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## DOCTORS, PATIENTS AND THE CONSTITUTION: A THEORETICAL ANALYSIS OF THE PHYSICIAN'S ROLE IN "PRIVATE" REPRODUCTIVE DECISIONS

SUSAN FRELICH APPLETON\*

However controversial its transformation, the "right to privacy," which first developed as tort law's recognition of an individual's right to avoid public disclosure of personal facts,<sup>1</sup> is now firmly established as a

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I originally presented the substance of this Article on November 11, 1983, as one of three invited and funded lectures that I delivered as part of the Grand Rounds of the Department of Obstetrics and Gynecology of the Washington University School of Medicine. As I reworked this material for publication, I am grateful to have had the benefit of the thoughtful comments of Janet Benschopf, Herma Hill Kay, Sylvia A. Law, Ronald M. Levin, and Karen L. Tokarz. Their numerous insightful suggestions and criticisms, many but not all of which I adopted, improved my work enormously. The usual disclaimer protects these friends and colleagues from responsibility for my analysis, opinions, and conclusions.

1. This right owes its earliest explicit recognition to Samuel D. Warren and his then-partner, Louis D. Brandeis, who subsequently sat on the United States Supreme Court. Warren and Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). Their brief for "an inviolate personality," *id.* at 205, posited that the common law of copyright implicitly protects individuals wishing to shield their "thoughts, emotions, and sensations," *id.* at 206, from disclosure not only by the "newspaper enterprise," but also through the use of brand-new technology, e.g., "instantaneous photographs" and "mechanical [eavesdropping or broadcasting] devices," *id.* at 195. They recommended that courts award damages in tort in all cases in which defendant breaches plaintiff's right to privacy and that courts issue injunctions in a limited class of such cases. *Id.* at 219.

The judicial response was mixed. Compare *Roberson v. Rochester Folding Box Co.*, 171 N.Y. 538, 64 N.E. 442 (1902) (rejecting cause of action to enjoin defendant from using plaintiff's portrait) with *Pavesich v. New England Life Ins. Co.*, 122 Ga. 190, 50 S.E. 68 (1905) (recognizing right of privacy derives from natural law and protects against unwanted publicity of one's portrait). Years

constitutional liberty protected by the due process clause of the fourteenth amendment.<sup>2</sup> This newer notion of privacy includes the freedom to decide in large part one's own reproductive destiny. In the United States Supreme Court's own words, the Constitution shields from unjustified governmental intrusion<sup>3</sup> "the right of privacy,"<sup>4</sup> "matters so funda-

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later the scholarly debate continued, exploring the source and content of the right described by Warren and Brandeis. For example, Prosser, writing in 1960, found four distinctly different rights masquerading as a single right to privacy; he concluded that only one of the four, "public disclosure of private facts," concerned Warren and Brandeis. Prosser, *Privacy*, 48 CALIF. L. REV. 383, 389, 392, 398, 401 (1960). Other scholarly formulations of the right to privacy, although differently phrased, reflect the essence of Prosser's restatement of Warren and Brandeis. See, e.g., Gavison, *Privacy and the Limits of Law*, 89 YALE L.J. 421, 423, 436-37 (1980); Parker, *A Definition of Privacy*, 27 RUTGERS L. REV. 275, 281 (1974). See also Zimmerman, *Requiem for a Heavyweight: A Farewell to Warren and Brandeis's Privacy Tort*, 68 CORNELL L. REV. 291 (1983).

2. See *Roe v. Wade*, 410 U.S. 113, 153 (1973) ("This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions on state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy"). The Court recently reaffirmed *Roe*. *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 (1983). The Court may soon address again issues of reproductive privacy. *Diamond v. Charles*, 105 S. Ct. 2356 (1985); *Thornburgh v. American College of Obstetricians and Gynecologists*, 105 S. Ct. 2015 (1985). See *infra* notes 28-31 and accompanying text.

3. Distinguishing between "justified" and "unjustified" governmental intrusions is no easy task, given the changing standards of review applied by the Supreme Court. The Court first held that regulations limiting the right to privacy must serve a compelling state interest, *Roe*, 410 U.S. at 155, and that no state interest in restricting abortion achieves "the 'compelling' point" during the first trimester of pregnancy, *id.* at 163. Despite a subsequent case upholding written-consent and recordkeeping requirements imposed even on first-trimester abortions, *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 65-67, 79-81 (1976), the Court continued to recite the compelling-state-interest test as the controlling standard. See *Carey v. Population Servs. Int'l*, 431 U.S. 678, 686 (1977). When the Court applied the rational-basis test in a series of unsuccessful challenges to government programs that subsidized childbirth for indigent women but did not fund abortions, however, e.g., *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977), it invited considerable confusion among lower courts, notwithstanding the apparent distinction between laws that actively impinge on the abortion right and those that call for state inaction. See generally Appleton, *Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis*, 81 COLUM. L. REV. 721 (1981). This confusion centered on the appropriate standard of review for evaluating the constitutionality of laws that actively regulate or limit access to abortion even during the first trimester, but that do not prohibit it entirely. Compare *Leigh v. Olson*, 497 F. Supp. 1340, 1343 (D.N.D. 1980) (regulations not unduly burdening the abortion decision need only be rationally related to a legitimate state purpose) with *Charles v. Carey*, 627 F.2d 772, 777 (7th Cir. 1980) ("'undue burden' defines the ultimate constitutional issue, not merely the threshold requirement for strict scrutiny"), supplemented *sub nom.* *Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *prob. juris. noted sub nom.* *Diamond v. Charles*, 105 S. Ct. 2356 (1985).

The Court's most recent opinions fail to offer a definitive resolution of the problem. They suggest that only those regulations creating "significant obstacles" to or having a "significant impact" on the abortion right must serve a compelling state interest and must be "reasonably designed to further

mentally affecting a person as the decision whether to bear or beget a child,"<sup>5</sup> "individual autonomy in matters of childbearing,"<sup>6</sup> "an intimate relation of husband and wife,"<sup>7</sup> "the right of the individuals to use contraceptives if they choose to do so,"<sup>8</sup> and "a woman's decision whether or not to terminate her pregnancy."<sup>9</sup>

Whether regarded as a direct descendant of the tort principle or as a renaissance of the previously discredited constitutional doctrine of substantive due process,<sup>10</sup> modern constitutional privacy<sup>11</sup> logically ought to

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that state interest." *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 434 (1983). On the other hand, according to the Court, laws having "no significant impact" or imposing "only an insignificant burden" on the right must simply further "important health-related state concerns." *Id.* at 430, 435. But on what principled basis can one distinguish "significant" burdens from "insignificant" ones? *Compare* *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 489-90 (1983) (opinion of Powell, J., joined by Burger, C.J.) (pathology report requirement "does not significantly burden a pregnant woman's abortion decision") *with* at 497-98 (Blackmun, J., dissenting, joined by Brennan, Marshall and Stevens, JJ.) (cannot agree that "pathologist requirement has 'no significant impact'").

Even now lower courts remain divided, with some relying primarily on the *Roe* formula, e.g., *Charles v. Daley*, 749 F.2d 452, 458-59 (7th Cir. 1984), *prob. juris. noted sub nom. Diamond v. Charles*, 105 S. Ct. 2356 (1985); *American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283, 291-92 (3d Cir. 1984), *juris. postponed*, 105 S. Ct. 2015 (1985), and others attempting to follow the more complex refinements of the Court's 1983 opinions, e.g., *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 360-61 (6th Cir. 1984).

4. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965) (holding unconstitutional a Connecticut law prohibiting use of contraceptives by married couples).

5. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (holding unconstitutional, as a denial of equal protection, a Massachusetts law barring distribution of contraceptives to unmarried persons).

6. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687 (1977) (holding unconstitutional New York criminal statutes restricting access to contraceptives).

7. *Griswold*, 381 U.S. at 482.

8. *Carey*, 431 U.S. at 689.

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

10. In *Roe*, the Court expressly disclaimed reliance on the *Lochner* era's practice of using the due process clause to invalidate any social or economic legislation with which a majority of the Justices disagreed. *Id.* at 117 (citing *Lochner v. New York*, 198 U.S. 45, 76 (1905) (Holmes, J., dissenting)). The disclaimer persuaded neither Justice Rehnquist, 410 U.S. at 174, nor the commentators, e.g., Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920 (1973); Epstein, *Substantive Due Process by Any Other Name: The Abortion Cases*, 1973 SUP. CT. REV. 159. The *Roe* majority, like that in *Griswold* before it, moreover, placed considerable weight on precedents that contained language about the "privacy" of decisions within the family, but in fact struck down as violations of due process statutes interfering with the economic interests of teachers and private schools. See *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923). In other words, the Court relied on precedents that resembled *Lochner* more closely than the Court acknowledged. See *Roe*, 410 U.S. at 152-53; *Griswold*, 381 U.S. at 482.

11. The Court has observed that modern constitutional privacy protects two different interests: that "in avoiding disclosure of personal matters, and [that] in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). The first of these interests

belong to the individual seeking to exercise reproductive freedom—for example, the person seeking to use contraceptives or the pregnant woman seeking an abortion. That would certainly be the most plausible conclusion to draw from either earlier line of cases, tort or substantive

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mirrors the tort principle posited by Warren and Brandeis in 1890, *see supra* note 1, and elevated to constitutional status under the fourth amendment. *See, e.g., United States v. Karo*, 104 S. Ct. 3296, 3303 (1984) (warrantless monitoring by beeper of private residence in area not accessible to visual surveillance violates fourth amendment rights of those having justifiable interest in privacy of residence); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (Constitution protects “right to be let alone” now threatened by wiretapping and other technological advances). The second privacy interest is the heart of *Roe* and other cases affording constitutional protection to an individual’s right to reproductive self-determination.

The precise point at which “privacy” acquired its second meaning remains unclear. Arguably, *Griswold v. Connecticut*, 381 U.S. 479 (1965), which held a married couple’s use of contraceptives falls within a zone of privacy created by the penumbras of several constitutional amendments, marks the turning point. *See Whalen*, 429 U.S. at 589, 599-600 nn.25-26 (citing *Griswold* in support of both privacy interests). Yet a closer reading of *Griswold* suggests that the majority cared more about inaccessibility or nondisclosure than about freedom. The opinion not only voiced special concern about law enforcement efforts that would invade the marital bedroom, but also conceded that a prohibition on the manufacture or sale of contraceptives would present a different set of legal questions. 381 U.S. at 485. *See Ely, supra* note 10, at 930; *The Supreme Court, 1964 Term*, 79 HARV. L. REV. 103, 162 (1965). The opinions of the concurring Justices provide much stronger support for the conclusion that *Griswold* introduced the second meaning of “privacy.” These five Justices would have invoked the due process clause to strike down the Connecticut law as an unconstitutional deprivation of liberty. *See* 381 U.S. at 486 (Goldberg, J., concurring, joined by Warren, C.J., and Brennan, J.); *id.* at 500 (Harlan, J., concurring); *id.* at 502 (White, J., concurring). White’s opinion, for example, discussed at length cases affording protection to other family-centered decisions. *Id.* at 502-03.

Alternatively, *Eisenstadt v. Baird*, 405 U.S. 438 (1972), may be the transitional case in the development of constitutional privacy. Although the Court eschewed deciding whether the Constitution affords a right of access to contraceptives and relied on the equal protection clause to invalidate a ban on the distribution of such products to unmarried persons, its dicta left no ambiguity about the new meaning of privacy: “If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” *Id.* at 453. The Court took that notion one step further in *Roe*.

Commentators, including some of the Justices, have noted the double meaning of “privacy.” *E.g., Roe*, 410 U.S. at 172 (Rehnquist, J., dissenting); *Griswold*, 381 U.S. at 509-10 & n.1 (Black, J., dissenting). *See, e.g., Karst, The Freedom of Intimate Association*, 89 YALE L.J. 624, 664 (1980); Comment, *A Taxonomy of Privacy: Repose, Sanctuary, and Intimate Decision*, 64 CALIF. L. REV. 1447, 1448 (1976). Whatever notion of “privacy” *Griswold* may have encompassed when it was written, hindsight has established it as a case about reproductive decision-making. *See Carey v. Population Servs. Int’l*, 431 U.S. 678, 687 (1977) (“read in light of its progeny, the teaching of *Griswold* is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State”); *Doe v. Bolton*, 410 U.S. 179, 217 (1973) (Douglas, J., concurring) (“We held in *Griswold* that the States may not preclude spouses from attempting to avoid the joinder of sperm and egg.”).

due process.<sup>12</sup> And it would be the most plausible conclusion to draw from the Court's recognition of both the extreme burden imposed upon women by abortion prohibitions<sup>13</sup> and the unsuitability for legislative resolution of an intimate matter of conscience such as abortion.<sup>14</sup> Although reaching generally sound results in striking down abortion restrictions, the Supreme Court has used an unnecessarily problematic route, however. On close analysis the Court's opinions, mirroring the entire history of the law's treatment of reproductive control, reveal that the real focus has been not the individual patient, but the physician and current standards of medical practice.<sup>15</sup>

This Article examines the role of the physician and current medical practice in the changing legal status of abortion restrictions. In doing so, this Article considers "constitutional privacy" from a perspective different from other inquiries, which almost always emphasize the individual patient as the right-holder, and concludes that, at least in the abortion context, the Court's vision of privacy consistently makes the doctor, not his patient, the centerpiece of the analysis.<sup>16</sup>

The Court's early abortion opinions used language explicitly recognizing the physician's authority over all aspects of a woman's abortion choice.<sup>17</sup> Although the Court's most recent opinions have abandoned

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12. One could plausibly draw this conclusion from the fourth amendment cases as well. See *supra* note 11.

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

14. See *id.* at 159, 162.

15. Although not all physicians are male, I shall refer to them by masculine pronouns. Abortion and obstetric patients are all female, and to the extent this Article considers other patients who may be of either gender, I shall use female pronouns to refer to them.

16. Other physician-focused analyses include Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51 (1983); Marcin & Marcin, *The Physician's Decision-Making Role in Abortion Cases*, 35 THE JURIST 66 (1975); Wood & Durham, *Counseling, Consulting and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U.L. REV. 783. See *The Supreme Court, 1982 Term*, 97 HARV. L. REV. 70, 78-79, 84-85 (1983). See also Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C.L. REV. 375, 382 (1985) (criticizing *Roe* for, *inter alia*, its "medical approach"). But see Kapp, *Abortion and Informed Consent Requirements*, 144 AM. J. OBSTET. GYNECOL. 1 (1982) (arguing modern debates have ignored the physician). I found Asaro's piece particularly interesting because it relies on many of the same sources that I considered and it reaches many of the same conclusions that I reached. Yet our analyses contain substantial differences, for example, our treatment of the abortion-funding cases, compare *infra* notes 152-67 and accompanying text with Asaro, *supra*, at 88-93, and some of our observations on informed consent, compare *infra* notes 195-303 and accompanying text with Asaro, *supra*, at 76-88. Our articles, therefore, may be profitably studied together.

17. See *infra* notes 98-108 and accompanying text.

that language in favor of a more woman-centered rhetoric<sup>18</sup> and have reached results that offer great practical benefits to women because these results legitimize the realities of modern abortion-clinic practice,<sup>19</sup> the analysis in these newest opinions reflects the increasing importance of questions of medical standards and physicians' prerogatives.<sup>20</sup>

The limited right of reproductive choice that has accrued to the patient through the Court's recurring solicitude for the physician is incompatible with the theoretical foundation of this right, "privacy."<sup>21</sup> This solicitude for the physician and his profession, moreover, has committed the Court to a method of analysis in which it must articulate fine distinctions about the appropriate way to practice medicine<sup>22</sup>—distinctions that often bury the larger social issue and the interests at stake for abortion patients. As a result of this approach, the cases have failed to resolve satisfactorily the possible tension between the abortion patient's rights and her doctor's autonomy, a tension that emerges most prominently in assessments of abortion restrictions defining informed consent.<sup>23</sup>

Alternative ways to address questions of reproductive control, such as Sylvia Law's argument that abortion restrictions create unconstitutional gender-based discrimination<sup>24</sup> or Donald Regan's thesis that such laws unconstitutionally single out pregnant women as unwilling good samaritans conscripted to endure life- and health-threatening physical burdens,<sup>25</sup> help elevate the individual woman's status in the constitutional analysis and avoid the doctrinal weaknesses in the Court's current meth-

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18. See *Akron*, 462 U.S. at 421 n.1 ("a woman has a fundamental right"), 427 ("the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment'").

19. See, e.g., *id.* at 446-49 (invalidating physician-counseling requirement), 449-51 (invalidating mandatory waiting period).

20. See, e.g., *infra* notes 77-92 and accompanying text.

21. This incompatibility follows regardless of the particular meaning of privacy used. See *supra* note 11 and text accompanying note 12.

22. See *infra* notes 89 & 90 and accompanying text.

23. See *infra* notes 168-303 and accompanying text.

24. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955 (1984). See Brief Amici Curiae for Committee for Abortion Rights and Against Sterilization Abuse, *Simopoulos v. Virginia*, 462 U.S. 506 (1983); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983) (brief submitted by Sylvia A. Law, Nadine Taub and Ellen J. Winner challenging abortion restrictions as unconstitutional sex-based discrimination). See also Ginsburg, *supra* note 16, at 382 (attributing widespread criticism of *Roe* to Court's focus on "woman tied to her physician" instead of on woman alone).

25. Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569 (1979).

odology.<sup>26</sup> Such women-focused approaches provide a firmer constitutional foundation for reproductive freedom than the present medicine-based formula, avoid the difficult and unnecessary problems created by this formula, and yield sound solutions to even the most troublesome questions raised in abortion litigation.<sup>27</sup> Issues presented by the most recent abortion cases scheduled for the Supreme Court's docket, *Thornburgh v. American College of Obstetricians and Gynecologists*<sup>28</sup> and *Diamond v. Charles*,<sup>29</sup> including the constitutionality of certain specific "informed consent" requirements,<sup>30</sup> provide a timely and useful context for contrasting these different approaches.<sup>31</sup>

## I. AN HISTORICAL REVIEW OF CRIMINAL ABORTION RESTRICTIONS

In one sense, the dominance in modern abortion law of the physician and whatever constitutes "accepted medical practice"<sup>32</sup> should evoke little surprise. A similar pattern emerges from the earliest legal treatment of the subject—the thirteenth-century English common law's punishment only of those who performed abortions after the fetus had quickened.<sup>33</sup> Like its English antecedents, the initial American approach, first common law and later statutory, punished the abortionist, but not his patient, and then only for postquickening abortions.<sup>34</sup> Several early anti-abortion restrictions singled out particular methods, for example, poison-

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26. See *supra* notes 10 & 11.

27. See *infra* notes 304-80 and accompanying text.

28. 105 S. Ct. 2015 (1985). The Court postponed "[f]urther consideration of the question of jurisdiction" until the hearing on the merits. Pennsylvania appealed the ruling below, reported at 737 F.2d 283 (3d Cir. 1984), which struck down numerous provisions of that state's Abortion Control Act.

