THE ABORTION ALTERNATIVE AND THE PATIENT'S RIGHT TO KNOW

The Supreme Court removed the legal obstacles to abortion in *Roe v. Wade*[1] and *Doe v. Bolton*[2], leaving the decision to terminate pregnancy to the patient and her physician. Because the decision whether to abort now encompasses, in part, a professional judgment, a physician's or hospital's failure to perform or discuss abortion could prompt a medical malpractice suit.[3] State legislatures and Congress, fearful that the Court's abortion opinion would lead to such suits, enacted "conscience clauses" which shield from liability hospitals, doctors, and other medical personnel who for moral or religious reasons object to performing abortions. These statutes have not, however, resolved numerous questions about the doctor's role in discussing abortion with the patient.[4]

This Note examines the potential liability of a medical provider[5] who refuses or neglects to advise a pregnant patient of the availability of abortion as an alternative to carrying the pregnancy to term.[6] Section I examines *Roe* and *Doe* and subsequent cases that define the constitutional limitations on government regulation of abortion. Section II discusses the doctor's common law duty to inform his patient about the nature of medical procedures before he proceeds with treatment and the development of the modern doctrine of informed consent. Section III examines the elements of an informed consent cause of action and the arguments a plaintiff seeking damages from a physician who failed to inform her of the abortion alternative should assert to satisfy each element. Section IV analyzes the impact of federal and state conscience clauses on the physician's disclosure obligations. This Note concludes that a physician may have a legal duty to inform his pregnant patient about the abortion

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

2. 410 U.S. 179 (1973).

3. Note, *Abortion Conscience Clauses*, 11 COLUM. J.L. & SOC. PROB. 571, 572-73 (1975).

4. *See* Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 YALE L.J. 920, 922 (1973); 19 CATH. LAW. 36, 53-54 (1973).

5. Although this Note discusses the physician's duty to his patient, a hospital or clinic treating pregnant outpatients has the same potential malpractice liability.

6. *See* Note, *supra* note 3, at 578-79.

alternative, and that most conscience clauses offer no defense to a medical malpractice action alleging a breach of the duty to inform.

I. RECOGNIZING THE RIGHT TO AN ABORTION

In the 1973 cases of *Roe v. Wade*[7] and *Doe v. Bolton*,[8] the Supreme Court overturned state statutes that outlawed or sharply curtailed the performance of abortions.[9] The Court ruled that the restrictions unconstitutionally infringed personal privacy rights guaranteed by the due process clause of the fourteenth amendment,[10] using a four-step analysis.[11] First, a state may infringe certain "fundamental rights" only if it has a "compelling state interest."[12] Second, the right to privacy, though not explicitly enumerated in the Constitution, is a "fundamental right."[13] Third, this "fundamental right" includes personal privacy in activities related to marriage, procreation, contraception, and family relationships.[14] Finally, this right is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[15]

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7. 410 U.S. 113 (1973).

8. 410 U.S. 179 (1973).

9. In *Roe*, the Court struck down the Texas criminal abortion law that proscribed procuring or attempting an abortion except when deemed medically necessary to save a mother's life. 410 U.S. at 117-19. The Texas statute was similar to statutes then in effect in the majority of states. *Id.* at 118 & n.2.

The Georgia statute struck down in *Doe* was a "liberalized" abortion statute, patterned after the American Law Institute's Model Penal Code, § 230.3 (Proposed Official Draft, 1962). It provided that an abortion was noncriminal if performed by a licensed physician when, "based upon his best clinical judgment," an abortion was necessary because (1) continuing the pregnancy would endanger health or life of the mother; (2) the fetus was likely to have a grave mental or physical defect; or (3) the pregnancy resulted from rape or incest. 410 U.S. at 182-84. Similar statutes were then in effect in about one-fourth of the states. *Id.* at 182 & n.3.

10. 410 U.S. at 113, 147-64.

