liberty interests are at stake in the decision to obtain a divorce.<sup>280</sup> It is

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277. *Id.*

278. One of the distressing ironies implicit in the "harassment" rhetoric is that it pays lipservice to the value of woman's autonomy without fully respecting it. To charge that counseling is ultimately a form of harassment is to overlook the deep need a woman facing the abortion choice has of coming to grips with the full implications of her decision. More importantly, it underestimates the likelihood that a woman considering an abortion might decide, after deeper reflection, to continue her pregnancy. After all, abortion is not the inevitable end product of rational, autonomous choice, and the decision to continue a pregnancy is not necessarily the consequence of coercion or subtle psychological wizardry. Counseling may demand painful self-assessment, but to attempt to shield a woman from the imposition of this type of evaluative burden under the guise of protecting her from harassment is ultimately to insulate her from assuming the full responsibility for personal self-determination. Freedom of choice stripped of such self-confrontation is a hollow mockery of genuine autonomy and perhaps the most devious form of paternalism.

279. *See, e.g.* UNIFORM MARRIAGE AND DIVORCE ACT § 305(b)(2).

280. *Boddie v. Connecticut*, 401 U.S. 371, 380-83 (1971).

difficult to see why the state's interests in requiring counseling are any less significant or permissible in the abortion context. Assuming that the state does not attempt to dictate the orientation of the counseling and the ultimate decision to which it leads, counseling would appear to be perfectly consonant with the role allocated the medical profession by *Roe v. Wade*.

Despite the close practical connection between informed consent and counseling requirements, there are a number of reasons for preferring the latter, or a combination of the two. As a practical matter, much of the information required for informed consent declarations may be gathered by someone other than the attending physician and glanced at only perfunctorily by the doctor. Moreover, even if the physician conducts the consent procedure himself, it is all too likely to degenerate into a *Miranda*-type ritual.<sup>281</sup> Requiring the doctor to spend a reasonable amount of time in a one-on-one encounter with the patient, preferably a day or more before the proposed abortion,<sup>282</sup> and then to verify that the decision to proceed with the abortion was reached only after careful joint consideration of all relevant factors, would have a number of salutary effects. Contrary to present realities, a requirement of this nature would assure that genuine doctor-patient consultation occurred. More importantly, by placing the emphasis on the significance of the personal encounter, much could be done to dissolve the woodenness of informed consent procedure. Finally, a counseling requirement leaves much greater flexibility to the doctor and the patient in developing their relationship. Whatever the force of Justice Blackmun's remark about straitjacketing the physician in the context of informed consent statutes,<sup>283</sup> it is inapplicable with regard to nondirective counseling.

The situation with regard to directive counseling schemes is more complex. In part, it depends on what is meant by "directive counseling." If the scheme requires only that the counseling direct the woman's attention to certain facts relevant to her abortion decision, as in France, the counseling requirement is indistinguishable in effect from detailed informed consent provisions, and should be sustained for the same reasons. On the other hand, if those providing the counseling are required to actively attempt to dissuade a woman from obtaining an abortion, as in the Ger-

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281. See note 202 and accompanying text *supra*.

282. See notes 205-18 and accompanying text *supra*.

283. *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 n.8 (1976). See notes 196-98 and accompanying text *supra*.

man system, the scheme is much more questionable. There is a major difference between providing information that will contribute to the making of a rational and autonomous choice and state efforts to determine the content of that choice. A statute requiring directive counseling in this stronger sense would impose a significant burden on the right to seek an abortion. Rather than a mere effort to assure that meaningful doctor-patient interaction occurred, the requirement would constitute active intervention in the decisionmaking process of doctor and patient. It would demean rather than respect the woman's autonomy. Accordingly, a statute of this nature should be unconstitutional.

The question whether women can be required to receive counseling from parties other than their physicians is probably the most difficult from a theoretical perspective. At issue are two conflicting values shielded by the woman's privacy right. If the stress is placed on nondisclosure of intimate concerns,<sup>284</sup> and if *Roe* and *Danforth* stand for the proposition that at least within the first trimester there is no justification for the incremental intrusion into a woman's privacy that would be required if the woman was forced to seek counseling from someone other than a doctor,<sup>285</sup> third-party counseling requirements would appear to be unconstitutional. On the other hand, if rational autonomy is the primary value at stake,<sup>286</sup> there are a number of reasons why a nondirective counseling requirement with qualified personnel should be permissible. As noted by the constitutional court in connection with the German counseling scheme,<sup>287</sup> doctors may be less qualified than trained counselors to provide the information and support that a woman considering an abortion needs. If the aim of counseling is expanding the woman's autonomy, restricting the field of potential counselors to physicians may be counterproductive. Since a doctor's time is typically much more expensive than the time of a qualified counselor or social worker, the doctor requirement is also unattractive for economic reasons.