29. 105 S. Ct. 2356 (1985). The Court noted probable jurisdiction. The opinions below, invalidating several Illinois abortion restrictions, appear as *Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), and *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980). Although Supreme Court review was sought on behalf of the state, current reports indicate that the Attorney General's office had decided not to pursue the case. Lauter, *Was the Court Bamboozled?*, Nat'l Law J., June 10, 1985, at 1, col. 1. "[T]he effect, if any, of the misrepresentation [on the Court's decision to note probable jurisdiction] cannot be assessed." *Id.* at 40, col. 1.

30. See *Charles*, 749 F.2d at 461-62; *Thornburgh*, 737 F.2d at 295-96, 298.

31. See *infra* notes 304-87 and accompanying text.

32. See *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 431 (1983).

33. H. DE BRACON, 2 ON THE LAWS AND CUSTOMS OF ENGLAND 341 (S.E. Thorne trans. 1968).

34. See Appleton, *Abortion* in 1 ENCYCLOPEDIA OF CRIME AND JUSTICE 2 (1983). These limitations prevailed until New York enacted a substantially stricter law in 1845. 1845 N.Y. LAWS ch. 260, amended by 1846 N.Y. LAWS ch. 22 (repealed).



ing.<sup>35</sup> Such narrow coverage and the traditional inculcation of only the abortionist (the historical counterpart of the physician in the modern analysis)<sup>36</sup> have led scholars to conclude that the law sought to protect the patient from the hazards of certain abortifacients rather than to criminalize abortion itself.<sup>37</sup> In essence, early abortion restrictions, both common-law and statutory, were early efforts to regulate the practice of medicine.<sup>38</sup>

Similarly, the quickening rule, differentiating permissible from illegal abortions,<sup>39</sup> also reflects how the law of abortion took its shape from medical practices of the time. According to historian James C. Mohr, quickening—the time when the pregnant woman first feels fetal movements<sup>40</sup>—owed its legal importance to the unavailability of any accurate pregnancy test.<sup>41</sup> Without such tests only fetal movements could confirm the fact of pregnancy; before such movements, terminating an early pregnancy was indistinguishable from treating a “menstrual obstruction.”<sup>42</sup> In other words, only after quickening was it clear that the practitioner had performed an abortion and not some other medical procedure. The quickening criterion also served an important evidentiary function, providing the only indication that the abortion procedure had in fact caused destruction of a live fetus rather than the expulsion of a fetus that had

35. *E.g.*, CONN. PUB. STATS. tit. 22, § 14 (1821) (repealed).

36. I mean not to equate the skill and qualifications of modern physicians with yesterday's “irregular” practitioners, *see* J. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900*, at 33-45 (1978), but rather to emphasize the distinction between whoever it is that performs the abortion procedure and the pregnant woman or patient.

37. *See, e.g.*, Means, *The Phoenix of Abortional Freedom: Is a Penumbra or Ninth-Amendment Right about to Arise from the Nineteenth Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?*, 17 N.Y.L.F. 335 (1971); Means, *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411 (1968).

38. *See* J. MOHR, *supra* note 36, at 22-24; Appleton, *supra* note 34, at 2.

39. This distinction persisted in many jurisdictions until the second half of the nineteenth century. *See* J. MOHR, *supra* note 36, at 200; Appleton, *supra* note 34, at 3. Even later, some states imposed higher penalties for postquickening abortions than for earlier terminations. *See* MODEL PENAL CODE § 230.3 commentary at 440-41 (1980).

40. This subjective and variable experience usually occurs when the woman has reached between 16 and 18 weeks of pregnancy.

41. J. MOHR, *supra* note 36, at 4. For a fascinating review of early (and unreliable) pregnancy tests, *see* Forbes, *Early Pregnancy and Fertility Tests*, 30 YALE J. OF BIOLOGY & MED. 16 (1957). For a description of early twentieth-century laboratory tests for pregnancy, *see* J. B. DELEE, *PRINCIPLES AND PRACTICE OF OBSTETRICS* 277-78 (6th ed. 1933) (describing urine test, reported by Zondek and Aschheim in 1928); J.B. DELEE, *PRINCIPLES AND PRACTICE OF OBSTETRICS* 260-61 (2d ed. 1915) (describing Abderhalden's blood test); J.W. WILLIAMS, *OBSTETRICS* 202-03 (4th ed. 1920) (describing Abderhalden's blood test, reported in 1912).

42. J. MOHR, *supra* note 36, at 4.

previously died *in utero*.<sup>43</sup>

Later, the medical community's increased understanding of the gestational process, together with the desire of doctors both to improve the standards of their profession and to eliminate "irregular" practitioners<sup>44</sup> from their ranks, spawned a "physicians' crusade"<sup>45</sup> to tighten abortion restrictions.<sup>46</sup> The resulting state legislation barred abortion at all stages of pregnancy unless the procedure was necessary to save the mother's life.<sup>47</sup> In many jurisdictions, prohibitions of this sort endured until the United States Supreme Court found them unconstitutional in 1973;<sup>48</sup> their life attests to the powerful and lasting influence of the nineteenth century "physicians' crusade."<sup>49</sup> On the other hand, medical opinion favoring decriminalization played a considerable role in those states that had modernized their laws before 1973.<sup>50</sup>

That the limits of medical technology have dictated the limits of the law is hardly more than a truism. As a practical matter, enforceable abortion restrictions cannot rest on a technology that does not yet exist.<sup>51</sup>

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43. See Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *FORD. L. REV.* 807, 815-16 (1973). Today, modern pregnancy-monitoring techniques such as ultrasound imaging make obsolete reliance on quickening for this evidentiary purpose. See, e.g., Hubbard, *Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy*, 7 *WOMEN'S RTS. L. RPTR.* 201, 208 (1982). To the extent that quickening roughly divides pregnancy into two stages, its legal importance may also have served to allow early (and thus relatively safe) abortions while criminalizing late (and thus comparatively more hazardous) terminations. See *Roe v. Wade*, 410 U.S. 113, 151-52 (1973).

44. See, e.g., J. MOHR, *supra* note note 36, at 160-63.

45. *Id.* at 147.

46. *Id.* at 147-70.

47. See Appleton, *supra* note 34, at 3. See generally J. MOHR, *supra* note 36, at 200-45.

48. *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973).

49. J. MOHR, *supra* note 36, at 147.

50. See, e.g., P. STEINHOFF & M. DIAMOND, *ABORTION POLITICS* 9-10, 16, 46-47, 73-75, 91-93 (1977) (documenting influence of physicians in abortion law reform in Hawaii). See also *Roe*, 410 U.S. at 142-44. In addition, to the extent that judicial decree has precipitated law reform, physicians have appeared as plaintiffs in many important constitutional challenges. E.g., *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 62 (1976); *Doe v. Bolton*, 410 U.S. 179, 188 (1973).

51. A legislature hostile to abortion logically could prohibit *all* procedures that *might* cause abortion, even in the absence of any scientific basis for distinguishing pregnancy from a "menstrual obstruction." See *supra* note 42 and accompanying text. In fact, laws that prohibited "attempted abortions" sought to do that, but these laws ultimately proved ineffective because of proof problems resulting from the nonexistence of a reliable pregnancy test. See Appleton, *supra* note 34, at 2-3. In addition, a flat ban on *all* procedures that *might* cause abortion could entail costs (for example, health risks to those who in fact suffer from "menstrual obstructions") that even an anti-abortion legislature would have been unwilling to impose.

Of course, a legislature might decide to ban a procedure or technique before it becomes scientifically feasible. See Note, *Asexual Reproduction and Genetic Engineering: A Constitutional Assess-*

Likewise, that physicians and their understanding of the underlying biological processes have influenced state legislatures in this area simply reaffirms the fact that abortion is inevitably a medical procedure,<sup>52</sup> a fact that has not escaped judicial recognition.<sup>53</sup> Yet this unremarkable dependence of law upon medical science differs significantly from their current relationship, fashioned by the Supreme Court, in which "standard medical practice" not only influences law but dictates its constitutional outer limits. Because the Court has invited states to offer medical justifications for their abortion restrictions and because the Court has undertaken to evaluate these justifications under the compelling-state-interest test,<sup>54</sup> a bright constitutional line now separates present medical custom from nonstandard practice, a line that effectively delegates to the medical community the responsibility of defining the right to privacy.

## II. A CONSTITUTIONAL RIGHT TO CHOOSE ABORTION

### A. *The Boundaries of the Right: Comparative Safety and Accepted Medical Practice*

Although a number of state legislatures began to relax their abortion restrictions in the 1960s,<sup>55</sup> the judicial forum ultimately produced the most sweeping changes. Following several successful constitutional chal-

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*ment of the Technology of Cloning*, 47 S. CAL. L. REV. 476, 492-93 (1974) (noting proposed legislative bans on human cloning before it becomes possible). Cf. La Pierre, *Technology-Forcing and Federal Environmental Protection Statutes*, 62 IOWA L. REV. 771 (1977) (how law can force technological innovation).

52. Of course, illegal abortion, often by persons not qualified to practice medicine, was long a prevalent occurrence. See MODEL PENAL CODE § 230.3 commentary at 426-27 (1980). A pregnant woman may also perform "self-abortion," see *id.*, at 436-39, and some advocate continued use of such self-help techniques even though the present constitutional regime does not protect these practices. See THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *THE NEW OUR BODIES, OURSELVES* 295 (1984) (menstrual extraction to avoid menstrual periods and terminate very early pregnancies); Barnes, *Commentaries: National Medical Trends and Future Implications*, in H.F. OSOFSKY & J.D. OSOFSKY, *THE ABORTION EXPERIENCE* 530, 533-34 (1973) (envisioning "block committees" or "neighborhood clubs" where members perform menstrual extraction on each other). See also *Connecticut v. Menillo*, 423 U.S. 9 (1975) (privacy right does not encompass abortions by nonphysicians); Law, *supra* note 24, at 1020 n.233 (abortion no more medically complex than other services performed by nonphysicians).

53. See *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 427 (1983); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 699-700 n.25 (1977) (plurality opinion); *Roe*, 410 U.S. at 166.

54. See *infra* notes 62-72 and accompanying text.

55. See Comment, *A Survey of the Present Statutory and Case Law on Abortion: The Contradictions and the Problems*, 1972 U. ILL. L.F. 177.

lenges to restrictive abortion laws in state and lower federal courts,<sup>56</sup> in 1973 the Supreme Court decided *Roe v. Wade*<sup>57</sup> relying in part on the current positions of the American Medical Association, which no longer condemned abortion,<sup>58</sup> and the American Public Health Association, which urged the availability of abortion, subject to certain recommended standards.<sup>59</sup>

*Roe* announced that the right to privacy, now clearly tied to the "Fourteenth Amendment's concept of personal liberty and restrictions on state action,"<sup>60</sup> encompasses "a woman's decision whether or not to terminate her pregnancy."<sup>61</sup> The Court's framework for analysis required states to tailor their abortion restrictions narrowly to advance only compelling governmental interests.<sup>62</sup> Within this framework, the Court observed that, when states first prohibited abortion, they sought to protect the pregnant woman from the risks associated with the abortion procedure and not to protect her fetus.<sup>63</sup> The Court determined that modern medical practice undermined such purported justification.<sup>64</sup> Because in 1973 the mortality rate from carrying a pregnancy to term exceeded the mortality rate from early abortion, the Court concluded that protecting maternal health no longer offered a sufficiently compelling reason to support abortion restrictions during the first trimester of pregnancy.<sup>65</sup> After the first trimester, however, when the risks of abortion increase, the Constitution permits a state to enact reasonable regulations to safeguard maternal health.<sup>66</sup> Similarly, another state interest, protecting "potential life," becomes compelling only upon viability of the fetus;<sup>67</sup> at this point, which requires an individual medical determination

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56. See Morgan, *Roe v. Wade and the Lesson of the Pre-Roe Case Law*, 77 MICH. L. REV. 1724 (1979).

57. 410 U.S. 113 (1973).

58. *Id.* at 141-44.

59. *Id.* at 144-46.

60. *Id.* at 153.

61. *Id.*

62. *Id.* at 155. For subsequent refinements in the standard of review, see *supra* note 3.

63. 410 U.S. at 148-52, 158.

64. *Id.* at 149-50.

65. *Id.* at 163.

66. *Id.*

67. *Id.* The Court failed to explain adequately why this interest becomes compelling at viability and only then. See Ely, *supra* note 10, at 924-25 (Court mistakes "a definition for a syllogism"); 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, 4 (1973) (same); but see *id.* at 28 (postviability abortions can be prohibited because state has no practical way to distinguish them from infanticides).

in each patient's case,<sup>68</sup> the state can prohibit abortion, except when continued pregnancy endangers maternal life or health.<sup>69</sup> In this way, the Court not only delegated to physicians the task of distinguishing protected abortions from those within the state's power to outlaw,<sup>70</sup> but also concededly picked a " 'compelling' point"<sup>71</sup> inescapably tied to developments in medical technology.<sup>72</sup>

Under the Court's approach, which encourages states to advance medical reasons for their antiabortion laws, a woman's constitutional right of reproductive control owes its scope, if not its very existence, to the state of the art of contemporary medicine and the safety of its procedures.<sup>73</sup> Several cases after *Roe* have tested and confirmed this hypothesis. For example, in 1976 the Supreme Court held unconstitutional Missouri's ban on post-first-trimester abortions performed by saline amniocentesis.<sup>74</sup> Whatever the health concerns about this method of abortion,<sup>75</sup> the Court held that a state could not outlaw it until the medical profession had developed an equally available alternative method.<sup>76</sup> In other words, the

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68. See *Colautti v. Franklin*, 439 U.S. 379, 387-89, 395-96 (1979); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 63-65 (1976).

69. *Roe*, 410 U.S. at 163-64.

70. The physician's task thus also includes determining when risks to maternal health or life indicate a postviability abortion. See *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (reciting broad definition of "health" to be considered by physician).

71. *Roe*, 410 U.S. at 163.

72. See, e.g., *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 456-57 (O'Connor, J., dissenting) ("technological improvements will move *backward* the point of viability"); *Colautti*, 439 U.S. at 387 (point left "flexible for advancements in medical skill"); *Ely*, *supra* note 10, at 924. See also *Roe*, 410 U.S. at 161 (acknowledging possibility of "artificial wombs" in discussing difficulty of deciding when life begins).

73. See *Akron*, 462 U.S. at 429 n.11, 437; *id.* at 453-59 (O'Connor, J., dissenting). But see Rhoden, *The New Neonatal Dilemma: Live Births from Late Abortions*, 72 GEO. L.J. 1451 (1984). Rhoden submits that the Court's use of the trimester timetable rested on symbolic and practical considerations rather than on medical data; the Court wished to adopt a compromise position, according different legal status to early and late abortions and avoiding the dilemma of allowing abortions likely to produce live births. Drawing lines at the end of the first trimester and at viability achieved these goals. The Court has not retreated from this compromise despite technological advancements. *Id.* at 1498, 1506.

74. *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 75-79 (1976).

75. The use of saline amniocentesis has decreased with the development of newer methods offering more effective second-trimester abortions and posing fewer risks to the patient. See Bygdeman, *Prostaglandin Procedures in SECOND TRIMESTER ABORTION* 89, 101 (G. Berger, W. Brenner, & L. Keith eds. 1981); Grimes & Cates, *Dilatation and Evacuation in SECOND TRIMESTER ABORTION*, *supra*, at 119, 128-29. See also Rhoden, *supra* note 73, at 1501 (discussing safety of abortion techniques used after first trimester).

76. 428 U.S. at 77-78.

Constitution requires state legislatures to await additional scientific progress before imposing such restrictions.

Conversely, in 1983 the Court held that medical progress compels legal change. A number of jurisdictions had adopted laws, pursuant to *Roe's* timetable,<sup>77</sup> requiring hospitalization for all abortions performed after the first trimester.<sup>78</sup> *Roe's* language seemed to have provided an ample basis for hospitalization laws; indeed, the *Roe* Court explicitly mentioned hospitalization as an example of a permissible health-related regulation after the first trimester.<sup>79</sup> Nonetheless, the Court struck down such requirements,<sup>80</sup> observing that abortion techniques and their relative safety had advanced considerably in the decade between 1973 and 1983.<sup>81</sup> According to the Court, a new abortion procedure, dilatation and evacuation or D&E, "is now widely and successfully used for second-trimester abortions."<sup>82</sup> The Court continued: "[A]n even more significant factor is that experience indicates that D&E may be performed safely on an outpatient basis in appropriate nonhospital facilities."<sup>83</sup> The Court noted the American Public Health Association and the American College of Obstetricians and Gynecologists no longer recommend hospitalization for *all* second-trimester abortions.<sup>84</sup> The Court read the Constitution to oblige all state legislatures to follow: "We conclude . . . that 'present medical knowledge' . . . convincingly undercuts [the] justification for requiring that *all* second-trimester abortions be performed in a hospital."<sup>85</sup>

Under this reasoning, the state interests to which the Court will defer are coextensive with accepted medical practice, and only those laws conforming to this standard will survive judicial scrutiny. The constitutional right to choose abortion thus ends where this standard ends. Accordingly, the Court upheld a Connecticut law barring nonphysicians from

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77. 410 U.S. at 164-66.

78. See, e.g., *Akron*, 462 U.S. at 431-32; Planned Parenthood Ass'n of Kansas City, Inc. v. Ashcroft, 462 U.S. 476, 481 (1983); Note, *Hospitalization Requirements for Second-Trimester Abortions: For the Purpose of Health or Hindrance?*, 71 GEO. L. REV. 991 (1983).

79. 410 U.S. at 163.

80. *Akron*, 462 U.S. at 438-39; *Ashcroft*, 462 U.S. at 482.

81. *Akron*, 462 U.S. at 435-37.

82. *Id.* at 436.

83. *Id.*

84. *Id.* at 436-37.

85. *Id.* at 437. The Court, however, refused to depart from the trimester timetable adopted in *Roe*, stating that it "continues to provide a reasonable legal framework for limiting a state's authority to regulate abortions." *Id.* at 429 n.11. For Nancy Rhoden's explanation, see *supra* note 73.

performing abortions, observing that *Roe's* safety calculus holds true only when physicians perform the procedure.<sup>86</sup> The Court concluded that "[e]ven during the first trimester . . . prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference."<sup>87</sup> The Court also held that Virginia may require physicians to perform all abortions after the first trimester in licensed clinics and outpatient hospitals because, according to the American Public Health Association and the American College of Obstetricians and Gynecologists, such limits are consistent with accepted medical practice even if full-service hospitalization is not.<sup>88</sup> Similarly, Missouri may require a pathologist's report following all abortions because "[a]s a rule it is accepted medical practice to submit all tissue to the examination of a pathologist."<sup>89</sup> Four of the nine justices on the Court disagreed that obtaining a pathology report accords with accepted medical practice.<sup>90</sup> Perhaps more significant than resolving this particular disagreement is recognizing the transformation of the constitutional analysis: judicial evaluations of the appropriate way to practice medicine have become determinative in deciding questions of individual privacy.