11. Heymann & Barzelay, *The Forest and the Trees*: Roe v. Wade *and Its Critics*, 53 B.U.L. REV. 765, 765-66 (1973). The Court's reasoning in *Roe* has been discussed extensively. *See, e.g.*, Dellapenna, *Nor Piety Nor Wit: The Supreme Court on Abortion*, 6 COLUM. HUMAN RIGHTS L. REV. 379 (1974-75); Ely, *supra* note 4; Granfield, *The Legal Impact of the Roe and Doe Decisions*, 33 JUR. 113 (1973); Perry, *Abortion, the Public Morals, and the Police Power: The Ethical Function of Substantive Due Process*, 23 U.C.L.A. L. REV. 689 (1976); 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 (1973); 19 CATH. LAW. 36 (1973); 51 N.C.L. REV. 1573 (1973).

12. Roe v. Wade, 410 U.S. at 155.

13. *Id.* at 152.

14. *Id.* at 152-53. The Court noted it had previously recognized individual rights in these areas: marriage (Loving v. Virginia, 388 U.S. 1 (1967)); procreation (Skinner v. Oklahoma, 316 U.S. 535 (1942)); contraception (Eisenstadt v. Baird, 405 U.S. 438 (1972)); and family relationships (Prince v. Massachusetts, 321 U.S. 158 (1944)).

15. 410 U.S. at 153. Justice Brennan, speaking for the Court in Eisenstadt v. Baird,

During the first trimester of pregnancy, the Court held, there was no "compelling state interest" justifying infringement of the woman's right.[16] Because modern medical techniques make first trimester abortion as safe or safer than childbirth, the state cannot justify its intrusion as a protection of the woman's health.[17] Under prevailing medical conditions, said the Court, the first trimester "abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."[18] Physical, emotional, psychological, age, and familial factors all influence this decision:[19]

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases . . . the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.[20]

Roe and *Doe* thus changed the focus of abortion decisionmaking from the state to the woman and her doctor.[21] The Court demonstrated its

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405 U.S. 438 (1972), discussed the "fundamental" right to choose whether to bear children: "If the right to privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion in matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Id.* at 453. *See* Abele v. Markle, 351 F. Supp. 224, 227 (D. Conn. 1972), *vacated on other grounds*, 410 U.S. 951 (1973).

16. 410 U.S. at 163-64. In the second trimester, the state may promulgate abortion regulations that reasonably relate to protecting maternal health. During the final trimester, the state may regulate or proscribe abortion except when it is necessary to protect maternal health. The Court reached these division points by balancing the woman's right to terminate her pregnancy against the legitimate state interest in protecting the woman's health and preserving the potential life of the fetus. Although the former outweighs the latter in the first trimester, as the pregnancy develops and the fetus becomes viable, the latter justifies infringement of the former. *Id.* at 162-65.

17. *Id.* at 149 & n.44. The discussion here is limited to first trimester abortion. State regulation of abortion in later trimesters presents questions not necessary to this Note. Any rules that govern a doctor's liability in the first trimester would also apply to later trimesters subject only to the additional permissible state regulations.

18. *Id.* at 166.

19. Doe v. Bolton, 410 U.S. at 192.

20. Roe v. Wade, 410 U.S. at 153. *See* United States v. Vuitch, 402 U.S. 62, 71-72 (1971) ("health" includes psychological as well as physical well-being).

21. *See* note 18 *supra* and accompanying text. Roe v. Wade states: "[T]he abortion

determination that the woman's doctor play a critical role in the woman's abortion decision by striking down Georgia's procedural limitations, challenged in *Doe*, that interfered with the doctor's exercise of responsibility for the abortion decision.[22] It is this shift in decisionmaking that causes the doctor's present exposure to liability.

Because the *Roe-Doe* abortion guidelines differed radically from the state laws then in effect,[23] state legislatures were compelled to rewrite their abortion statutes. While some states enacted laws conforming to the Supreme Court's directive,[24] others attempted to limit the practical availability of abortion through procedural regulation and financial deprivation.[25] Challenges to these restrictions on abortion have resulted in a second level of abortion cases that attempt to clarify the legal status of a woman's right to obtain an abortion since *Roe* and *Doe*.[26]

The major challenge to state procedural regulation of abortion came in *Planned Parenthood v. Danforth*.[27] The Supreme Court held Missouri's spousal[28] and parental[29] consent requirements unconstitutional because

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decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." 410 U.S. at 164.