In deciding between the conflicting privacy values, one should remember that the concern for nondisclosure is artificial in the abortion context. In addition to the attending physician, a number of satellite medical personnel are invariably involved in carrying out abortion procedures. On the whole, the Court has been much more concerned about intervention in the abortion

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284. See notes 30-33 and accompanying text *supra*.

285. See notes 87-89 and accompanying text *supra*.

286. See notes 28-29, 39-47 and accompanying text *supra*.

287. See notes 251-52 and accompanying text *supra*.

choice than about nondisclosure.<sup>288</sup> There are thus strong grounds for arguing that a third-party counseling requirement should be permissible to the extent that it effectively expands the rational autonomy of those seeking abortions. As a practical matter, however, the tendency of the Court to strike down third-party constraints on the abortion decision<sup>289</sup> is so pronounced that a third-party counseling requirement would probably not be held constitutional. Moreover, the incremental burden of locating the counseling agency and attending a counseling session, while insignificant when compared with other values involved, might be deemed a significant burden on the decision to obtain an abortion. Under *Carey v. Population Services International*,<sup>290</sup> this might be enough to invalidate the third-party scheme.

While the constitutionality of a mandatory third-party counseling scheme is somewhat shaky, a mandatory nondirective counseling scheme with a third-party option should be permissible for the same reasons that an Icelandic-type scheme would be.<sup>291</sup> Some of the economic advantages of nondoctor counseling might be obtained by passing a statute requiring counseling, but allowing the woman to receive it in whole or in part from someone other than her doctor if she wished. A state might set up free counseling centers and require women seeking an abortion to receive counseling either from her personal physician or from the free counseling center. Even though such a scheme would provide obvious financial incentives to obtain counseling at the free center, it would not be constitutionally objectionable under *Maher* if the counseling requirement itself is permissible.<sup>292</sup>

One final issue that must be considered in conjunction with counseling schemes concerns the qualifications of those providing the counseling. At present, there are few standards for abortion counselors.<sup>293</sup> Since abortion counseling is complex and emotional, the counseling role should be filled by someone with the requisite expertise. This may necessitate a statutory mandate

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288. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 709-10 (1977) (Powell, J., concurring in part and concurring in the judgment) (contending that requiring minors to seek parental guidance, thereby requiring disclosure, would be consistent with existing case law).

289. *Planned Parenthood v. Danforth*, 428 U.S. 52, 67-75 (1976) (spousal and parental consent requirements); *Doe v. Bolton*, 410 U.S. 179, 195-200 (1973) (hospital committee of physician review of attending physician's judgment).

290. 431 U.S. 678, 688-89 & n.5 (1977).

291. See notes 264-71 and accompanying text *supra*.

292. See generally *Maher v. Roe*, 432 U.S. 464 (1977).

293. Dauber, *Profile of an Abortion Counselor*, 6 *FAM. PLAN. PERSPECTIVES* 185, 186-87 (1974).

that physicians fulfill this role in the absence of counselors who have complied with some type of certification procedure. The state might even require that doctors providing such counseling be certified themselves. This is not the place to explore the precise nature of counseling qualifications or the structure of a certification procedure. At some point, however, these issues must be faced.

## V. CONCLUSION

This Article is written from the perspective of two individuals deeply saddened by the spectacle of mounting abortion rates in the United States. We are not insensitive to the issues and values of advancing the autonomy of women, and recognize that among the myriad abortions being performed, many occur only after the deepest kind of soul-searching, in an agony of conscience that ultimately cannot be second-guessed by an outsider to the decision. But the staggering statistics on the number of abortions being performed, with the figures on fetal deaths in many areas outracing the figures on live births, compel the conclusion that the increment in female autonomy assured by liberalized abortion laws is being purchased at a horrendous price in terms of innocent life. We are saddened by this spectacle not only because of the terrible toll that is being paid in the coinage of tiny bodies, but also because we are conscious of other legal systems in which the tragic dilemma of women's rights and fetal life appears to have been resolved with greater sensitivity. We are convinced that even within the now well-entrenched confines established by the Supreme Court's abortion decisions, responsible steps can be taken to enhance this country's sensitivity and effectiveness in protecting potential life without detracting from the degree of autonomy that has now been guaranteed to women. Without embracing *Roe v. Wade* and its progeny as an ideal solution to the abortion dilemma, this Article has attempted to articulate avenues of sensitivity that have been left open by the Supreme Court—avenues that, if implemented, could effectuate not only a net savings in fetal life, but also a significant expansion and deepening of the genuine and rational exercise of female autonomy as well.