From 1973 to 1983 the Supreme Court has repeatedly relied on the boundaries of accepted medical practice and present medical knowledge to define the boundaries of the right to privacy. The Court's vision of privacy and its method of analysis make the physician and his profession ineluctably important. Although standard medical practice is a familiar legal concept,<sup>91</sup> the Court's reliance on this concept is both interesting and disturbing. It is interesting because the cases could have invoked a

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

87. *Id.* at 11.

88. *Simopoulos v. Virginia*, 462 U.S. 506, 516-17 (1983).

89. *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 487 (1983) (opinion of Powell, J., joined by Burger, C.J.; result supported also by O'Connor, White, and Rehnquist, JJ.).

90. *Id.* at 495 (Blackmun, J., dissenting, joined by Brennan, Marshall, and Stevens, JJ.). As Justice Blackmun observed, the legislature failed to require that the pathologist perform a microscopic examination of the tissue; under the statute, he must simply perform a gross visual examination, duplicating the usual responsibility of the attending physician. *Id.* at 496-97. The statutory requirement thus adds nothing to the protection of the patient's health. Interview with Michael Frieman, M.D. and Associate Professor of Clinical Obstetrics and Gynecology, Washington University School of Medicine in St. Louis, MO. (Mar. 4, 1985).

91. Standard medical practice ordinarily defines the physician's duty and determines whether he breached it in malpractice litigation. See generally W.P. KEETON, D. DOBBS, R. KEETON, & D. OWEN, PROSSER AND KEETON ON TORTS 187 (5th ed. 1984).

firmer constitutional ground to recognize and define a woman's right of reproductive choice.<sup>92</sup> It is disturbing because the doctor's role in constitutionally protected privacy, according to the Court's early opinions, perhaps extends well beyond these medical aspects of abortion.

*B. The Early Cases: Portraying the Physician as Decision-Maker*

*Roe v. Wade*<sup>93</sup> probably best fits with the very limited authority of courts in a constitutional democracy when *Roe* is described as a decision about decision-making.<sup>94</sup> Under this reading, the *Roe* Court did not express a value judgment favoring abortion, as some critics have contended,<sup>95</sup> but rather concluded simply that the Constitution commits certain highly personal choices to the individual most intimately affected by them.<sup>96</sup> This explanation of *Roe*'s holding or result, with its focus on the pregnant woman, is both plausible and sensible given the genesis of the right to privacy.<sup>97</sup>

Nonetheless, the Court's language in *Roe*, as distinguished from its result, portrays the doctor and not the patient as the primary decision-maker in the abortion context: "[F]or the period of pregnancy prior to this compelling point [at the end of the first trimester], *the attending physician*, in consultation with his patient, *is free to determine*, without regulation by the State, that, *in his medical judgment*, the patient's pregnancy should be terminated."<sup>98</sup> Making the same point later in the opinion, the Court stated: "For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the *medical judgment of the pregnant woman's attending physician*."<sup>99</sup> As the Court put it, *Roe* "vindicates the right of the physician to administer medical treatment according to his professional judgment," subject to the

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92. See *infra* notes 304-87 and accompanying text.

93. 410 U.S. 113 (1973).

94. See Tribe, *supra* note 67.

95. See, e.g., J. NOONAN, A PRIVATE CHOICE: ABORTION IN AMERICA IN THE SEVENTIES (1979); Byrn, *supra* note 43; Destro, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 CALIF. L. REV. 1250 (1975); Uddo, *A Wink from the Bench: The Federal Courts and Abortion*, 53 TUL. L. REV. 398 (1979).

96. See Tribe, *supra* note 67, at 11. The Court expressly adopted this reading of *Roe* in *Akron*. See *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 n.1 (1983) ("basic principle that a woman has a fundamental right to make the highly personal choice whether or not to terminate her pregnancy").

97. See *supra* notes 1 & 11.

98. 410 U.S. at 163 (emphasis added).

99. *Id.* at 164 (emphasis added).



state's compelling interests.<sup>100</sup> "Up to those points, the abortion decision *in all its aspects* is inherently, and primarily, a medical decision. . . ."<sup>101</sup>

*Roe's* companion case, *Doe v. Bolton*,<sup>102</sup> in which the Court struck down Georgia's modern abortion restrictions that allowed some abortions under specified conditions,<sup>103</sup> offers a more revealing glimpse of the Court's initial view of the physician and his constitutional role. Although it follows from both the nature of the abortion process and the language of *Roe* that a woman can exercise her right to terminate a pregnancy only to the extent she can find a doctor who will agree to effectuate her decision, *Doe* suggests that the Court contemplated the doctor's role as something more than that of a medical technician who carries out the abortion choice already reached by the patient. According to *Doe*, the physician's "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. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment."<sup>104</sup>

Such considerations necessarily would inject the physician into the most intimate of details that weigh in the woman's deliberation whether to terminate her pregnancy. Although *Doe* encompasses these variables within the physician's "medical judgment," the Court's list may extend the physician's inquiry beyond the ordinary limits of that term.<sup>105</sup> Be-

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100. *Id.* at 165-66. This part of the opinion avoids any express reference to the pregnant woman.

101. *Id.* at 166. The Court continued by alluding to the remedies available when doctors abuse their discretion. *Id.*

102. 410 U.S. 179 (1973).

103. *Id.* at 182. The Georgia statute, based on the Model Penal Code, included special hospitalization, accreditation, committee-approval, two-doctor-concurrence, and residency requirements.

104. *Id.* at 192.

105. Although for some doctors counseling or allied treatment is central to their practice, *e.g.*, psychiatrists, the Court's description of the factors entering a physician's decision whether or not to perform an abortion seems unjustifiably broad. The description not only invites the physician to consider matters not ordinarily considered "medical," *e.g.*, whether the physician (not the patient) feels the patient's family is "large enough" or "too large," but also distorts the role most physicians feel competent to assume. See *infra* notes 132 & 133 and accompanying text. In addition, if "health" is so broadly defined that it is implicated in *any* choice between abortion and childbirth, then *Roe's* statement of the health-based exception to the viability limit, see *supra* note 69, becomes meaningless, as do distinctions drawn in other cases between "nontherapeutic" and "medically necessary" abortions. Compare *Maher v. Roe*, 432 U.S. 464, 479 (1977) (Connecticut regulation withholding funds for "nontherapeutic abortion" is constitutional) with *Harris v. McRae*, 448 U.S. 297, 317 (1980) (Hyde Amendment, which withholds federal funding for certain "medically necessary abortions," is constitutional). See *Appleton, supra* note 3, at 724 n.22, 734 n.97. Moreover, in the analogous although distinct context of contraception, a plurality of the Court has repudiated the

sides, when a doctor refuses to effectuate a patient's abortion choice for reasons other than those considered "medical" under any definition of that word, state "conscience clauses" approved by the Court protect him.<sup>106</sup>

In addition, after rejecting the argument that the overview of a hospital-staff abortion committee would subject a pregnant woman to the committee's moral disapproval of the sexual activity that resulted in her predicament,<sup>107</sup> the Court in *Doe* offered this description of the doctor:

The appellants' suggestion is necessarily somewhat degrading to the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concerns of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called "error," and needs. The good physician—despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are "good"—will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling.<sup>108</sup>

Such excerpts led the authors of one early analysis to conclude that the Supreme Court adopted a model of the doctor as a "medical counselor."<sup>109</sup> Because "medical considerations alone will rarely dictate the

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vision of the physician as a moral counselor. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 699-700 & nn.24-25 (1977). The state cannot constitutionally delegate to physicians a counseling function regarding decisions in which "no medical judgment is involved at all." *Id.* at 699 n.24.

106. *E.g.*, CAL. HEALTH & SAFETY CODE § 25955 (Deering Supp. 1985) (prohibiting, *inter alia*, employer or other person from requiring physicians or other employees who have filed "moral, ethical, or religious" objection to abortion to participate directly in such procedures); ILL. ANN. STAT. ch. 38 § 81-33 (Smith-Hurd Supp. 1985) (no physician or health care institution shall be required "against his or its conscience declared in writing to perform, permit or participate in any abortion"); MO. REV. STAT. § 197.032 (1978) (no physician or institution shall be required to treat any woman for abortion contrary to his or its "established policy [or] moral, ethical or religious beliefs"); see 42 U.S.C. § 300a-7(b) (1982) (protection in federally funded family planning programs of "religious beliefs or moral convictions" of individuals and entities opposing abortion). See also S.D. CODIFIED LAWS ANN. § 21-55-3 (Supp. 1984) (prohibiting action for wrongful life: "The failure or the refusal of any person to prevent the live birth of a person may not be considered in awarding damages or in imposing a penalty in any action.").

The Court implicitly approved such conscience clauses in *Doe v. Bolton*, 410 U.S. 179, 197-98 (1973), when it cited Georgia's statute without disapproval, and in *Poelker v. Doe*, 432 U.S. 519 (1977), when it upheld a city-operated hospital's antiabortion policy, based in part on a staffing practice of drawing personnel from a sectarian medical school opposed to abortion.

107. 410 U.S. at 196.

108. *Id.* at 196-97.

109. See Wood & Durham, *supra* note 16, at 791-93. Although Wood and Durham express the hope that the role accorded to the physician will reduce "the terrible toll that is being paid in the

outcome of the abortion choice,"<sup>110</sup> these commentators wrote, the Court must have intended the patient to consult the physician for assistance in reaching the initial decision whether or not to seek an abortion for any possible reasons, medical or otherwise.<sup>111</sup> In this light, the right to privacy recognized by the Court would not be a right to "unfettered self-determination," but rather a right to "rational choice"<sup>112</sup> in which the physician actively participates through directive counseling.<sup>113</sup> In other words, only the professional advice of the physician would allow the woman to "choose" and to do so rationally regardless of her initial, uncounseled preference.<sup>114</sup> The language of *Roe* may even suggest that the doctor ought to "choose" whether or not to terminate a pregnancy on behalf of his patient.<sup>115</sup> From this reading of *Roe* and *Doe* it would follow that the Court took from the state legislature and assigned to the doctor the responsibility for drawing a line between permissible and impermissible abortions. If the Court did so, it gave the doctor authority over both "medical" and "nonmedical" aspects of the decision.<sup>116</sup>

Chief Justice Burger's concurring opinion in *Roe* and *Doe* reflects this understanding.<sup>117</sup> He declined to interpret the majority's opinion as authorizing and protecting a woman's decision to abort for any reason at all, because he believed that the doctor's judgment would serve as the necessary screening mechanism. Burger wrote:

I do not read the Court's holdings today as having the sweeping consequences attributed to them by the dissenting Justices; the dissenting views discount the reality that the vast majority of physicians observe the standards of their profession, and act only on the basis of carefully deliberated medical judgments relating to life and health. Plainly, the Court today rejects any claim that the Constitution requires abortions on demand.<sup>118</sup>

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coinage of tiny bodies" and will help "effectuate . . . a net savings in fetal life," *id.* at 845, their article contains observations useful to analyses that do not appear to share the same goal. *See, e.g., The Supreme Court, supra* note 16, at 84 n.48.

110. Wood & Durham, *supra* note 16, at 791. *See* Nathanson, *Sounding Board: Deeper into Abortion*, 291 N. ENG. J. MED. 1189, 1189 (1974) ("there are seldom any purely medical indications for abortion"). Of course, the accuracy of this conclusion depends on the meaning ascribed to "medical" and to related terms such as "health." *See supra* notes 70 & 105.

111. Wood & Durham, *supra* note 16, at 791.

112. *Id.* at 789. *See id.* at 789-93.

113. *See* Marcin & Marcin, *supra* note 16, at 73.

114. Wood & Durham, *supra* note 16, at 792-93.

115. *See supra* text accompanying notes 98 & 99.

116. *See supra* notes 105 & 110 and accompanying text.

117. 410 U.S. at 207-08.

118. *Id.* at 208.

How accurate or realistic is this vision of the physician as counselor on matters medical and nonmedical and as ultimate decision-maker? After *Roe* and *Doe*, free-standing abortion clinics proliferated,<sup>119</sup> and today, most abortions are performed in such facilities,<sup>120</sup> where physicians are employees of the clinic<sup>121</sup> and usually see each patient only just before the abortion itself begins.<sup>122</sup> Patients receive counseling, usually in groups, from nonphysicians.<sup>123</sup> Empirical studies indicate that fewer than one percent of first-trimester abortion patients visiting clinics are likely to decide not to terminate their pregnancies,<sup>124</sup> that health officials of any sort participate in only one quarter of the decisions to abort<sup>125</sup> and in still fewer decisions to deliver,<sup>126</sup> that most women discuss unwanted pregnancies with several persons before consulting a physician,<sup>127</sup> that only two-thirds of these women reported full discussions with the physician to be possible,<sup>128</sup> that doctors were among the most unsympathetic

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119. Telephone interview with Sylvia Hampton, Director of Community Education, Reproductive Health Services, Inc., St. Louis, Mo. (July 1, 1985).

120. Bracken, *Psychosomatic Aspects of Abortion: Implications for Counseling*, 19 J. REPRO. MED. 265, 266 (1977); Sullivan, Tietze & Dryfoos, *Legal Abortion in the United States, 1975-1976*, 9 FAM. PLAN. PERSP. 116, 127 (1977). See THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 52, at 300-01. Ninety percent of all abortions today occur in clinics. Telephone interview with Janet Benschhof, Director, Reproductive Freedom Project, American Civil Liberties Union Foundation, New York, N.Y. (July 23, 1985).

121. Telephone interview, *supra* note 119.

122. See Goldsmith, *Early Abortion in a Family Planning Clinic*, 6 FAM. PLAN. PERSP. 119, 121 (1974). See also *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 91 n.2 (1976) (Stewart, J., concurring) (physician has no contact with minor patient prior to abortion procedure).

123. See THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 52, at 301; Bracken, *supra* note 120, at 266-67; Dornblaser, *Pregnancy Termination, The Abortion Decision*, MINN. MED., Jan. 1981, at 45.

124. Bracken, *supra* note 120, at 268.

125. Friedlander, Kaul & Stimel, *Abortion: Predicting the Complexity of the Decision-Making Process*, 9 WOMEN & HEALTH 43, 48 (1984). But see Bracken, Klerman & Bracken, *Abortion, Adoption or Motherhood: An Empirical Study of Decision-Making during Pregnancy*, 130 AM. J. OBSTET. & GYN. 251, 255-56 (1978) (physicians played role in about half the decisions to abort).

126. Bracken, Klerman & Bracken, *supra* note 125, at 256.

127. Ashton, *Patterns of Discussion and Decision-Making among Abortion Patients*, 12 J. BIOSOC. SCI. 247, 249 (British study charting order and frequency of key discussions). See Bracken, Klerman & Bracken, *supra* note 125, at 255-56 (discussion with significant others); Friedlander, Kaul & Stimel, *supra* note 125 (64% discuss decision with sexual partner, 25% with health professionals, 5% with counselors, 2% with no one); Lupfer & Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 FAM. PLAN. PERSP. 75, 76 (1981) (88% of abortion patients reported discussing decision before seeing abortion counselor).

128. Ashton, *supra* note 127, at 250, 257 (British study finds full discussion with family doctors possible in only 66% of cases).

or unconcerned about the patient's predicament;<sup>129</sup> and that women reported virtually no change of mind following consultation with the doctor.<sup>130</sup> The data fail to support the model portrayed by the Court.<sup>131</sup>

Perhaps even more revealing is the physician's own view of his role in the abortion process. One doctor observes that the *Roe* Court's "phrase 'between a woman and her physician' is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in her decision."<sup>132</sup> Another physician agrees, asking "Why the gratuitous addition [by the Court] of the words 'and her physician'? What, in the last analysis, has the physician to do with this decision? Since the majority of pregnancy terminations are for socioeconomic reasons, how can the doctor know these reasons as acutely as the woman herself?"<sup>133</sup>

Lawrence Tribe, who attributes no substantive effect to the "medical terminology"<sup>134</sup> in *Roe* and *Doe*, speculates that the Court may have "believed that the public acceptability of its result would be enhanced if it couched the abortion holding in medical rather than ethical terms."<sup>135</sup> Yet, contrary to Tribe, the Court's language acknowledges the ethical aspects of each abortion decision but appears to assign responsibility for them to the physician and not his patient.<sup>136</sup>

Whatever the realities of abortion practice, the reasons behind the Court's early approach and the constitutional questions raised by a true delegation of abortion decision-making to the doctor,<sup>137</sup> the Court did not abandon the paradigm described in *Roe* and *Doe*<sup>138</sup> until after it had decided subsidiary issues in a manner reinforcing the view that the doc-

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129. *Id.* at 252, 258.

130. *Id.* at 255. See *supra* note 124 and accompanying text.

131. See Comment, *Justice Harry A. Blackmun: The Abortion Decisions*, 34 ARK. L. REV. 276, 288 n.82 (1980).

132. Nathanson, *supra* note 110, at 1189.

133. Barnes, *supra* note 52, at 530. Cf. Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 173 (1977) (in discussing contexts other than abortion, author states that physicians "see themselves as ultimate decisionmakers").

134. See Tribe, *supra* note 67, at 38 n.168. But see generally Asaro, *supra* note 16.

135. Tribe, *supra* note 67, at 38 n.168. But see Ginsburg, *supra* note 16, at 382-83 (reaching opposite conclusion and attributing criticism of *Roe* to Court's failure to focus on woman alone rather than on "woman tied to her physician").

136. See *supra* notes 104 & 105 and accompanying text.

137. Tribe, *supra* note 67, at 37 (first-amendment violation to give this associational choice to doctor or some other disinterested expert).

138. Opinions issued a decade after *Roe* and *Doe* more accurately reflect the reality of modern abortion-clinic practice and the physician's de minimus counseling function, see *City of Akron v.*

tor's discretion is an intrinsic part of the patient's "privacy" and something more than an inevitable incident of the medical nature of the abortion procedure.

For example, in 1976 in *Singleton v. Wulff*,<sup>139</sup> the Court held that doctors had standing to assert the privacy interests of their patients in a constitutional challenge to legislative restrictions on the public funding of abortions.<sup>140</sup> Although other cases, both earlier and later, allowed physicians to challenge abortion restrictions not only as potential criminal defendants implicated by the violation of such laws but also as the guardians of their patients' interests,<sup>141</sup> the restrictions attacked in *Singleton* differed significantly. They did not criminalize the performance of abortions and thus did not directly threaten physicians; doctors remained free to perform abortions though without state reimbursement for those rendered to indigent patients.<sup>142</sup> The Justices explicitly refused to decide whether doctors have a constitutionally protected right to practice medicine.<sup>143</sup> Instead, they permitted the doctors to challenge the funding restrictions on behalf of their patients because the patient's right is "inextricably bound up with the activity the [physician] wishes to pursue"<sup>144</sup> and because the doctor is "fully, or very nearly, as effective a proponent of the [patient's privacy] right as the [patient herself]."<sup>145</sup>

Giving physicians standing to challenge both criminal and noncrimi-

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Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983), but without resolving the analytic difficulties produced by the earlier approach. See *infra* notes 232-303 and accompanying text.