22. The portion of the statute that was overturned required certain accreditation for the hospital, approval of a hospital abortion committee, and confirmation by two physicians of the performing doctor's abortion decision. Doe v. Bolton, 410 U.S. at 192-200. The Court said that the requirement of committee approval was "unduly restrictive of the patient's rights and needs" and that it placed an impermissible limitation on "the physician's right to administer" the care he thought was best for the patient. *Id.* at 197-98.

23. *See* note 9 *supra*.

24. Starting with volume 2 (1973), the FAM. PLAN./POPULATION RPTR. has reported on legislation and cases at both the state and federal level concerning abortion regulation.

25. Pilpel & Patton, *Abortion, Conscience and the Constitution: An Examination of Federal Institutional Conscience Clauses*, 6 COLUM. HUMAN RIGHTS L. REV. 279, 282 (1974-75). *See* Bryant, *State Legislation on Abortion After* Roe v. Wade: *Selected Constitutional Issues*, 2 AM. J.L. & MED. 101 (1976); Note, *Implications of the Abortion Decisions: Post Roe and Doe Litigation and Legislation*, 74 COLUM. L. REV. 237 (1974).

26. *See* notes 27-36 *infra* and accompanying text.

27. 428 U.S. 52 (1976). *Danforth* is commented on in 15 J. FAM. L. 537 (1977) and 16 WASHBURN L.J. 462 (1977).

28. In *Danforth*, the Court acknowledged the father's interest in the abortion decision, but said: "Inasmuch as it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy, as between the two, the balance weighs in her favor." 428 U.S. at 71. *See generally* Note, Roe v. Wade: *What Rights the Biological Father?*, 1 HASTINGS CONST. L.Q. 251 (1974); Note, *Abortion: The Father's Rights*, 42 U. CIN. L. REV. 441 (1973).

29. The Court said the parental consent statute was overbroad because it gave parents an absolute veto over the minor's abortion decision. The Court indicated, however, that it was not precluding a parental role in the abortion decision. 428 U.S. at 75. Bellotti v. Baird, 428 U.S. 132 (1976), the companion case to *Danforth*, was remanded for a

the state cannot "delegate to a [third party] a veto power which the state itself is absolutely and totally prohibited from exercising during the first trimester of pregnancy."[30] Missouri's prohibition of saline amniocentesis, an abortion technique, in second trimester pregnancies was also invalidated because, although the state said the prohibition protected maternal health, it had the practical effect of inhibiting most second trimester abortions.[31] The Court, however, upheld a provision requiring a woman's written "informed" consent to an abortion, reasoning that such a requirement for other medical procedures would not be constitutionally defective.[32]

The 1976 *Danforth* decision indicated that the Court would overrule state legislation that had the *effect* of limiting women's access to abor-

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determination of whether the challenged Massachusetts parental consent statute required less burdensome parental consultation. *Danforth* was not the first case to invalidate a parental consent statute. *See, e.g.*, State v. Koome, 84 Wash. 2d 901, 530 P.2d 260 (1975). *See generally* Note, *The Minor's Right to Abortion and the Requirement of Parental Consent*, 60 VA. L. REV. 305 (1974).

30. 428 U.S. at 69. In *Roe*, the Court reserved judgment on the constitutionality of such provisions. 410 U.S. at 165 n.67. Prior to *Danforth*, some lower courts had held both spousal and parental consents invalid. *See, e.g.*, Poe v. Gerstein, 517 F.2d 787 (5th Cir. 1975), *aff'd mem.*, 428 U.S. 901 (1976); Wolfe v. Schroering, 388 F. Supp. 631 (W.D. Ky. 1974), *modified on other grounds*, 541 F.2d 523 (6th Cir. 1976); Doe v. Rampton, 366 F. Supp. 189 (D. Utah), *vacated on other grounds*, 410 U.S. 950 (1973).