139. 428 U.S. 106 (1976).

140. *Id.* at 118 (plurality opinion); see *id.* at 121-22 (opinion of Stevens, J., concurring in result). But see Sedler, *The Assertion of Constitutional Jus Tertii: A Substantive Approach*, 70 CALIF. L. REV. 1308, 1332 (1982) (physicians in *Singleton* could have asserted their own equal protection rights).

141. See, e.g., *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 440 n.30 (1983); *Doe v. Bolton*, 410 U.S. 179, 188 (1973). See also, e.g., *Eisenstadt v. Baird*, 405 U.S. 438, 443-46 (1972) (distributor of contraceptives has standing to raise constitutional rights of unmarried persons denied access by prohibition against distribution); *Griswold v. Connecticut*, 381 U.S. 479, 481 (1964) (those who gave medical advice to married couples about contraception "have standing to raise the constitutional rights of the married people with whom they had a professional relationship"). But see *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 62 n.2 (1976) (physicians have no standing to challenge statute imposing state wardship on infant born alive following abortion).

142. See 428 U.S. at 113 (challenged statute imposes "concrete injury" on physicians who allege that they have performed and will continue to perform otherwise reimbursable abortions; if physicians prevail, "they will benefit, for they will then receive payment for the abortions").

143. *Id.* (plurality opinion). Cf. Kapp, *supra* note 16, at 3 (advocating protection of physician's own rights in abortion litigation).

144. 428 U.S. at 114 (plurality opinion).

145. *Id.* at 115 (plurality opinion).

nal abortion restrictions assists women who seek to assert privacy claims by providing them with a vehicle that protects their anonymity.<sup>146</sup> Yet *Singleton* reached this useful result by treating the doctor and patient as one, with coextensive interests at stake.<sup>147</sup> Under *Roe* and *Doe*, these interests encompass not only the aspects of abortion that are ordinarily considered medical, but also the “familial,” moral, personal, and social dimensions of the choice as well.<sup>148</sup> Although a physician has strong and important interests in administering medical care free from arbitrary state restrictions,<sup>149</sup> common sense dictates that these interests differ qualitatively from the interests of a woman seeking to determine her own reproductive destiny.<sup>150</sup> Her claim, moreover, rests on more substantial constitutional roots than his.<sup>151</sup> *Singleton’s* fusion of physician and patient blurs these lines.

Although the Court’s deference to accepted professional standards<sup>152</sup> and to the physician’s expansive decision-making authority has protected the abortion right from unfavorable legislation,<sup>153</sup> this deference may also shed some light on the one string of opinions in which the Court has uniformly upheld laws hostile to abortion. In the trilogy of abortion-

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146. See *id.* at 117 (plurality opinion). The Justices also considered the technically “imminent mootness . . . of any individual woman’s claim.” *Id.* (plurality opinion). But see *id.* at 126 (Powell, J., concurring in part and dissenting in part) (*Roe v. Wade* allowed women to use pseudonyms and to avoid mootness of claims).

147. See 428 U.S. at 128 (Powell, J., concurring in part and dissenting in part) (“I do not read these cases as merging the physician and his patient for constitutional purposes.”).

148. See *supra* notes 104, 105 & 110 and accompanying text.

149. The Court found constitutional protection for some of these interests in its old substantive-due-process doctrine. See *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *supra* note 10. But see *Harris v. McRae*, 448 U.S. 297, 318 n.21 (1980) (rejecting argument that selective funding violates due process rights of physicians).

150. See *infra* notes 304-80 and accompanying text.

151. See *supra* notes 11 & 12 and accompanying text.

152. See *supra* at notes 64-90 and accompanying text.

153. With the exception of regulations of minors’ abortion rights, see, e.g., *H.L. v. Matheson*, 450 U.S. 398 (1981) (upholding parental notification requirement); *Bellotti v. Baird*, 443 U.S. 622 (1979) (state may require parental or judicial consent substitutes for immature minors, so long as these minors receive permission for abortions in their best interests), few abortion restrictions have survived constitutional scrutiny. See, e.g., *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) (striking down hospitalization, informed-consent and waiting-period requirements); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52 (1976) (striking down spousal and parental consent requirements and ban on saline amniocentesis). But see *Simopoulos v. Virginia*, 462 U.S. 506 (1983) (upholding requirement that physicians perform abortions after first trimester in clinics); *Planned Parenthood Ass’n of Kansas City, Inc. v. Ashcroft*, 462 U.S. 476 (1983) (upholding mandatory pathology report and requirement of second physician at postviability abortions).

funding cases decided in 1977<sup>154</sup> and the pair that followed in 1980,<sup>155</sup> a majority of the Justices held that the government had not infringed any protected privacy right by subsidizing childbirth but not abortion, even though such selective funding might totally foreclose some indigent women from obtaining both therapeutic and elective abortions.<sup>156</sup> Although I have attempted previously to explain how these decisions might be harmonized with *Roe v. Wade* and its descendants because selective funding does not "impinge" on the woman's constitutional right recognized in those cases,<sup>157</sup> it may also be no coincidence that public funding allocations do not "entangle"<sup>158</sup> the state in second-guessing prevailing professional standards or overseeing the exercise of medical judgment.<sup>159</sup> However questionable the majority's conclusion that "[a]n indigent woman who desires an abortion suffers no disadvantage as a consequence of [the government's] decision to fund [only] childbirth,"<sup>160</sup> one can argue much more cogently that the funding restrictions do not limit the *physician's* freedom to counsel and perform abortions in ways consistent with current practice. Despite these restrictions, the physician's options and decision-making authority—including whether or not to see an abortion patient free of charge—remain his own.<sup>161</sup> Funding

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154. *Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977).

155. *Harris v. McRae*, 448 U.S. 297 (1980); *Zbaraz v. Williams*, 448 U.S. 358 (1980).

156. Although the scope of the restriction on a St. Louis public hospital was ambiguous, *see Poelker v. Doe*, 432 U.S. 519, 520 (1977); Appleton, *supra* note 3, at 731 n.80, the 1977 cases stand for the proposition that neither the Social Security Act nor the Constitution compels the government to fund abortions that are not medically necessary. The Court reached the same constitutional conclusion in 1980 regarding medically necessary abortions. *See id.* at 731.

157. *See generally* Appleton, *supra* note 3. *But see* Perry, *Why the Supreme Court Was Plainly Wrong in the Hyde Amendment Case: A Brief Comment on Harris v. McRae*, 32 STAN. L. REV. 1113 (1980).

158. This term, borrowed from establishment clause jurisprudence, *see, e.g., Lemon v. Kurzman*, 403 U.S. 602, 613-20 (1971), aptly reflects one of the Court's chief reasons for keeping the state out of the doctor's domain and for good reason: when legislatures enter that domain, "they don't always know what they are doing." Interview, *supra* note 90.

*Cf.* Tribe, note 67, at 32 ("first-amendment concern for religious-political disentanglement" provides model for making previability abortion a personal, not a governmental, question).

159. *See supra* notes 105 & 110 (examining broad and narrow definitions of "medical" and "health").

160. *Harris v. McRae*, 448 U.S. 297, 314 (1980) (quoting *Maher v. Roe*, 432 U.S. 464, 474 (1977)) (emphasis added). Judge Ginsburg suggests that the Court would have recognized the unfairness (and unconstitutionality) of funding restrictions if it had "acknowledged a woman's equality aspect, not simply a patient-physician autonomy constitutional dimension to the abortion issue." Ginsburg, *supra* note 16, at 385.

161. This would certainly be true of physicians in private practice. Even in free-standing clinics,



restrictions may affect physicians as "businessmen," but not physicians as embodiments of the medical ideal embraced by the Court.<sup>162</sup> In this setting, the indigent pregnant woman's exercise of choice depends entirely on the *nonmedical* decision<sup>163</sup> of her possibly uncharitable doctor. The doctor's power to reject a woman's abortion choice on financial grounds resembles the third-party consent requirements that the Court has condemned as "possibly arbitrary"<sup>164</sup> vetoes of the abortion right.<sup>165</sup>

In other words, in the funding cases the Court upheld antiabortion laws that foreclosed some women's reproductive choices but did not compromise a physician's exercise of medical judgment or decision-making authority.<sup>166</sup> This result confirms the conclusion emerging from the cases in which the Court has accorded more protection to the abortion

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where physicians are employees, physicians retain discretion to reduce or eliminate their fees for women unable to pay the full price of an abortion. Telephone interview with Sylvia Hampton, Director of Community Education, Reproductive Health Services, Inc. (a not-for-profit, tax-exempt corporation), St. Louis, Mo. (July 1, 1985).

If these cases constrain a physician's discretion at all, that result is attributable to the relatively little-noted opinion in *Poelker v. Doe*, 432 U.S. 519 (1977), upholding St. Louis' ban on abortions at a city hospital. A physician may be unable to effectuate his medical judgment if the necessary facilities are off-limits. *Cf. id.* at 523 (Brennan, J., dissenting) ("Public hospitals that do not permit the performance of elective abortions will frequently have physicians on their staffs who would willingly perform them."). The majority never addressed this issue but noted instead that individuals drawn from "a Jesuit-operated institution opposed to abortion" staffed the clinic at the hospital in question under a longstanding practice. *Id.* at 520. *See Nyberg v. City of Virginia*, 667 F.2d 754 (8th Cir. 1982) (city may not prohibit physicians from performing abortions on paying patients at community's only hospital), *appeal dismissed, cert. denied*, 462 U.S. 1125 (1983). *Cf. McCabe v. Commas County Medical Center*, 453 F.2d 698, 704 (2d Cir. 1971) (physicians' refusal to sterilize patient at public hospital "was based not on medical factors peculiar to her case but on an arbitrary age-parity formula").

162. *See supra* note 108 and accompanying text. The unavailability of public funds for a specific kind of medical treatment or practice may well dissuade physicians from entering a particular speciality at all or from continuing one already entered. The physician makes a business choice, which may significantly diminish the opportunities for a patient to effectuate her right to privacy.

163. The Court has observed that the indigent woman "continues as before to be dependent on private sources for the services she desires." *Maher*, 432 U.S. at 474.

164. *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

165. *See id.* at 67-75 (holding unconstitutional spousal and parental consent requirements for abortion).

166. The Court in *Singleton v. Wulff*, 428 U.S. 106, 113 (1976), found that physicians suffered "concrete injury" from abortion-funding restrictions. Robert Sedler concluded that physicians could have challenged such restrictions as violations of their own equal protection rights to payment. Sedler, *supra* note 140, at 1332. In a footnote to *Harris v. McRae*, the Court rejected a claim that funding restrictions "violate the due process rights of the physician who advises a Medicaid recipient to obtain a medically necessary abortion." 448 U.S. at 318 n.21. Nevertheless, none of the funding restrictions in either *Singleton* or *McRae* purported to tell the doctor how to exercise his (even broadly defined) medical discretion. He may refuse to see indigent patients for financial reasons and,

choice: the Court has repeatedly shown as much solicitude for the physician's prerogatives as for the patient's interests—and in some respects even more.<sup>167</sup>

C. *Later Problems: Clinic Practice, Medical Discretion and the "Truly Informed" Abortion Patient*

Nowhere did the tension invited by the Court's joinder of the doctor and the patient and its attachment to an idealized vision of the doctor as abortion counselor and decision-maker surface as prominently as in challenges to abortion restrictions enacted by many states purportedly to ensure the patient's "truly informed consent."<sup>168</sup>

The doctrine of informed consent to medical treatment evolved in tort law from a patient's protection against assault and battery.<sup>169</sup> It matured into a right of self-determination for patients that requires disclosure of whatever is necessary for the patient to make an intelligent choice about whether to undergo any particular treatment,<sup>170</sup> including the risks of proposed treatment as well as the alternatives and their hazards.<sup>171</sup> To

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if he should decide to see some patients without compensation, he remains free to exercise his medical judgment regarding abortion.

167. Asaro, *supra* note 16, refers to the Court's treatment of the funding cases as the "judicial abandonment of medical discretion." *Id.* at 88. I disagree. As elaborated in the text, funding restrictions leave the physician free to exercise his medical discretion while disadvantaging the patient whose abortion option is often left to the mercy of the physician's financial (and thus nonmedical) judgment. The patient's privacy right is diminished; the physician's discretion is not.

168. See, e.g., *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 442-49 (1983); *Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1013-22 (1st Cir. 1981); *Womens Servs., P.C. v. Thone*, 636 F.2d 206, 210 (8th Cir. 1980), *vacated on other grounds*, 452 U.S. 911 (1981); *Charles v. Carey*, 627 F.2d 722, 779-86 (7th Cir. 1980), *supplemented sub nom. Charles v. Daley*, 749 F.2d 453 (7th Cir. 1984), *prob. juris. noted sub nom. Diamond v. Charles*, 105 S. Ct. 2356 (1985).

169. A useful summary of the evolution of the doctrine of informed consent, including analyses of the principal cases, appears in Katz, *supra* note 133, at 143-64. See Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance between the Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413 [hereinafter "Exceptions"]; Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977) [hereinafter *Expansion*].

170. See Katz, *supra* note 133, at 149-54 (examining *Salgo v. Leland Stanford, Jr., Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (Dist. Ct. App. 1957); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960)). See also Note, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172 (1981) (urging additional duties for physicians to enhance patient choice).

171. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780-81, 787-88 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); *Gray v. Grunnagle*, 423 Pa. 144, 157-58, 223 A.2d 663, 670 (1966). See also *Truman v. Thomas*, 27

day, violations of the patient's right of informed consent are a form of negligent malpractice, compensable in damages.<sup>172</sup> Although jurisdictions vary regarding the standard of care<sup>173</sup> and recognize several exceptions to the rule that relieve the physician of the duty of disclosing information waived by the patient,<sup>174</sup> information within the average patient's common knowledge,<sup>175</sup> or information harmful to the patient (the so-called therapeutic privilege),<sup>176</sup> the essence of the modern doctrine is that an uninformed patient who authorizes a particular treatment has not really consented to it.<sup>177</sup> The law of torts purports to view<sup>178</sup> the disclosure of information about a contemplated medical procedure as critical to the exercise of a patient's right to meaningful choice.

"Informed consent" became a constitutional issue in 1976 when the

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Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (physician's disclosure duty includes statement of risks of foregoing diagnostic procedure).

172. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 239-41, 502 P.2d 1, 7-8, 104 Cal. Rptr. 505, 511-12 (1972); *Katz*, *supra* note 133, at 150-64. Cf. *id.* at 165 (theorizing that shift from battery to negligence masks law's preference for doctors' paternalism over patients' self-determination).

173. Compare *Natanson v. Kline*, 186 Kan. 393, 409, 350 P.2d 1093, 1106 (1960) (physician has duty to make "those disclosures which a reasonable medical practitioner would make under the same or similar circumstances") with *Canterbury v. Spence*, 464 F.2d 772, 784-87 (D.C. Cir.) (standard set by law, not by physicians; standard focuses on risks material to "reasonable person, in what physician knows or should know to be the patient's position"), *cert. denied*, 409 U.S. 1064 (1972) and *Scott v. Bradford*, 606 P.2d 554, 558-59 (Okla. 1979) (court rejects *Canterbury's* "reasonable patient" standard; patient's right of self-determination requires resolving whether the patient would not have consented to the treatment if he had been informed of the risks). See generally *Katz*, *supra* note 133, at 154-60.

174. See, e.g., Meisel, "Exceptions", *supra* note 169, at 453-60.

175. See, e.g., *Canterbury v. Spence*, 464 F.2d at 788; Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 415 (1974); Meisel, *Expansion*, *supra* note 169, at 89-90.

176. See *Katz*, *supra* note 133, at 155-58, 168; Meisel, "Exceptions", *supra* note 169, at 433. See also J. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE 102-23 (1982) (discussing narrow justifications for active paternalism in health care); Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163, 215 (1984) ("Legislative elimination of the therapeutic privilege would more consistently reflect the patient's right of self-determination."); Meisel, "Exceptions", *supra* note 169, at 467-69 (suggesting abolition of therapeutic privilege because of threat to patient's right to self-determination); Comment, *Informed Consent: The Illusion of Patient Choice*, 23 EMORY L.J. 503 (1974) (advocating restrictions on therapeutic privilege).

177. Meisel, "Exceptions", *supra* note 169, at 420-22; Note, *The Abortion Alternative and the Patient's Right to Know*, 1978 WASH. U.L.Q. 167, 175. Disclosure to the patient also may offer therapeutic benefits and improve the physician's decision-making. Andrews, *supra* note 176, at 165-71.

178. Jay Katz, however, calls a "fairy tale" the belief that informed consent protects the patient's right to self-determination because even this legal doctrine defers to physicians as the ultimate decision-makers. See generally *Katz*, *supra* note 133. See also Meisel, "Exceptions", *supra* note 169, at 413 n.2 (citing medical authorities positing fiction and absurdity of informed consent).

Supreme Court upheld in *Planned Parenthood of Central Missouri v. Danforth*<sup>179</sup> a Missouri law imposing criminal liability on any physician who failed to obtain his patient's written consent to abortion.<sup>180</sup> The Court rejected the argument that *Roe* prohibited any such "extra layer and burden of regulation on the abortion decision" beyond those imposed on other medical procedures.<sup>181</sup> It reasoned:

The decision to abort, indeed, 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. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent.<sup>182</sup>

Yet a footnote hinted that the infringement of the *doctor's* freedom, not the patient's, might prove a more pressing concern in future cases. The Court defined "informed consent" as "the giving of information to the patient as to just what would be done and as to its consequences."<sup>183</sup> The Court added: "To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable strait-jacket in the practice of his profession."<sup>184</sup>

After Missouri's written-consent law survived constitutional challenge even though it was an abortion regulation imposed on the first trimester (the period free from compelling state interests under *Roe*),<sup>185</sup> a number of states took "informed consent" a step further. Undoubtedly to discourage abortion,<sup>186</sup> they enacted criminal laws listing many specific "facts" that each patient had to receive to be "truly informed." Under two Akron, Ohio, provisions that typified such legislation and that ultimately reached the Supreme Court, the patient first must be "orally informed by her attending physician"<sup>187</sup> of the status of the "unborn child"<sup>188</sup> as a "human life from the moment of conception;"<sup>189</sup> the "characteristics of the particular unborn child . . . including . . . appear-

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179. *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52 (1976).

180. *Id.* at 65-67. See generally Note, *Abortion Regulation: The Circumscription of State Intervention by the Doctrine of Informed Consent*, 15 GA. L. REV. 681 (1981).

181. 428 U.S. at 66.

182. *Id.* at 67.

183. *Id.* at 67 n.8.

184. *Id.*

185. See *supra* notes 65 & 67 and accompanying text.

186. See *infra* notes 200, 216 & 233 and accompanying text.

187. *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 423 n.5 (1983).

188. *Id.*

189. *Id.*

ance, mobility, tactile sensitivity, including pain;<sup>190</sup> the physical and psychological hazards of abortion;<sup>191</sup> and the availability of agencies to assist her regarding birth control, continued pregnancy, childbirth, and adoption.<sup>192</sup> Second, the attending physician must disclose “the particular risks associated with her own pregnancy and the abortion technique to be employed [and] other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.”<sup>193</sup> Akron imposed as an accompanying requirement a waiting period of twenty-four hours, said to insure thorough contemplation of the communicated information.<sup>194</sup>

The Court’s early abortion jurisprudence had portrayed the interests of the doctor and his patient as entirely compatible, if not identical.<sup>195</sup> Yet, outside the abortion context, the law of informed consent had developed, at least in theory,<sup>196</sup> to protect the patient from possible excesses of the physician.<sup>197</sup> Because of this inconsistency between doctrines, lower courts striking down abortion-information statutes like Akron’s found the reasons difficult to articulate.<sup>198</sup> The tort law doctrine would suggest that the more information the law guarantees the patient, the better able she should be to decide, in *Roe*’s words, “whether or not to terminate her pregnancy.”<sup>199</sup> Although abortion-information statutes like Akron’s appear patently designed to dissuade any patient contemplating abortion,<sup>200</sup>

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190. *Id.*

191. *Id.*

192. *Id.* at 424 n.5.

193. *Id.*

194. *See, e.g., id.* at 449.

195. *See supra* notes 93-118 and accompanying text.

196. *See supra* note 178.

197. *See generally* McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Note, *supra* note 170.

198. *See, e.g.,* Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006, 1016-22 (1st Cir. 1981); Women’s Servs., P.C. v. Thone, 483 F. Supp. 1022, 1042-50 (D. Neb. 1979), *aff’d*, 636 F.2d 206 (8th Cir. 1980), *vacated on other grounds*, 452 U.S. 911 (1981). *See also infra* note 202 (citing additional cases).

199. 410 U.S. at 153.

200. *See, e.g., Akron*, 462 U.S. 444. *Cf.* Planned Parenthood League of Mass. v. Bellotti, 641 F.2d at 1017 (*Roe* “protects the outcome of the decision, providing a shield against state requirements that attempt to skew the choice one way or another”). In some states the legislation itself made clear the underlying antiabortion motive. *See, e.g., Akron*, 462 U.S. at 421 n.2; American College of Obstetricians and Gynecologists v. Thornburgh, 737 F.2d 283, 304 (3d Cir. 1984) (quoting directive for construction of Pennsylvania statute), *juris. postponed*, 105 S. Ct. 2015 (1985); Wynn v. Scott, 449 F. Supp. 1302, 1332 (N.D. Ill. 1978) (quoting legislative statement of intent underlying Illinois statute), *aff’d sub. nom.* Wynn v. Carey, 599 F.2d 193 (7th Cir. 1979).

the greater the likelihood that particular information will influence her decision, the more essential the information arguably becomes for securing her informed consent.<sup>201</sup> When lower courts apparently could not explain why requiring such information infringed the patient's right, they referred instead to the physician.<sup>202</sup> Seizing on the physician's "straight-jacket" language from *Danforth*,<sup>203</sup> these lower courts held that such statutes must fall because they unconstitutionally invade the province of the doctor.<sup>204</sup> This approach makes sense if one assumes, as the Supreme Court has, that the doctor's and the abortion patient's interests are interchangeable or are equally entitled to judicial protection.

But if such assumptions beg the question when the question is informed consent, how does the reasoning used by the lower courts address the interests of the pregnant woman, to whom the constitutional privacy right must belong?<sup>205</sup> More specifically, suppose that the physician's views and the patient's initial preference conflict. The Supreme Court's early opinions depict the physician as the patient's counselor who directs her deliberation and reaches the ultimate decision whether to terminate her pregnancy, in consultation with her;<sup>206</sup> he can also refuse to partici-

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201. See *Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d at 1018-19. Cf. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.) (therapeutic privilege "does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs"), *cert. denied*, 409 U.S. 1064 (1972); Meisel, "Exceptions", *supra* note 169, at 445-46 ("paternalistic to an extreme" to judge patient's competency by outcome of decision-making process).

202. E.g., *Margaret S. v. Edwards*, 488 F. Supp. 181, 210 (E.D. La. 1980); *Wynn v. Scott*, 449 F. Supp. 1302, 1317 (N.D. Ill. 1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979). See *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978), *aff'd*, 440 U.S. 941 (1979).

203. See *supra* note 184 and accompanying text.

204. See *supra* note 202 (citing cases invoking physician's "straitjacket").

205. Some courts that struck down the required communication of medical information nonetheless upheld provisions compelling the transmission of *nonmedical* information. See, e.g., *Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1017, 1020-21 (1st Cir. 1981) (upholding mandatory consent form that does not require physician personally to read contents to patients, which describes availability of alternatives to abortion and public assistance); *Leigh v. Olson*, 497 F. Supp. 1340, 1346 (D.N.D. 1980) (upholding as "reasonably related to the giving of informed consent" statute requiring physician or counselor to disclose to patient alternatives to abortion, such as childbirth and adoption, as well as information on economic assistance); *Margaret S. v. Edwards*, 488 F. Supp. 181, 211-12 (E.D. La. 1980) (upholding as "rationally related to the giving of an informed consent" statute requiring physician to provide information about available social services should patient choose childbirth). See also *Leigh v. Olson*, 497 F. Supp. at 1345 n.2 ("[Though *Roe*] held that the abortion decision be made in consultation with a physician, it is the woman's right that is protected. The physician has no fundamental right to perform an abortion or any other medical procedure.").

206. See *supra* notes 98-105 and accompanying text.

pate in any abortion she may want—even if she cannot find another physician willing to assist her.<sup>207</sup> It follows that a physician may on his own initiative impart to a patient the same information as that included in any “truly informed consent” statute, even if he intends his statements to dissuade her from terminating her pregnancy.<sup>208</sup> By the same reasoning, the doctor violates no constitutional right of his patient<sup>209</sup> if the information that he chooses to convey, whether inadvertently or by design, convinces her to abort despite her initial preference for carrying to term.<sup>210</sup>

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207. See *supra* note 106 and accompanying text.

208. As one lower court pointed out:

The provisions of the [state-required] informed consent form may be said to be material only to the extent that they differ from the prevailing medical standard of desirable information. Insofar as they require only what a physician would do in their absence, they are on the one hand unnecessary but on the other untroubling. In assessing the statute's burdens and benefits, then, the critical cases are those in which information contained in the form would not be provided in the exercise of standard medical care.

*Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d at 1018 n.16.

A physician who chooses to communicate false or erroneous information to influence the patient's choice of treatment may be liable to the patient for malpractice, assault and battery, fraud or misrepresentation. See, e.g., *Natanson v. Kline*, 186 Kan. 393, 406, 350 P.2d 1093, 1103 (1960). Cf. Meisel, “Exceptions”, *supra* note 169, at 458 (material misrepresentation makes waiver of informed consent involuntary). He may be criminally liable as well. See, e.g., *People v. Phillips*, 64 Cal. 2d 574, 578, 414 P.2d 353, 357, 51 Cal. Rptr. 225, 229 (1966) (grand theft), *on remand*, 270 Cal. App. 2d 381, 75 Cal. Rptr. 720 (Dist. Ct. App. 1969) (second-degree murder), *cert. denied*, 396 U.S. 1021 (1970).

209. When a private physician counsels a patient, no constitutional issue arises because the physician's conduct is not state action. Even when a physician employed by a government-operated institution, however, influences a patient's choice of treatment, what constitutional right has he violated? Even apart from the state-action question, see, e.g., *Blum v. Yaretsky*, 457 U.S. 991 (1982) (limits on doctrine), the patient has no constitutional right to avoid hearing particular information. Moreover, to the extent that the Court has recognized a constitutional right to decide, free from state interference, “whether or not to terminate her pregnancy,” *Roe*, 410 U.S. at 153, the Court has expressly held that right to be circumscribed by the physician's exercise of medical judgment, see *Doe v. Bolton*, 410 U.S. 179, 197, 199 (1973). See also *McCabe v. Nassau County Medical Center*, 453 F.2d 698, 708 (2d Cir. 1971) (Moore, J., dissenting) (woman has no right to be sterilized over doctor's refusal; physician's judgment must be left “as uncontrolled as possible”). Cf. J. CHILDRESS, *supra* note 176, at 115 (patient has no right to particular treatment from particular doctor; hence, doctor's refusal to acquiesce in treatment he considers ill-advised is not morally unjustified). Finally, under the abortion-funding cases, see *supra* notes 154-67 and accompanying text, the right to choose abortion does not include the positive right to state assistance in that choice. See *Appleton*, *supra* note 3.

210. The physician's disclosure of hazards to the patient, see *infra* note 229 and accompanying text (risk of pregnancy generally); *Harris v. McRae*, 448 U.S. 297, 339 (Marshall, J., dissenting) (special risks of pregnancy to some women), or of her risks of bearing a congenitally anomalous child may produce this result, see, e.g., *Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984) (parents and child with birth defects allege that mother would have obtained abortion but for physician's negligent genetic counseling); *Becker v. Schwartz*, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978) (same). In an empirical study of single, generally young, black, poor and previously pregnant

Given the enormous power of the physician to influence the patient's decision through his transmission or withholding of information<sup>211</sup>—a power necessarily recognized in the doctrine of informed consent—advocates of patient choice favor required disclosure when the contemplated medical procedure is sterilization. They hope to insure that a patient will receive all the information necessary to reach a meaningful decision about sterilization,<sup>212</sup> regardless of what the physician may wish her to hear or to decide.<sup>213</sup> Why, then, the resistance to such requirements in the name of patient freedom<sup>214</sup> in the abortion context?<sup>215</sup>

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patients, one in 20 reported some persuasion from physicians to abort. Bracken, Klerman & Bracken, *supra* note 125, at 257. *But see* Law, *supra* note 24, at 1020 n.233 ("There are virtually no situations in which a physician would recommend an abortion to a woman who sought to continue the pregnancy and who was able to cooperate in doing so.").

The physician's role and behavior may vary with his culture. *See* J. CHILDRESS, *supra* note 176, at 122 (how doctors in China "persuade" patients to change their minds about treatment in their "best interest," including abortion); Weisskopf, *China's Crusade Against Children*, Wash. Post Nat'l Weekly Ed., Jan. 28, 1985, at 6, col. 1 ("heart-to-heart chats" by "persuasion groups" in China to convince pregnant woman who already has a child to undergo abortion).

211. *See* Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124 (examining reasons for possible bias, e.g., physician's economic interests, and consequences for doctrine of informed consent); Note, *supra* note 170, at 175-76. *See also* Waltz and Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 645-46 (1970) (physician may use salesmanship to persuade patient); Hubbard, *supra* note 43, at 206 (how physicians have produced "unnecessary medicalization" of obstetrics).

212. *See, e.g.*, Comment, *Sterilization Abuse: A Proposed Regulatory Scheme*, 28 DEPAUL L. REV. 731 (1979). *See also* Asaro, *supra* note 16, at 93-101 (documenting and criticizing sterilization abuse by physicians). *Cf.* Comment, *Sterilization Regulation: Government Efforts to Guarantee Informed Consent*, 18 SANTA CLARA L. REV. 971 (1978) (acknowledging that regulations may both protect right to choose sterilization by preventing abuse of patients by doctors and burden that right by injecting state into doctor-patient relationship). Even outside the sterilization context, commentators have written favorably about the concept of informed-consent statutes through which the legislature specifies the required disclosures for medical treatment. *See* Andrews, *supra* note 176.

213. *Cf.* Morrow, *Women's Health Care and Informed Consent: Who Should Decide What Is Best for Women—Patients or Doctors?*, 9 GOLDEN GATE U.L. REV. 553 (1978-79) (urging revision of traditional doctor-patient relationship to require doctors to disclose information and women patients to make their own health care decisions).

214. *See, e.g.*, *Margaret S. v. Edwards*, 488 F. Supp. 181, 186 n.2 (E.D. La. 1980) (challenge to statute including detailed informed consent requirements by, *inter alia*, class consisting of "all women in Louisiana capable of bearing children who are now or may become pregnant and who desire or may desire an abortion to be performed in Louisiana by the physician of their choice").

215. Although the comparison between abortion and sterilization for purposes of informed-consent requirements is a useful one, a thorough analysis must consider a number of important distinctions. While the purpose behind limits on consent to sterilization may be equivocal, *compare* Asaro, *supra* note 16, at 93-101 (showing how women have been unwillingly sterilized) *with* *McCabe v. Nassau County Medical Center*, 453 F.2d 698 (2d Cir. 1971) (showing how women seeking sterilization had been denied that procedure), one can reliably infer an antiabortion motive from abortion restrictions like Akron's informed consent requirements, *see infra* notes 216-20 & 257 and accompa-



One tempting response is that “truly informed consent” provisions like Akron’s regularly appear as just one part of a comprehensive system of abortion restrictions, enacted for the unmistakable purpose of curbing abortion. Anti-abortion motives masquerade as concern for patient choice.<sup>216</sup> Though this feature alone—a legislative intent to undermine a choice previously identified as constitutionally protected—ought to be damning enough, the Supreme Court has never found antiabortion motives alone determinative. Rather the Court has considered abortion regulations individually,<sup>217</sup> ignoring their place in a larger legislative plan,<sup>218</sup> and on some occasions it has approved governmental efforts to limit abortion so long as those efforts do not go too far<sup>219</sup> in thwarting the protected choice.<sup>220</sup>

Another answer, based on a closer look at the content of specific statutory consent requirements, focuses on the speculative, if not erroneous, warnings of abortion complications<sup>221</sup> and details of fetal anatomy,<sup>222</sup> pain sensitivity,<sup>223</sup> and legal status<sup>224</sup> that these laws compel the physi-

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nying text. The contrasting realities of abortion and sterilization practice are also significant. Coerced sterilization has a well-known history in this country. *See Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Buck v. Bell*, 274 U.S. 200 (1927). Forced abortion plainly does not. The legal literature has documented many cases of women in especially vulnerable situations, *e.g.*, just after childbirth, who “consent” to sterilization under extreme pressure from physicians. *See, e.g., Asaro, supra* note 16. Yet one cannot so easily explain why a woman who did not want an abortion would visit an abortion clinic, the most likely source of any imaginable pressure from a doctor to terminate a pregnancy. *But see supra* note 210. These legal, historical, and factual distinctions may well support different approaches to informed consent and required disclosure for each procedure.

216. *See supra* note 200.

217. *E.g., City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52 (1976). *See American College of Obstetricians & Gynecologists v. Thornburgh*, 737 F.2d 283, 292 (1984), *juris. postponed*, 105 S. Ct. 2015 (1985). The severability clauses contained in the statutes encourage this approach. *See* 462 U.S. at 425 n.8; 428 U.S. at 88-89 (appendix).

218. In other recent cases, the Court has invalidated facially neutral laws when it has found the legislative motivation constitutionally impermissible. *E.g., Hunter v. Underwood*, 105 S. Ct. 1916 (1985) (Alabama provision disenfranchising those convicted of certain crimes violates equal protection because racial discrimination was a but-for motivation of its enactment). *But see Palmer v. Thompson*, 403 U.S. 217, 224-26 (1971) (earlier case rejecting consideration of legislative motive).

219. *See supra* note 3.

220. *See, e.g., H.L. v. Matheson*, 450 U.S. 398, 413 (1981) (in upholding Utah’s parental notification requirement, Court finds state action “encouraging childbirth except in the most urgent circumstances” to be “rationally related to the legitimate governmental objective of protecting potential life”); *Harris v. McRae*, 448 U.S. 297 (1980) (upholding funding restrictions designed to encourage childbirth over abortion). *See generally Appleton, supra* note 3.

221. *See, e.g.*, 462 U.S. at 423 n.5 (quoting Akron ordinance).

222. *See, e.g., Margaret S. v. Edwards*, 488 F. Supp. at 206 n.76.

223. *See, e.g., Akron*, 462 U.S. at 423 n.5; *Charles v. Carey*, 627 F.2d 772, 782 (7th Cir. 1980),

cian to recite. Obviously, communication of questionable or untrue information, whether by physician discretion or force of law, neither makes the patient's consent more knowing nor enhances her choice. Because almost all abortion patients understand the consequences of an abortion to the fetus before consulting a physician about the procedure,<sup>225</sup> requiring the explicit communication of such "facts" does not inform the patient at all.<sup>226</sup> The common knowledge exception to the informed consent doctrine<sup>227</sup> embodies this principle.

In addition, legislation in this area has been notably one-sided, usually listing the risks and consequences of abortion without including comparable coverage of the patient's only alternative course,<sup>228</sup> continued pregnancy and childbirth, in fact the more hazardous of her choices.<sup>229</sup> Women preferring to carry to term receive no state-mandated warn-

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*supplemented sub nom.* Charles v. Daley, 749 F.2d 452 (7th Cir. 1984), *prob. juris. noted sub nom.* Diamond v. Charles, 105 S. Ct. 2356 (1985).

224. See, e.g., 462 U.S. at 423 n.5; 627 F.2d at 781 n.13.

225. See Note, *supra* note 180, at 707 n.167. Cf. Note, *supra* note 177, at 196 (even a woman who knows abortion is an alternative to childbirth may not know "enough about abortion to make her consent to childbirth informed").

In some contexts, moreover, even a woman who appreciates the consequences of abortion may not understand without disclosure by her physician or his agent that particular methods of birth control prevent implantation of fertilized eggs, rather than preventing fertilization. Cf. Charles v. Daley, 749 F.2d 452, 461-62 (7th Cir. 1984) (holding unconstitutional statute requiring doctor who prescribes "abortifacient" method of birth control to inform patient he has done so; law intrudes on physician-patient relation, foists on patient state's view that abortifacients cause death of unborn children, and infringes individual decision-making in matters relating to contraception), *prob. juris. noted sub nom.* Diamond v. Charles, 105 S. Ct. 2356 (1985); *infra* notes 261-85 and accompanying text (examining hypothetical variation of Illinois statute).

226. This "information" may cause emotional distress. See Note, *supra* note 180, at 708. To the extent the informed consent doctrine includes a therapeutic privilege, see *supra* note 176 and accompanying text; but see *infra* notes 278 and accompanying text, the theory is that such distressing "information" does not promote a patient's right to self-determination. See Meisel, *Expansion*, *supra* note 169, at 101 (therapeutic privilege ought to apply when information would make patient too distraught to reach rational decision).

227. See *supra* note 175 and accompanying text.

228. See, e.g., 462 U.S. at 423 n.5 (quoting Akron ordinance); Note, *supra* note 180, at 708-10 & n.171. It is true that the Akron ordinance requires the physician to inform the patient "of the particular risks associated with her own pregnancy" and other information that he judges "relevant to her decision as to whether to have an abortion to carry her pregnancy to term." *Id.* at 424 n.5. But the statute, directed only at consent to abortion, not consent to childbirth, covers the consequences and risks of abortion in considerably more detail than those presented by the alternative of continued pregnancy. See also *Womens Servs., P.C. v. Thone*, 636 F.2d 206, 210 (8th Cir. 1980) (holding unconstitutional a Nebraska informed consent statute requiring abortion patients to be advised "of the reasonably possible medical and mental consequences resulting from an abortion, pregnancy, and childbirth"), *vacated on other grounds*, 452 U.S. 911 (1981).