31. 428 U.S. at 75-79. The Court based its conclusion on evidence that showed that 68 to 80% of all post-first trimester abortions in the country were done by saline amniocentesis and that there were no practical alternatives. *Id.* at 77. It is suggested here that the Court's refusal to permit Missouri to make a policy decision against the use of saline amniocentesis may be undermined by subsequent Court decisions. *See* notes 33-38 *infra* and accompanying text.

32. 428 U.S. at 65-67. The Akron, Ohio City Council recently enacted an ordinance that requires all abortion patients to sign an informed consent form containing anti-abortion information such as accounts of fetal development. N.Y. Times, Mar. 1, 1978, § A, at 14, col. 6.

The Court also upheld state record-keeping requirements because the records served a legitimate state purpose, 428 U.S. at 79-81. One lower court had said that such a requirement was unconstitutional because records were not required for comparable medical procedures. *See* Doe v. Zimmerman, 405 F. Supp. 534 (M.D. Pa. 1975) (also invalidated parental and spousal consent provisions).

Examples of state regulation of abortion and abortion facilities that were struck down after *Roe* and *Doe* but before *Danforth* include: Hallmark Clinic v. North Carolina Dept. of Human Resources, 519 F.2d 1315 (4th Cir. 1975) (ordinance requiring abortion clinic be affiliated with general hospital); Friendship Medical Center, Ltd. v. Chicago Bd. of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) (regulations concerning abortion facilities); Word v. Poelker, 495 F.2d 1349 (8th Cir. 1974) (special abortion clinic licensing). *See also* Framingham Clinic, Inc. v. Board of Selectmen, — Mass. —, 367 N.E.2d 606 (1977) (town zoning laws forbidding abortion clinic unconstitutionally burden right to first trimester abortion).

tions, but the next year the Court upheld state regulations that effectively denied indigent women their right to abort. *Maher v. Roe*[33] and *Poelker v. Doe*[34] held that state and local governments are not constitutionally compelled either to pay for indigent women's nontherapeutic abortions or to provide municipal hospitals that perform elective abortions although funding or facilities are provided for childbirth. The Court said that these regulations placed "no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion."[35] The state or local government, reasoned the Court, was merely exercising its policy prerogative to encourage childbirth by making it a "more attractive alternative" than abortion.[36] The Court has apparently drawn a constitutional distinction between " 'obstacles' which prevent a decision altogether and 'encouragements' which merely make an alternative decision 'more attractive.' "[37]

Although the distinction drawn by the Court in *Maher* and *Poelker* is tenuous,[38] it enabled the Court to decide the funding cases without

33. 432 U.S. 464 (1977). Beal v. Doe, 432 U.S. 438 (1977) was decided the same day as *Maher*. There the court held that Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1970), did not require funding of nontherapeutic abortions as a condition of participation in the joint federal-state Medicaid program established by that statute. The Court said the question was one of statutory construction, and it concluded that the statute did not require the state to pay for all permissible abortions. The state could refuse to pay for "*unnecessary*—though perhaps desirable—medical services." 432 U.S. at 445. *See* Butler, *The Right to Medicaid Payment for Abortion*, 28 HASTINGS L. J. 931, 953-61 (1977). *See also* HEW regulations on abortion funding in 46 U.S.L.W. 2403 (Feb. 7, 1978).

Prior to these cases, lower courts had invalidated state Medicaid regulations that paid for therapeutic abortion and childbirth expenses, but not elective abortions. *See, e.g.*, Doe v. Rose, 499 F.2d 1112 (10th Cir. 1974); Klein v. Nassau County Medical Center, 409 F. Supp. 731 (E.D.N.Y. 1976), *vacated*, 97 S. Ct. 2962 (1977) (for further consideration in light of *Beal* and *Maher*); Doe v.Westby, 383 F. Supp. 1143 (W.D.S.D. 1974), *vacated on procedural grounds*, 420 U.S. 968 (1975), *aff'd*, 402 F. Supp. 140 (D.S.D. 1975), *vacated*, 97 S. Ct. 2962 (1977) (for reconsideration in light of *Maher* and *Beal*); Roe v. Norton, 380 F. Supp. 726 (D. Conn. 1974); Doe v. Wohlgemuth, 376 F. Supp. 173 (W.D. Pa. 1974). *Cf.* Wulff v. Singleton, 508 F.2d 1211 (8th Cir. 1974), *rev'd on other grounds*, 428 U.S. 106 (1976) (physicians had standing to challenge Medicaid nonpayment of elective abortion expenses on equal protection grounds). *See generally* Butler, *supra*; 5 FAM. PLAN./POPULATION RPTR. 92 (1976).

34. 432 U.S. 519 (1977).

35. Maher v. Roe, 432 U.S. at 474.

36. *Id.*; 432 U.S. at 521.

37. *The Supreme Court, 1976 Term*, 91 HARV. L. REV. 72, 142 (1977).

38. Karst, *The Supreme Court, 1976 Term—Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 59 (1977); *The Supreme Court, 1976 Term, supra* note 37, at 137-46.

overruling *Roe v. Wade* and *Doe v. Bolton*.[39] The Court continues to uphold the basic premise that abortion is a legally recognized alternative to childbirth that cannot be unduly interfered with,[40] and does not appear to be abandoning the view, which can be gleaned from *Roe* and *Doe*, "that abortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy."[41]

II. THE DOCTOR'S DUTY TO DISCLOSE: THE POLICY AND ITS PURPOSE

Medical malpractice, the professional liability of a doctor, has been recognized for at least six centuries.[42] The tort arises when a physician's breach of duty injures his patient.[43] A physician's duty to his patients requires that he possess the degree of skill and learning ordinarily possessed by physicians, and use reasonable care in applying that skill and learning when treating patients.[44]

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39. Maher v. Roe, 432 U.S. at 473-74. *See* Framingham Clinic v. Board of Selectmen, — Mass. —, —, 367 N.E.2d 606, 612 (1977). The Court in *Maher* said it was merely applying the rule of *Roe* and *Doe* to the facts presented. In *Roe* and *Doe* the Court held that only a compelling state interest could justify a sweeping prohibition on the constitutionally protected interest in choosing between birth and abortion; the Court found no such interest present there. In *Danforth*, state restrictions that had the effect of impermissibly interfering with the woman's freedom of choice were struck down. In *Maher*, the Court said the right recognized in *Roe* and *Doe* "can be understood only by considering both the woman's interest and the nature of the state's interference with it." 432 U.S. at 473. Although the cases clearly state that a woman cannot be unduly burdened with interference in exercising her abortion right, the right "implies no limitation on the authority of a state to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds." *Id.* at 474.

40. Although abortion is a legal alternative to pregnancy, the Court has said that "not all distinction between abortion and other procedures is forbidden" and that "[t]he constitutionality of such distinction will depend upon its degree and the justification for it." Bellotti v. Baird, 428 U.S. 132, 149-50 (1976). It is suggested here that although the Court finds certain distinctions permissible when they serve a legitimate state interest, these distinctions do not undermine the legal recognition of the abortion alternative.

41. Roe v. Norton, 408 F. Supp. 660, 663 n.3 (D. Conn. 1975).

42. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 550 (1959).

43. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32 (4th ed. 1971).

44. Rickett v. Hayes, 256 Ark. 893, 904, 511 S.W.2d 187, 195 (1974). *See* W. PROSSER, *supra* note 43, § 32; Note, *Abortion Conscience Clauses* , 11 COLUM. J.L. & SOC. PROB. 571, 577 (1975). The Courts have begun to question physicians' role in setting this standard. *See* Helling v. Carey, 83 Wash. 2d 514, 518-19, 519 P.2d 981, 983 (1974) (en banc), commented on in 1975 B.Y.U.L. REV. 572.

Another type of malpractice, not recognized until the early 1900s, occurs when a doctor performs a medical procedure on a nonconsenting patient.[45] This doctrine developed from the common law of battery;[46] a battery action allows a plaintiff to vindicate his interest in freedom from intentional and unpermitted contacts.[47] Because "[t]he right of a person to protect or disregard his own health is inherent in the basic rights of bodily freedom and individual choice,"[48] a doctor's nonconsensual "touching" of a patient may give rise to a battery action.[49] Battery principles were assimilated into the law governing physician-patient relationships to protect the individual's right to be free from unwanted procedures that the physician thinks are desirable or necessary.[50] A physician's duty to secure consent is thus not obviated by subsequent proper performance of treatment.[51]

The doctor has a fiduciary duty[52] to inform the patient about proce-

45. *See* Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913).