229. See *Roe v. Wade*, 410 U.S. at 163; see also *Akron*, 462 U.S. at 429 n.11.

ings.<sup>230</sup> “Truly informed consent” requires a description of what each option entails—including the option of not aborting.<sup>231</sup>

The United States Supreme Court offered its contributions to this subject in *City of Akron v. Akron Center for Reproductive Health, Inc.*,<sup>232</sup> which invalidated the three provisions of the Akron ordinance noted earlier. The Court’s reasoning combined consideration of the legislature’s obvious antiabortion motives,<sup>233</sup> for the first time identified as a constitutional vice,<sup>234</sup> together with generous deference to the physician’s role and discretion.<sup>235</sup> The opinion also broke away from the Court’s earlier rhetoric by implicitly acknowledging the realities of modern abortion clinic practice, where physicians serve chiefly as medical technicians but not as counselors and decision-makers for each of their patients.<sup>236</sup>

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230. One may reasonably argue that childbirth (and the continued pregnancy that precedes it) is an alternative for which a patient must give informed consent. See Note, *supra* note 177, at 181. See also Appleton, *The Abortion-Funding Cases and Population Control: An Imaginary Lawsuit (and Some Reflections on the Uncertain Limits of Reproductive Privacy)*, 77 MICH. L. REV. 1688, 1699-700 (1979) (today medical assistance and care almost always accompany childbirth).

231. See *Cobbs v. Grant*, 8 Cal. 3d 229, 242-43, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 514 (1972); see also *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (informed consent includes disclosure of material risks of refusal to submit to medical procedure).

The conclusion that “truly informed consent” necessarily requires consideration of all the options carries particular force if the abortion cases protect a right to *choose* or *decide*. See *supra* notes 5-9 and accompanying text. Government action with respect to even one option inescapably affects the entire range of alternatives. See Appleton, *supra* note 3, at 725. See also Andrews, *supra* note 176, at 192-93 (empirical research shows that discussing options in unequal degrees of detail skews patients’ choices).

232. 462 U.S. 416 (1983).

233. The Court clearly considered the legislature’s motives. See 462 U.S. at 444 (information “designed” to persuade woman to withhold consent); *id.* at 445 (information “intended” to suggest abortion is dangerous). This approach contrasts with other parts of the opinion in which the Court focused instead on the legislation’s effects. See *id.* at 438 (hospitalization requirement has “the effect of inhibiting” second-trimester abortions). The Court did not, however, examine the effects of the informed-consent requirements, *i.e.*, whether they in fact deterred women from choosing abortion.

234. See *supra* notes 216-20 and accompanying text. The *Akron* Court distinguished its tolerance of anti-abortion motives in the abortion-funding cases. 462 U.S. at 444 n.33.

235. See 462 U.S. at 443-44:

It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances. *Danforth’s* recognition of the State’s interest in ensuring that this information be given will not justify abortion regulations designed to influence the woman’s informed choice between abortion or childbirth.

236. For example, the Court held unconstitutional Akron’s requirement that the attending physician personally counsel the abortion patient about the procedure, its risks, and its consequences. 462 U.S. at 446-49. Today, most abortions occur in clinics, and in most clinics nonphysicians counsel the patients. See *supra* notes 119-30 and accompanying text. In addition to reflecting the realities of clinic practice in its holding, the Court used language stressing the prominence of the woman, not

Following the lead of some of the more thoughtful lower courts, which had explained why protecting the physician ought to safeguard the woman's choice,<sup>237</sup> the Supreme Court found the flaw in the first part<sup>238</sup> of Akron's "truly informed consent" law to be the legislature's unreasonable placement of "obstacles in the path of the doctor upon whom [the woman is] entitled to rely for advice in connection with her decision."<sup>239</sup> As the Court elaborated, this kind of requirement violates the Constitution both because it attempts to discourage abortion through the transmission of preselected information, much of dubious validity,<sup>240</sup> and because it impermissibly intrudes "upon the discretion of the pregnant woman's physician,"<sup>241</sup> contrary to *Danforth's* warning against confining the physician in an "undesired and uncomfortable straitjacket."<sup>242</sup> Akron's mandatory twenty-four hour waiting period<sup>243</sup> fell for this latter reason alone, the invasion of physician discretion.<sup>244</sup>

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her doctor, in the constitutional analysis. See, e.g., 462 U.S. at 427 ("full vindication of the woman's fundamental right necessarily requires that her physician" be allowed to exercise his medical discretion); *id.* at 434 (additional cost to women of hospitalization requirement).

237. See, e.g., *Charles v. Carey*, 627 F.2d 772, 782 (7th Cir. 1980), *supplemented sub nom.* *Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *prob. juris. noted sub nom.* *Diamond v. Charles*, 105 S. Ct. 2356 (1985). The Court in *Charles v. Carey* relied on *Whalen v. Roe*, 429 U.S. 589 (1977), an unsuccessful privacy challenge to a New York law requiring physicians to identify patients receiving prescriptions for particular drugs. *Whalen* had interpreted *Doe v. Bolton* to invalidate abortion restrictions that "encumbered the woman's exercise of [her] constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision." *Id.* at 604-05 n.33. Although *Doe v. Bolton* referred repeatedly to the "physician's right" to administer medical care, see 410 U.S. at 197-98, 199, *Whalen* found any such right "derivative from, and therefore no stronger than, the patients'." 429 U.S. at 604. See also *Akron Center for Reproductive Health, Inc. v. City of Akron*, 479 F. Supp. 1172, 1203 (N.D. Ohio 1979) (state specification of information violates "physician straitjacket" rule; "[t]his is not impermissible because of any perceived interference with rights of the physician [but rather] because it interferes with the woman's right to consult a physician who is free from such state interference"), *aff'd in part and rev'd in part*, 651 F.2d 1198 (6th Cir. 1981), *aff'd in part and rev'd in part*, 462 U.S. 416 (1983).

238. See *supra* text accompanying notes 187-88.

239. 462 U.S. at 445 (quoting *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977)).

240. See *id.* at 444.

241. *Id.* at 445. In striking down the first part of Akron's informed-consent requirement, see *supra* notes 187-92 and accompanying text, the Court not only condemned the city's effort to influence the patient's choice but also said that "[a]n additional, and equally decisive, objection to [this provision] is its intrusion upon the discretion of the pregnant woman's physician." 462 U.S. at 445.

242. 462 U.S. at 445 (quoting *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 67 n.28 (1976)). See *supra* note 184 and accompanying text.

243. See *supra* text accompanying note 194.

244. 462 U.S. at 450. The Supreme Court recited but did not expressly adopt the finding by the district court that Akron's waiting period increased the costs of abortions, nor did the Court explicitly accept plaintiffs' arguments that the waiting period creates additional health risks. *Id.* Rather, a

But the Court went on to point out that a state may require in general terms, leaving "the precise nature and amount of . . . disclosure to the physician's discretion and 'medical judgment,'"<sup>245</sup> that the patient "be told of the particular risks of her pregnancy and the abortion technique to be used, and be given general instructions on proper postabortion care."<sup>246</sup> The second informational provision of the Akron ordinance,<sup>247</sup> which thus required the communication of some material that the Court found acceptable, was nonetheless unconstitutional because it compelled the attending physician to perform that task. In so holding, the Court implicitly abandoned the illusion of the physician as the woman's personal counselor and moral decision-maker<sup>248</sup> and approved instead the fact that most abortions are performed in clinics where nonphysicians counsel patients before they consent to the procedure.<sup>249</sup> According to the Court, "the critical factor [in the state's interest in assuring a patient's informed and unpressured consent] is whether she obtains the necessary information from a qualified person, not the identity of the person from whom she obtains it."<sup>250</sup> The state cannot prohibit the physician's delegation of the required communication<sup>251</sup> so long as the physician remains "ultimately responsible for the medical aspects of the decision to perform the abortion."<sup>252</sup>

Have the results in *Akron*, which advance patients' interests in minimizing the cost of abortions and in receiving abortion counseling from those best able to provide it,<sup>253</sup> finally resolved the tension between the Court's systematic deference to the physician and the conflicting notion

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physician will advise delay when *he thinks* the patient will benefit. *Id.* *Cf.* *Andrews supra* note 176, at 200-01 & n.197 (general advisability of waiting periods before other medical procedures).

245. 462 U.S. at 447.

246. *Id.* at 446-47.

247. *See supra* text accompanying note 193.

248. *See supra* notes 98-118 and accompanying text.

249. *See supra* notes 119-31 and accompanying text. Members of the Court had previously expressed disapproval of this reality. *See Bellotti v. Baird*, 443 U.S. 622, 641 n.21 (1979) (plurality opinion); *Danforth*, 428 U.S. at 91 n.2 (Stewart, J., concurring).

250. 462 U.S. at 448.

251. *See id.*

252. *Id.* But what does "medical" mean? *See supra* notes 104 & 105 and accompanying text.

253. Those challenging the Akron ordinance had argued and presented supporting data to the Court that nonphysician counselors employed by abortion clinics performed the counseling role more effectively than the attending physicians and at less cost to patients. *See Respondents' and Cross-Petitioners' Brief, City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), at 16-17 & n.32.

(derived from both intuition and precedent<sup>254</sup>) that the woman has at stake a privacy right independent of and entitled to greater constitutional protection than the interests of her doctor? Not really, for although the outcome in *Akron* is completely defensible in the factual context presented by the case,<sup>255</sup> the broader implications of the opinion are uncertain and susceptible of troubling conclusions about the Court's vision of privacy. Putting aside what the Supreme Court condemned in *Akron* as a "parade of horrors"<sup>256</sup> "designed not to inform the woman's consent but rather to persuade her to withhold it altogether,"<sup>257</sup> the larger questions remain: Would a state-required "litany"<sup>258</sup> of accurate, material<sup>259</sup> and "two-sided"<sup>260</sup> information, enforced by criminal penalties against the physician, infringe the patient's right to choose? Why?

Consider a hypothetical variation of a recently challenged Illinois abortion restriction that the Supreme Court may review during its 1985 term.<sup>261</sup> The court of appeals read the pertinent part of the statute to require "physicians who prescribe or administer abortifacients to inform their patients that they have done so."<sup>262</sup> The court of appeals held the provision unconstitutional because the operative word, "abortifacient," incorporated the term "fetus," which another provision defined as "a

254. See *supra* notes 11 & 12 and accompanying text.

255. See *supra* note 253 and accompanying text.

256. 462 U.S. at 445.

257. *Id.* at 444.

258. *Id.* "Miranda" warnings, see *Miranda v. Arizona*, 384 U.S. 436 (1966), may provide an apt analogy. See Capron, *supra* note 175, at 370; Meisel, "Exceptions", *supra* note 169, at 456 & n.141.

259. I use the word "material" here to describe information that not all patients know before consulting a physician (or abortion counselor), see *supra* note 225 and accompanying text, and that might influence a given woman's choice. The variation of the Illinois statute discussed in the text accompanying *infra* notes 261-85 provides a useful example.

260. Here I mean a recitation of the risks and consequences of each alternative course of action, e.g., continued pregnancy and childbirth, on the one hand, and abortion, on the other. Cf. *supra* text at notes 228-29 (describing "one-sided" legislation).

261. See *Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *prob. juris. noted sub nom. Diamond v. Charles*, 105 S. Ct. 2356 (1985).

262. 749 F.2d at 461. This section of the statute, whose language would reach not only physicians but also, for example, vendors of mutagenic pesticides, provides in its entirety:

Any person who sells any drug, medicine, instrument, or other substance which he knows to be an abortifacient and which is in fact an abortifacient, unless upon prescription of a physician, is guilty of a Class B misdemeanor. Any person who prescribes or administers any instrument, medicine, drug or other substance or device, which he knows to be an abortifacient, and intentionally, knowingly, or recklessly fails to inform the person for whom it is prescribed or upon whom it is administered that it is an abortifacient commits a Class C misdemeanor.

*Id.* at 456 (quoting Illinois Abortion Law of 1975, as amended by S.B. 47).

human being from fertilization until death.”<sup>263</sup> According to the court, the abortifacient-information requirement “not only intrude[d] upon the medical discretion of the attending physician, but it also impermissibly impose[d] the State’s theory of when life begins on the physician’s patient.”<sup>264</sup> Although the incorporation of unconstitutional assertions about when human life begins necessarily dooms the regulation and the Supreme Court should invalidate the Illinois law for this reason among others,<sup>265</sup> suppose the legislature had enacted a similar provision without such illegal references. Suppose this hypothetical provision, clearly directed at physicians prescribing methods of birth control that prevent implantation of fertilized ova but do not prevent fertilization, required a description of how the particular preimplantation method is thought to work<sup>266</sup> and a statement of its effectiveness and risks, together with disclosure of alternative methods of birth control, their effectiveness, and

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263. *Id.* at 462. The statute defined “abortifacient” to mean “any instrument, medicine, drug or any other substance or device which is known to cause fetal death when employed in the usual and customary use for which it is manufactured, whether or not the fetus is known to exist when such substance or device is employed.” *Id.* at 456 (quoting Illinois Abortion Law of 1975, as amended by S.B. 47).

264. *Id.* at 462.

265. Defining precisely “abortifacient” and its implications is difficult, and this difficulty suggests void-for-vagueness problems in the Illinois statute that even the *scienter* elements, *see supra* notes 262 & 263, may not cure. *See Colautti v. Franklin*, 439 U.S. 379 (1979). *Stedman’s Medical Dictionary* defines “abortifacient” as “producing abortion,” T. STEDMAN, *STEDMAN’S MEDICAL DICTIONARY* 3 (22d ed. 1972), and defines “abortion” as “[g]iving birth to an embryo or fetus prior to the stage of viability . . .,” *id.* Although the definition of “embryo” becomes operative beginning at “conception,” *id.* at 404, and “conception” is defined as “successful implantation of the blastocyst in the uterine lining,” *id.* at 276, the terms “conception” and “fertilization” are often used interchangeably, *see, e.g.*, THE BOSTON WOMEN’S HEALTH BOOK COLLECTIVE, *supra* note 38, at 22. Methods of birth control that do not prevent fertilization but rather inhibit implantation of fertilized eggs may therefore be considered “abortifacients.” *See id.* at 249-50 (discussing how “morning-after pill” and intrauterine devices work); Note, *Criminal Law—Abortion—The “Morning-After Pill” and Other Pre-Implantation Birth-Control Methods and the Law*, 46 ORE. L. REV. 211 (1967) (pre-*Roe* analysis of applicability of abortion restrictions to these methods); *but see American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283, 293 (3d Cir. 1984) (citing Pennsylvania statute excluding such methods from definition of “abortion”), *juris. postponed*, 105 S. Ct. 2015 (1985). Nonetheless, “fetus,” the term used in Illinois’ definition of “abortifacient,” usually becomes applicable well after implantation, *see T. STEDMAN, supra*, at 461. *See also Roe v. Wade*, 410 U.S. 113, 159 (1973) (the pregnant woman “carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus”).

266. Because of the inherent ambiguity in the term “abortifacient,” my hypothetical requirement would probably suffer from the same vagueness problems as the actual Illinois statute if it used this term. *See supra* note 265. As a result, a term such as “preimplantation method of birth control,” although cumbersome, is preferable.

their risks.<sup>267</sup> Presumably, the court of appeals would have invalidated even this hypothetical statute because, as the opinion put it, "[t]he State may not treat women [who prefer preimplantation methods of birth control] inequitably in order to protect the emotional health of women who oppose abortifacients."<sup>268</sup> But, from the perspective of the doctrine of informed consent as well as the constitutional right of reproductive choice, the issue should not be the proper balance between the competing preferences of two classes of women sufficiently knowledgeable to reach a decision. The real question should be whether the state can insure constitutionally that all women who do not know how certain birth control drugs and devices work learn such facts even if doing so forces some women (regardless of their preference) to hear information they already know.<sup>269</sup>

I find this example, based on an expanded and "sanitized" variation of the Illinois law, to be a particularly provocative one for testing the *Akron* Court's reasoning because I believe that many people—even well-educated individuals interested in matters of birth control—are unaware that both intrauterine devices and the "morning-after pill" do not necessarily prevent fertilization but rather most likely prevent implantation of fertilized eggs.<sup>270</sup> Many of these same individuals would regard that information as material to their choice of a method of birth control.<sup>271</sup> If some physicians would decline to disclose such information to protect what *they* perceive to be the emotional health of patients that *they* think should use such methods of birth control,<sup>272</sup> then would not the hypo-

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267. Cf. Morrow, *supra* note 213, at 578 (criticizing physicians who believe women should not be informed of risks of birth control pills and arguing doctor should "explain to his woman patient the risks of the use of birth control pills, the alternatives to the pills, and the risk of the alternatives").

268. 749 F.2d at 462.

269. Cf. *Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1019 (1st Cir. 1981) (analogizing to the law of evidence, the question is whether the "'prejudicial' effect of even admittedly relevant information outweighs its 'probative' value").

270. See THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 52, at 249-50; Note, *supra* note 265.

271. I base my "empirical" conclusions about such knowledge and materiality on the consistent student responses over the last six years in my Seminar on Reproductive Control at Washington University School of Law.

272. See Morrow, *supra* note 213, at 578; THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 52, at 561-62 (female patients' relationship with doctors). See also J. CHILDRESS, *supra* note 176, at 127-56 ("paternalistic deception, lies and nondisclosure" in health care). Although the Supreme Court has repeatedly limited its analyses to the "model of the competent, conscientious, and ethical physician," 462 U.S. at 448 n.39; see *supra* text at note 108, it is not at all clear that



thetical requirement enhance the patient's self-determination? This hypothetical requirement therefore forces us to consider whether mandatory information statutes, which always constrain physician discretion, inevitably invade the patient's freedom to choose as well.<sup>273</sup>

Applying the *Akron* reasoning to the hypothetical restriction, a court might find the intrusion on physician discretion decisive,<sup>274</sup> quite apart from whatever motives might have prompted the enactment.<sup>275</sup> In fact, *Akron's* disapproval of government-fashioned "straitjackets" for doctors<sup>276</sup> would invalidate any specific disclosure requirement directed at the physician, regardless of the accuracy, materiality, and "two-sidedness" of the information<sup>277</sup> detailed by the state. This conclusion suggests that the physician must always make the ultimate determination about the particular information his patient does and does not receive. To this extent, the *Akron* Court's stance tracks the traditional therapeutic exception to the doctrine of informed consent, which gives the physician discretion to withhold information he believes would be harmful to the patient. Yet commentators have criticized, and even advocated abolishing, this exception because it undermines the right of self-determination.<sup>278</sup> According to this aspect of *Akron*, then, the physician is not simply the instrument of the abortion patient's independent choice,<sup>279</sup> because his constitutionally protected discretion is the filter through which she will acquire information to reach her decision. To say that the

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physicians who paternalistically withhold information from their patients depart from that model. See generally J. CHILDRESS, *supra* note 176. The Court relies on intraprofessional remedies, not state legislation, for physicians who fall short of this model (see *Doe*, 410 U.S. at 199; *Roe*, 410 U.S. at 166), but that may reaffirm one observation in this Article—that standards developed by the medical profession ultimately determine whether any particular regulation of abortion will survive constitutional challenge. See *supra* notes 57-90 and accompanying text. But see *infra* note 353 and accompanying text.

273. No compelling state interest would support such regulation of birth control, but that conclusion would apply equally to informed consent provisions, like the one upheld in *Danforth*, 428 U.S. at 65-67, that cover even the first trimester of pregnancy.

274. See *supra* note 241 and accompanying text.

275. See *supra* notes 216-20, 241-44 and accompanying text.

276. See *supra* note 242 and accompanying text.

277. Cf. *supra* text accompanying note 247 (ordinance provision compelling communication of unobjectionable information invalid because of attending-physician requirement).

278. See *supra* note 176. Although the Supreme Court's approach is generally consistent with current tort law, the commentators' criticism of the therapeutic exception in the tort doctrine (it allows the doctor to negate the right of the patient to choose intelligently her own medical treatment) would seem equally pertinent to any therapeutic exception engrafted on the constitutional right to choose intelligently certain kinds of reproductive health care.

279. See *supra* text accompanying note 239.

abortion decision is "hers" is to speak very loosely or to recite a fairy tale, as Dr. Jay Katz has called the right of informed consent that tort law has given to patients.<sup>280</sup>

Perhaps unwilling to rely wholly on fairy tales, however, the Supreme Court in *Akron* nodded approvingly at requirements like the second part of Akron's ordinance, which addressed the risks of the particular patient's pregnancy, the abortion technique to be used, and general instructions on care, so long as the physician remains free to decide the precise contours of each disclosure.<sup>281</sup> A court might construe the hypothetical requirement to disclose the nature of preimplantation methods of birth control as a sufficiently general command to fit within these parameters. In allowing the state some room to legislate the disclosure of information, the *Akron* Court recognized that the woman has interests that are distinct from those of her physician and do not necessarily receive adequate protection from the exercise of his medical discretion. Yet in coming this far the Court avoided taking the next step—deciding whether the woman's right of reproductive choice might even supercede the interests of her physician; instead the Court reached an intriguing solution that did not compel retreat from its previous elevation and protection of the physician. Even Akron's inclusion of acceptable information in the ordinance could not stand because it obligated the attending physician to make the required disclosures.<sup>282</sup> The "doctor knows best" approach prevails in *Akron*, for even when the information is "not objectionable,"<sup>283</sup> the state must defer to the judgment of the physician who may conclude that someone other than himself should perform the counseling role.<sup>284</sup> The hypothetical derived from the Illinois statute, which also mandates disclosure by the physician,<sup>285</sup> would therefore fall *even if* it guaranteed patient exposure to new, helpful and true information.

Looking beyond *Akron*'s contextually appropriate results,<sup>286</sup> it is perhaps no coincidence that the Court has removed virtually all "obstacles"

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280. See generally Katz, *supra* note 133 (arguing that law really defers to physician's discretion even while speaking of patient's right of informed consent). See also J. CHILDRESS, *supra* note 176 (advocating limits on paternalism in health care).

281. See *supra* notes 245 & 246 and accompanying text.

282. See *supra* notes 250 & 251 and accompanying text.

283. See 462 U.S. at 446 n.37.

284. See *id.* at 448-49.

285. See *supra* note 262 and accompanying text.

286. See *supra* notes 253 & 255 and accompanying text.

from the physician's path<sup>287</sup> while allowing the state to continue to impose requirements on the patient. The state cannot force the doctor to talk, but it can force the patient to listen. Although this outcome safeguards the physician's first amendment right,<sup>288</sup> its impact on the woman's privacy right is unclear.

If all mandatory information *infringes* the right to privacy (a conclusion once suggested by the Court's fusion of physician and patient),<sup>289</sup> the patient should have at least as much freedom as, if not more than, her physician from a state-regulated relationship. Yet the *Akron* solution to the informed-consent problem extricates the physician from the state's grasp but not the patient. Alternatively, if some state-specified information arguably *protects* the patient's reproductive privacy by insulating her from the physician's preferences and thus enhancing her choice (a possible conclusion to draw from the hypothetical version of the Illinois statute),<sup>290</sup> then why does the Constitution forbid the state to force the doctor to bear the counseling role? Apart from the physician's first-amendment claim, an issue not addressed in *Akron*,<sup>291</sup> the constitutional right at stake properly belongs to the patient, and the physician should serve simply as the means for her to effectuate that right. In the abstract a state requirement that the attending physician convey particular information to the patient would seem *no more* "unreasonable"<sup>292</sup> than a state requirement that some other "qualified individual"<sup>293</sup> communicate precisely the same information. Requiring the physician to participate in counseling the patient before obtaining her consent may, for example, enhance the patient's trust and improve the physician's decision-making<sup>294</sup>—both consequences that benefit the patient. *Akron's* undocumented comparison between counseling by a physician and counseling by

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287. See *supra* text at note 239.

288. In her dissent in *Akron*, Justice O'Connor noted that a state may well violate the first amendment if the state requires physicians "to communicate its ideology." 462 U.S. at 472 n.16 (citing *Wooley v. Maynard*, 430 U.S. 705 (1977)). The challengers in *Akron* did not raise such claims, however.

289. See *supra* note 147 and accompanying text.

290. See *supra* note 272 and accompanying text.

291. See *supra* note 288.

292. 462 U.S. at 449 ("In light of these alternatives [allowing delegation of counseling, requiring verification by physician of counseling, etc.], we believe that it is unreasonable for a State to insist that only a physician is competent to provide the information and counseling relevant to informed consent.").

293. *Id.* at 448.

294. *Andrews, supra* note 176, at 205.

a professional counselor does not explain why, from the perspective of the patient's right, a state preference for the former over the latter is unreasonable.<sup>295</sup> Yet the Court could have emphasized the additional financial burden of this requirement, as it did when it invalidated Akron's post first-trimester hospitalization rule,<sup>296</sup> instead of equivocally and half-heartedly referring to cost.<sup>297</sup> Or the Court could have invoked evidence that nonphysician counselors actually performed the counseling function better than physicians.<sup>298</sup> The *Akron* Court took neither of these paths, which would have revealed the interests at stake for the patient.

In *Akron* the Court altered its rhetoric to speak more clearly of the woman as right-holder, quietly abandoned its idealized view of the physician as decision-maker, and implicitly approved the clinic setting in which most abortions are performed. At a deeper level, however, the Court failed to articulate a coherent theory explaining the connection between patient choice and informed consent,<sup>299</sup> and it came only to verge of recognizing that the woman may have rights superseding those of her doctor. One striking point is clear, nonetheless. The Court refused to allow the state to place any meaningful burden on the physician

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295. See 462 U.S. at 449.

296. Other questions of cost have evoked detailed analysis from the Justices and have sharply divided the Court. See *id.* at 434-35 (discussing significant additional cost imposed by hospitalization requirement); *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 490 (1983) (opinion of Powell, J., joined by Burger, C.J.) (cost of required tissue examination "does not significantly burden a pregnant woman's abortion decision"); *id.* at 498 (opinion of Blackmun, J., joined by Brennan, Marshall, & Stevens, JJ.) (requirement of "a pathologist's report unquestionably adds significantly to the cost of providing abortions").

This division on the Court may explain in part the majority's superficial analysis of the cost of physician-counselors, an approach that may reflect a compromise.

297. See *id.* at 447 ("Requiring physicians personally to discuss the abortion decision, its health risks, and consequences with each patient may in some cases add to the cost of providing abortions, though the record here does not suggest that ethical physicians will charge more for adhering to this typical element of the physician-patient relationship.").

298. See Respondents' and Cross-Petitioners' Brief, *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), at 16-17. The Supreme Court simply noted that the courts below had made no findings "that the nonphysician counselors at the plaintiff abortion clinics are not trained or qualified to perform [their] important function." 462 U.S. at 448.

299. Concluding that the Supreme Court has advanced no coherent understanding of patient choice and informed consent leaves the *Akron* opinion unexplained and unsupported, offering no clear guidance for subsequent legislative or judicial efforts. See *Diamond v. Charles*, 105 S. Ct. 2356 (1985) (noting probable jurisdiction in challenge to Illinois abortion restrictions); *Thornburgh v. American College of Obstetricians and Gynecologists*, 105 S. Ct. 2015 (1985) (postponing further consideration of jurisdiction in challenge to Pennsylvania abortion restrictions). The alternative approaches examined *infra* in Part III, however, fill the gap.

while permitting the state to oversee the patient's receipt of information. Although physicians plainly have important interests in practicing medicine free from unwarranted state "entanglement,"<sup>300</sup> these interests should not overshadow the more firmly grounded constitutional rights of the abortion patient. *Akron* perpetuates the pattern established in previous cases, judicial solicitude for the physician.<sup>301</sup> This persistent theme, which pulls the physician to the center of the analysis, means that modern privacy doctrine bears even less resemblance to its antecedents than the critics of the early reproductive-choice cases had contended,<sup>302</sup> and that the "fairy tale" of informed consent in tort litigation<sup>303</sup> has been retold as constitutional law.

### III. TOWARD A COHERENT ANALYSIS: ABORTION RESTRICTIONS AND DISCRIMINATION AGAINST WOMEN

*Roe v. Wade's* basic point, that the Constitution prohibits the state from usurping from its citizens the intensely personal and sensitive choice whether to terminate a pregnancy, embodies the most intelligible conclusion the Court could have reached on the question before it.<sup>304</sup> Yet a doctrine of reproductive privacy makes little intuitive or legal sense when it ties the underlying right to inevitably changing medical technology and currently accepted medical practice,<sup>305</sup> when it casts the doctor as the decision-maker with a status equal to or greater than the individual most intimately involved, even on nonmedical issues;<sup>306</sup> when it allows government-funding programs to target reproductive health care for

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300. See *supra* notes 149 & 158 and accompanying text.

301. See *supra* notes 57-167 and accompanying text.

302. See *supra* note 11.

303. See *Katz, supra* note 133. This vision of privacy, examined through the lens of informed consent, is consistent with Jay Katz's observation that the law of informed consent does not truly protect patient autonomy but rather shields physician discretion. And it is a vision of privacy that perpetuates paternalism. See generally J. CHILDRESS, *supra* note 176. But the solution does not necessarily lie in state-prescribed disclosures. As Katz concludes:

Decision-making in medicine ought to be a joint undertaking and depends much more on the nature and quality of the entire give-and-take process and not on whether a particular disclosure has or has not been made. How to translate the ingredients of this process into useful legal prescriptions which are respectful of patients' quest to maintain and impulse to surrender autonomy as well as of physicians' unending struggle with omnipotence and impotence is a difficult task which has not yet been undertaken.

*Katz, supra* note 133, at 173.

304. See, e.g., *Law, supra* note 24; *Tribe, supra* note 67.

305. See *supra* notes 55-92 and accompanying text.

306. See *supra* notes 93-151 and accompanying text.

uniquely disadvantageous treatment;<sup>307</sup> and when it offers no satisfactory resolution to the difficulties posed by offensive yet arguably "protective" informed-consent requirements.<sup>308</sup> Nonetheless, because women have enjoyed increased freedom of choice as the result of the law's respect for doctors, some writers supporting a woman's right of reproductive self-determination may be willing to settle for the current approach.<sup>309</sup>

This very pragmatic position is not the only path now that an increasing number of scholars have developed alternative, women-focused analyses of reproductive choice. Although still awaiting the precision that will come with use in litigation, the recent writing of Sylvia Law<sup>310</sup> and Donald Regan,<sup>311</sup> as well as Kenneth Karst<sup>312</sup> and Judge Ruth Bader Ginsburg,<sup>313</sup> goes far toward refining the existing protection of reproductive choice. Their work centers on a simple, incontrovertible fact, presented most cogently by Sylvia Law: only women can become pregnant, give birth, and have abortions.<sup>314</sup> Legislation that singles out abortion (or pregnancy or childbirth) for differential treatment singles out women for differential treatment; such laws thus raise issues of gender-based discrimination<sup>315</sup> despite the Supreme Court's unwillingness to recognize this point in some of its opinions.<sup>316</sup> With respect to abortion in particular, Law, Karst and Ginsburg appear generally to agree that laws which uniquely restrict access to medically feasible and available

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307. See *supra* notes 152-67 and accompanying text.

308. See *supra* notes 168-303 and accompanying text.

309. See Asaro, *supra* note 16, at 60, 93, 102.

310. Law, *supra* note 24; Brief Amici Curiae, *supra* note 24.

311. Regan, *supra* note 25.

312. Karst, *The Supreme Court, 1976 Term, Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 57-59 (1977).

313. Ginsburg, *supra* note 16.

314. See Law, *supra* note 24, at 955, 1016; Brief Amici Curiae, *supra* note 24, at 17-24. See also Regan, *supra* note 25, at 1631 (only women become pregnant and need abortions).

315. See generally Law, *supra* note 24. See also Kay, *Models of Equality*, 1985 U. ILL. L. REV. 39, 81-83 (limits of antidiscrimination principle in litigation involving immutable physical sex characteristics).

316. Compare *Geduldig v. Aiello*, 417 U.S. 484, 496-97 n.20 (1974) (upholding state insurance system because pregnancy-based discrimination is not gender-based discrimination) with *Michael M. v. Superior Court*, 450 U.S. 464, 471-73 (1981) (plurality opinion) (upholding male-only statutory rape prohibition because only women become pregnant and suffer disproportionate consequences of sexual activity); *id.* at 498 (Stevens, J., dissenting) (Court has finally acknowledged "that the capacity to become pregnant is what primarily differentiates the female from the male"). See also *Nashville Gas Co. v. Satty*, 434 U.S. 136 (1977) (employer's failure to provide sick pay for employees during pregnancy leave is not illegal sex discrimination under Title VII, but deprivation of seniority after pregnancy leave is).

services<sup>317</sup> not only purposely treat women differently from others seeking health care,<sup>318</sup> but also have the even more discriminatory impact of denying women an equal opportunity to choose their own roles in society.<sup>319</sup> Regan's point differs, but he sees the issue as one of equal protection nonetheless; when the state denies women abortions just so that their fetuses can survive until birth,<sup>320</sup> the state forces these women to be good samaritans at great potential cost to their physical and emotional health.<sup>321</sup> Yet no state imposes similar burdens on other individuals in even remotely comparable circumstances.<sup>322</sup> In Regan's phrase, abortion restrictions uniquely forbid women to be "bad samaritans."<sup>323</sup>

Viewing abortion restrictions from a woman-focused perspective does not provide automatic answers to many of the difficult questions addressed in *Roe v. Wade* and the cases that followed: What ought to be the governing standard of review?<sup>324</sup> Must a court review all abortion laws with equal rigor?<sup>325</sup> Can the state protect the fetus as a person?<sup>326</sup> How far can it go to protect the fetus as something less than a full consti-

317. See Law, *supra* note 24, at 1016. Pregnancy is a natural process, but medicine and science have developed techniques for safely interrupting that process. Any effort to justify restricting access to safe abortion services on the ground that women should "accept their maternal destiny," Brief Amici Curiae, *supra* note 24, at 25, makes no more sense than an effort to justify restricting access to, say, chemotherapy on the theory that those who contract cancer should accept their biological fate.

318. Despite the Supreme Court's conclusions to the contrary in *Geduldig v. Aiello*, 417 U.S. 484 (1974), and *General Electric Co. v. Gilbert*, 429 U.S. 129 (1976), Congress' recognition that pregnancy-based discrimination constitutes sex-based discrimination makes far more sense. See Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (Supp. V 1981). As a result, I consider laws that purposely classify on the basis of pregnancy (or abortion) equivalent to laws that purposely classify on the basis of gender. See Regan, *supra* note 25, at 1633; *Hayes v. Shelby Memorial Hosp.*, 726 F.2d 1543, 1548 (11th Cir. 1984) (presuming that employer's policy applicable only to pregnant women is facially discriminatory). See also *supra* note 316 (sometimes Court treats pregnancy-based discrimination as sex-based discrimination).

319. Ginsburg, *supra* note 16, at 383; Karst, *supra* note 312, at 58; Law, *supra* note 24, at 1007, 1028; Brief Amici Curiae, *supra* note 24, at 21-24.

320. Regan, *supra* note 25, at 1574-76.

321. *Id.* at 1579-83 (cataloguing burdens).

322. *Id.* at 1621-33. Regan concludes that abortion restrictions contravene the constitutional values of nonsubordination, freedom from physical invasion, and equal protection. *Id.* at 1639-40. Law criticizes Regan's bad-samaritan approach because it equates abortion with other "morally wrong but legally protected" refusals to aid. Law, *supra* note 24, at 1022.

323. See Regan, *supra* note 25, at 1572.

324. See *supra* note 3.

325. See *id.*

326. See Karst, *supra* note 312, at 58 ("principle of equal citizenship" is "not a means of defining who a person is"); Law, *supra* note 24, at 1020-21 (equally difficult under privacy and sex-equality approaches to determine whether state has compelling interest in restricting abortion). *But see* Re-

tutional person?<sup>327</sup> Law explains how and why she would apply a compelling state purpose test to any law "governing reproductive biology [that has] a significant impact in perpetuating either the oppression of women or culturally imposed sex-role constraints on individual freedom."<sup>328</sup> This strict scrutiny brings the analysis very close to the Court's framework in *Roe*,<sup>329</sup> which authorizes the state to prohibit all but medically necessary abortions upon viability.<sup>330</sup> Similarly, Regan's "bad-samaritan" approach would apply a heightened scrutiny to abortion-based classifications<sup>331</sup> and would allow state prohibitions at the end of the second trimester, the time of viability.<sup>332</sup>

Although beginning at a very different starting point from *Roe*, each of these alternative approaches *Roe's* final result. But they do so without burying what is essentially a woman's right in a formula that fixates on the prerogatives of the physician.

How do these alternative routes to *Roe's* result respond to the difficulties that the medical model has generated and to the issues posed in recent litigation?

The predicted "collision"<sup>333</sup> between viability and the protected first trimester<sup>334</sup> is one of the most problematic consequences of the current doctor-centered formula's dependence on changing technology. Law denies the imminence of the collision,<sup>335</sup> and this denial allows her to concede that postviability protection of fetal life could be a compelling state interest that justifies state interference with abortion freedom.<sup>336</sup> But Law's own observation that "[c]ontrol of reproduction is the *sine qua*

gan, *supra* note 25, at 1640-41 (argument based on samaritan doctrine supports abortion freedom even if state regards fetus as a person).

327. See Ely, *supra* note 10, at 926 ("Dogs are not 'persons in the whole sense' nor have they constitutional rights, but that does not mean the state cannot prohibit killing them").

328. Law, *supra* note 24, at 1008-09.

329. Law's analysis would find compelling state interests in addition to those so recognized in *Roe*. Specifically, her approach would allow "a compelling state interest to be established in relation to the broader substantive concerns of sex equality, including the oppression of women and the constraints of traditional sex roles." *Id.* at 1011.

330. 410 U.S. at 163-64.

331. Regan, *supra* note 25, at 1630-33.

332. *Id.* at 1642-43.

333. *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 458 (1983) (O'Connor, J., dissenting).

334. See *Roe v. Wade*, 410 U.S. 113, 163-64 (1973).

335. Law, *supra* note 24, at 1023-24 n.245 (empirical evidence cited by Justice O'Connor does not support her claim that first-trimester viability will soon be possible).

336. See *id.* at 1023-25 & n.247.



*non* of women's capacity to live as equal people"<sup>337</sup> suggests an additional response. *If* viability should ever occur early in pregnancy, then protection of viable fetal life may not be a *sufficiently* compelling state interest to override so completely a woman's opportunity to terminate a pregnancy. When *Roe v. Wade* held that the state must allow therapeutic abortions after viability,<sup>338</sup> the Court established that even compelling governmental interests do not defeat all competing claims. Yet the Court's present balancing test, with its emphasis on medical technology, might tolerate the obliteration of abortion freedom by early viability. A balancing test based on gender equality would more easily avoid that result, given the inseparable link between gender equality and reproductive self-determination.<sup>339</sup>

Regan's approach also evades the pitfalls threatened by technological change. To Regan, the beginning of the third trimester, the time at which *Roe* placed fetal viability,<sup>340</sup> is important not because it signals the capacity for extrauterine survival, but because it marks a point at which one might justifiably conclude under the samaritan doctrine that the woman has "waived her right of non-involvement with the fetus."<sup>341</sup> Her wish to terminate aid to the fetus comes too late. Relocating the viability point will not alter the appropriate time to conclude that the pregnancy has continued too long for a woman to invoke her equal right to be a bad samaritan.<sup>342</sup>

Under a woman-centered approach, technology's twin, "accepted medical practice," would no longer dominate the constitutional inquiry. In an equal protection analysis accepted practice might serve as one datum to help determine whether the state has singled out abortion patients (and thus women) for disadvantageous or burdensome requirements not imposed on those undergoing comparable medical procedures.<sup>343</sup>

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337. *Id.* at 1028.

338. See 410 U.S. at 163-64. Regan claims that his approach offers a firmer basis for this result than does the Court's opinion. See Regan, *supra* note 25, at 1642 (One "must admit that there is no other case in which we would even consider requiring one individual to sacrifice his life or health to rescue another.").

339. See Law, *supra* note 24, at 1028.

340. 410 U.S. at 160.

341. Regan, *supra* note 25, at 1643.

342. Regan finds "a line at the beginning of the third trimester" a reasonable compromise between the competing interests of the pregnant woman and the state. *Id.*

343. A reference to standard medical practice would reveal the other medical procedures with which abortion ought to be compared. If the legislature has regulated abortion more strictly than these medically comparable procedures, then the equal protection analysis proposed here would

Although under its privacy approach the Court has not consistently condemned a state's discriminatory treatment of abortion<sup>344</sup> or its imposition of an "extra layer . . . of regulation"<sup>345</sup> even during the first trimester,<sup>346</sup> such legislation has both a discriminatory purpose and effect. When such legislation reduces access to abortion, it undermines women's opportunities to determine their own reproductive fates and to choose their own positions in society.<sup>347</sup> But even when such laws do not limit access, they demean women by perpetuating stereotypes of women as a special class of medical patients in need of governmental protection.<sup>348</sup>

Missouri's required postabortion pathology reports, an issue that divided the Court in *Planned Parenthood of Kansas City, Inc. v. Ashcroft*,<sup>349</sup> provide a useful test. The Justices could not agree on whether the requirement comported with "accepted medical practice."<sup>350</sup> But whether or not the requirement met that test, it singled out abortion for such regulation.<sup>351</sup> With respect to other medical procedures, patients injured by deviations from standard medical practice can initiate malpractice litigation; the state simply assumes that they are sufficiently competent to obtain proper health care and to seek redress when they receive something less.<sup>352</sup> Returning "accepted medical practice" to its

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apply. Standard medical practice might thus contribute to the threshold inquiry but it would not, as it does under the current privacy approach, be the determinative constitutional variable. See *supra* notes 55-92 and accompanying text.

344. Compare *Harris v. McRae*, 448 U.S. 297, 325 (1980) ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.") with *Doe v. Bolton*, 410 U.S. 179, 197 (1973) ("We are not cited to any other surgical procedure made subject to committee approval as a matter of state criminal law.").

345. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 66 (1976) (upholding Missouri's written-consent requirement despite challengers' argument that *Roe* prohibits state from regulating abortion more closely than other medical procedures).

346. See *Roe*, 410 U.S. at 163 (during first trimester, decision "may be effectuated by an abortion free of interference by the state").

347. See Ginsburg, *supra* note 16, at 383; Karst, *supra* note 312, at 58; Brief Amici Curiae, *supra* note 24.

348. See Brief Amici Curiae, *supra* note 24, at 42-47 (unique hospitalization requirements for abortions "reflect and reinforce the assumption that woman are 'innately inferior' in their capacity to make appropriate medical decisions in consultation with their physicians").

349. 462 U.S. at 486-90; *id.* at 494-98 (Blackmun, J., dissenting).

350. See *supra* notes 89 & 90 and accompanying text.

351. The Missouri Administrative Code requires a pathologist's report following all but minor surgery performed in hospitals. See 462 U.S. at 486 (plurality opinion); *id.* at 497 (Blackmun, J., dissenting). Early abortions, however, are considered minor surgical procedures, see *Akron*, 462 U.S. at 444 n.35, and are not generally performed in hospitals, see *id.* at 436.

352. See generally W.P. KEETON, D. DOBBS, R. KEETON & D. OWEN, *supra* note 91, at 187.

normal role as a component of the law of torts makes far more sense than using the concept to define the boundaries of the right to privacy.<sup>353</sup> And returning this concept to its ordinary role avoids the harmful stereotyping of women imposed by even those laws that single out abortion for requirements consistent with accepted medical practice.<sup>354</sup>

The preceding analysis goes far toward resolving the remaining difficulties in the Court's current approach. Government funding programs that exclude therapeutic abortions while subsidizing all other medically necessary health care services pose serious equal protection problems, as Justice Stevens noted in *Harris v. McRae*.<sup>355</sup> This uniquely unfavorable treatment of therapeutic abortion presents an even clearer case of sex-based discrimination than the uniquely unfavorable treatment of normal pregnancy.<sup>356</sup> And it is discrimination that, while oppressing women and channeling them into narrow gender-determined roles in society,<sup>357</sup> could not survive Law's compelling-state-purpose standard.<sup>358</sup>

Recognizing the sex discrimination inherent in laws that single out abortion under either Law's or Regan's approach leaves no doubt that the woman, not her physician, decides whether to terminate her preg-

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353. See *supra* notes 73-90 and accompanying text.

354. In other words, an abortion patient needs no more legislative protection than any other patient. If her physician should have consulted a pathologist according to standard practice but failed to do so and the patient suffered injuries as a result, then she can sue him as any other patient might under similar circumstances. Cf. *Roe*, 410 U.S. at 166 (usual judicial remedies). By contrast, the Missouri statute imposes criminal penalties on physicians who fail to comply. See MO. REV. STAT. § 188.075 (Supp. 1984) (misdemeanor).

355. 448 U.S. 297, 351-57 (1980) (Stevens, J., dissenting). See Ginsburg, *supra* note 16, at 385.

356. As a result of the Hyde Amendment, abortion is virtually the only medically necessary health care service excluded from Medicaid coverage. See 448 U.S. at 322, 325 n.28. By contrast, in the cases in which the Court declined to recognize as sex-based discrimination the uniquely unfavorable treatment of pregnancy, the Court arguably relied on the often "normal" and "voluntary" nature of the condition. See, e.g., *General Electric Co. v. Gilbert*, 429 U.S. 125, 136 (1976) (pregnancy is not a "disease" and is often voluntarily undertaken and desired). One could not make similar assumptions about conditions that make pregnancy termination medically necessary, e.g., cancer or diabetes. See 448 U.S. at 339-40 (Marshall, J., dissenting) (cataloguing situations in which the Hyde Amendment withholds funds for medically necessary abortions). The physical and emotional effects of such abortion discrimination are thus probably more severe than the financial (and perhaps emotional) effects of the sort of pregnancy discrimination challenged in *Gilbert*.

357. Governmental refusals to subsidize only elective abortions, while subsidizing childbirth, would also have this role-channeling effect. See *Maher v. Roe*, 432 U.S. 464 (1977) (upheld as constitutional).

358. See Law, *supra* note 24, at 1016-17 n.219. Regan's thesis, on the other hand, would not compel the Court to reach different results in the abortion-funding cases. See Regan, *supra* note 25, at 1644-45.

nancy.<sup>359</sup> The physician will contribute medical advice and will often effectuate her decision,<sup>360</sup> but he can neither resolve the personal and moral issues for her nor choose her role in society.<sup>361</sup>

One of the most satisfying results of Law's analysis is its easy resolution of the difficulties presented by even "clean" informed-consent provisions,<sup>362</sup> like the hypothetical version of Illinois' "abortifacient"-disclosure rule.<sup>363</sup> When the state singles out abortion patients or female birth-control patients for special protection from their physicians by mandating waiting periods and detailed disclosure requirements, the state perpetuates outmoded and pernicious stereotypes of women as indecisive and incompetent health-care consumers, incapable of obtaining necessary information and time for reflection without paternalistic government intervention.<sup>364</sup> No compelling state interest supports this intervention.<sup>365</sup> If and when the state prescribes specific disclosures for other kinds of health care for both male and female patients<sup>366</sup> and penalizes in

359. Cf. *supra* notes 93-151 and accompanying text (physician as decision-maker).

360. See *supra* notes 119-33 and accompanying text (empirical reports of abortion decision-making).

361. Ginsburg writes of abortion as implicating "a woman's autonomous charge of her full life's course," Ginsburg, *supra* note 16, at 383. Karst relates abortion to "a woman's claim of the right to control her own social roles," Karst, *supra* note 312, at 58. Law phrases the issue as "a woman's capacity for individual self-determination," Law, *supra* note 24, at 1017, while Regan sees abortion as the moral question whether to aid one in peril, Regan, *supra* note 25. In addition, as the Court noted in *Roe v. Wade*, one's position on abortion requires choices among various conflicting religious and moral beliefs about matters not susceptible of definitive resolution. 410 U.S. at 116, 159. Is a pregnant woman's physician the appropriate individual to decide her "social role" or her moral beliefs?

362. See *supra* notes 168-303 and accompanying text.

363. See *supra* notes 265-67 and accompanying text.

364. See Brief Amici Curiae, *supra* note 24, at 26-39.

365. The Court has noted the "stressful" nature of the abortion decision, *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 67 (1976), but other surgery patients undoubtedly experience stress as well.

366. Even those states that have codified the informed consent doctrine, see generally Andrews, *supra* note 176, have enacted general statutes much less specific than the abortion-information requirements. Yet one notable exception provides an interesting counterpoint to this discussion: A Massachusetts statute specifically gives every breast-cancer patient in a hospital or comparable facility the right to be "provided by the physician in the facility" "complete information on all alternative treatments which are medically viable." MASS. ANN. LAWS ch. 111, § 70E (Michie/Law. Coop. Supp. 1985). Because men so rarely contract breast cancer and because the legislature undoubtedly envisioned the statute's beneficiaries as female, I regard this law as a gender-based classification. Like abortion-information statutes, it promotes a stereotype of women as particularly vulnerable medical patients needing special legislative protection. But does it serve a compelling state interest? Have breast cancer patients often chosen radical mastectomies because physicians have "oppressed" them by giving them less than complete information about alternative treatments? See THE BOSTON

an evenhanded way a physician's failure to comply,<sup>367</sup> then we may justifiably yield to the tempting conclusion that some such laws enhance the right of self-determination.<sup>368</sup>

The foregoing analysis would invalidate all of the required oral-disclosure and printed-information provisions scheduled for Supreme Court review in *Thornburgh v. American College of Obstetricians and Gynecologists*<sup>369</sup> and *Diamond v. Charles*.<sup>370</sup> Pennsylvania's special abortion-reporting requirements<sup>371</sup> would probably fall as well, to the extent they suggest in the absence of a compelling interest that women patients are particularly vulnerable to consulting "shoddy practitioners"<sup>372</sup> and especially in need of government oversight.<sup>373</sup>

Other challenged provisions that become operative after fetal viability<sup>374</sup> may appear to withstand Law's compelling-state-purpose test.<sup>375</sup>

WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 52, at 533-35. Law might well find the Massachusetts provision narrowly tailored to advance a compelling state interest related "to the broader substantive concerns of sex equality, including the oppression of women and the constraints of traditional sex roles." Law, *supra* note 24, at 1011.

367. Outside the abortion context, informed consent statutes generally codify the common-law doctrine and thus provide legislative standards for malpractice litigation. *See generally* Andrews, *supra* note 176. Abortion-information statutes, however, impose criminal penalties on the physician, *see, e.g.*, *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 425 (1983), or specify loss of his license for failure to comply, *see, e.g.*, *American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283, 305-06 (3d Cir. 1984), *juris. postponed*, 105 S. Ct. 2015 (1985).

368. *See supra* notes 269-303 and accompanying text.

369. 737 F.2d 283, 295-96, 298 (3d Cir. 1984) (informed-consent and printed-information provisions enforced by license revocation and criminal penalties), *juris. postponed*, 105 S. Ct. 2015 (1985).

370. *Charles v. Daley*, 749 F.2d 452, 461-62 (7th Cir. 1984), *prob. juris. noted sub nom. Diamond v. Charles*, 105 S. Ct. 2356 (1985).

371. The court of appeals upheld the requirement that abortion facilities file reports subject to public disclosure containing information about the facilities and their affiliates. 737 F.2d at 297-98. *See American College of Obstetricians and Gynecologists v. Thornburgh*, 613 F. Supp. 656 (E.D. Pa. 1985) (subsequent preliminary injunction against reporting requirement). The court struck down detailed reporting requirements imposed on the physician about each abortion performed. 737 F.2d at 301-02. *See* 613 F. Supp. 656.

372. 737 F.2d at 298 (upholding reporting requirement for abortion facilities because "state has proffered important justification that the provision will help insure that shoddy practitioners may not hide behind the corporate veil"). *See* 613 F. Supp. 656 (subsequent preliminary injunction against reporting requirement).

373. *See supra* note 364 and accompanying text.

374. *See* 749 F.2d at 459-60 (Illinois standard of care for aborting viable fetuses unconstitutionally encroaches on attending physician's medical judgment because statute fails to specify who determines viability); *id.* at 460-61 (standard of care for abortions of possibly viable fetuses unconstitutional because it interferes with woman's right to receive unimpeded medical judgment); 737 F.2d at 298-300 (in absence of convincing evidence of "unconstitutional chill," Pennsylvania's prohibition of postviability abortions is constitutional); *id.* at 300 (provision that abortions on viable

But like the Court in *Roe v. Wade*,<sup>376</sup> she would require the legislature to tailor such rules as narrowly as possible,<sup>377</sup> avoiding any encroachment on the previability period.<sup>378</sup> Moreover, even *Roe* dictated that courts must balance competing interests after the state has shown a compelling reason for its restriction.<sup>379</sup> Thus the Court must consider any oppressive consequences of these postviability measures, as the court of appeals did when it found unconstitutional Illinois' standard of care for aborting a fetus "known to be viable."<sup>380</sup>

#### IV. CONCLUSION

As the Court has turned from questions of contraception to issues of abortion,<sup>381</sup> it has increasingly transformed the values underlying constitutional "privacy" from protection of an individual's right of reproductive self-determination to an encomium to the medical profession. The abortion cases now awaiting review force the Supreme Court to address some of the troubling implications produced by its preoccupation with deference to doctors and the standards of their practice, so evident in the 1983 opinions.<sup>382</sup> Just as the Court once realized that the individuals unified in the married couple to which the Justices had accorded constitutional privacy merit separate consideration and protection,<sup>383</sup> so too

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fetuses be performed by the method most likely to produce live birth, in absence of significantly greater risk to the mother, is unconstitutional for failure to make maternal health paramount consideration); *id.* at 300-01 (second physician requirement for postviability abortions invalid for similar reasons).

375. See *supra* note 328 and accompanying text.

376. 410 U.S. 113, 155 (1973).

377. Law, *supra* note 24, at 1017 (law governing reproductive biology must be "best means for meeting a compelling state purpose").

378. For example, Illinois' standard of care for aborting "possibly viable fetuses" would fall on this ground. See 749 F.2d at 460-61.

379. 410 U.S. at 163-64 (even compelling state interest in protecting viable fetuses must give way to considerations of maternal life and health).

380. The court overturned this provision because it failed to specify whether the physician's or his assistant's assessment of viability would control. This uncertainty in turn hampers a woman's right to receive her physician's unimpeded medical judgment. 749 F.2d at 459-60.

381. Compare *Griswold v. Connecticut*, 381 U.S. 479 (1965) (contraception) with *Roe v. Wade*, 410 U.S. 113 (1973) (abortion).

382. *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476 (1983); *Simopoulos v. Virginia*, 462 U.S. 506 (1983).

383. Compare *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (right to privacy belongs to married couple) with *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (right to privacy belongs to "individual, married or single").

must the Court now “uncouple” the abortion patient’s constitutional rights from the interests of her physician.<sup>384</sup>

The abortion patient’s rights, unlike the interests of her physician—however important the latter may be—have solid roots in the Constitution. As scholars have recently recognized, reproductive self-determination is a logical and inseparable part of any meaningful inquiry into gender-based discrimination and gender equality. Reconsidering restraints on reproductive freedom from this equal-protection perspective offers not only a firmer constitutional foundation than the Court’s current methodology but also a more coherent framework for analysis. This framework resolves the unnecessary difficulties created by the medical model, provides answers for questions raised in current abortion litigation, and prevents the physician’s role in reproductive medical procedures from eclipsing the woman’s stake in overturning abortion restrictions.

Instead of presenting the opportunity to overrule *Roe v. Wade*,<sup>385</sup> as some have suggested,<sup>386</sup> the cases now before the Court invite it to clarify and strengthen its protection of what it must have recognized as the real issue all along: “a woman’s decision whether or not to terminate her pregnancy.”<sup>387</sup>

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384. I am indebted to Janet Benshoof for suggesting the comparison of the married couple and the “couple” composed of the doctor and his abortion patient. Telephone interview, *supra* note 120.

385. 410 U.S. 113 (1973).

386. *See, e.g.*, Brief for the United States as Amicus Curiae in Support of Appellants, Thornburgh v. American College of Obstetricians and Gynecologists, 737 F.2d 283 (3d Cir. 1984), *juris. postponed*, 105 S. Ct. 2015 (1985).

387. 410 U.S. at 153 (emphasis added).