46. Comment, *New Trends in Informed Consent?*, 54 NEB. L. REV. 66, 67 (1975).

47. W. PROSSER, *supra* note 43, § 9.

48. Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754, 755 (1970).

49. *See, e.g.*, cases cited in note 45 *supra*. *See generally* Note, *Advise and Consent in Medicine: A Look at the Doctrine of Informed Consent*, 16 N.Y.L.F. 863, 865 n.5 (1970).

50. Given the historic significance which Anglo-American society places on the inviolability of the human body, it is easy to understand why assault and battery principles were assimilated into the law of physician-patient relationships when no other adequate theory of recovery then existed: the protected interest would be jeopardized if the individual's right to be free from unwanted procedures on his body were made to depend on the subjective intentions or motivations of the physician.

Comment, *supra* note 46, at 68.

51. "The fact that the medical treatment to which there is no consent is not seriously harmful, or is in fact beneficial to the patient, does not excuse the doctor." McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 392 (1957). *See, e.g.*, ZeBarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, 29-30, 499 P.2d 1, 12 (1972); Holt v. Nelson, 11 Wash. App. 230, 237, 523 P.2d 211, 216-17 (1974); 2 F. HARPER & F. JAMES, THE LAW OF TORTS 59 (1956); Note, *supra* note 48, at 754.

52. McCoid, *supra* note 42, at 586-91 (1959); Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639, 651 (1968).

In holding themselves out as experts, the law holds [doctors] to a higher degree of care and skill in dealing with the general public than it would nonprofessionals. This relationship between the professional and the ordinary man is of the highest 'fiduciary' nature. It is one of trust, confidence, candor and scrupulous good faith. This is so because the layman literally places his life in the care of the professional. The law has recognized that the breach of such an extraordinary trust demands a viable remedy.

Note, *supra* note 49, at 863.

dures and obtain her consent to their use. He breaches this duty if he withholds any information that the patient needs to form an intelligent consent to the proposed treatment.[53]

The modern doctrine of "informed consent," which evolved in the late 1950s from the battery cases,[54] is a merger of two fundamental principles of Anglo-American jurisprudence:[55] the fiduciary relationship of the doctor to his patient and the basic right of self-determination[56] articulated in the early consent cases.[57] Informed consent was a logical refinement of the consent requirement: a patient not informed of what he is consenting to has not legally consented.[58] The physician's liability in informed consent cases is based on negligence because it arises from his failure to provide the patient with information necessary to give an informed consent.[59]

See, e.g., Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Miller v. Kennedy, 11 Wash. App. 272, 282, 522 P.2d 852, 860 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

53. Salgo v. Leland Stanford Junior Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

54. *See generally* Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628, 628 n.1 (1970). The refined definition of "consent" is frequently traced to two sources, Salgo v. Leland Stanford Junior Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957), and McCoid, *supra* note 51. *See* Plante, *supra* note 52, at 640-48. Two earlier cases acknowledging a doctor's duty to explain procedures are Theodore v. Ellis, 141 La. 710, 75 So. 655 (1917), and Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360 (1918).

55. Note, *supra* note 49, at 867.

56. Mason v. Ellsworth, 3 Wash. App. 298, 308, 474 P.2d 909, 916 (1970); Note, *supra* note 49, at 867.

57. *See* notes 45-49 *supra* and accompanying text. In Schloendorff v. Society of New York Hosp. 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), Judge Cardozo said: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." 211 N.Y. at 129, 105 N. E. at 93. Other jurists have agreed. *See, e.g.*, Sibbach v. Wilson & Co., 312 U.S. 1, 17-18 (1941) (Frankfurter, J., dissenting); Stack v. New York, N.H. & H.R.R., 177 Mass. 155, 157, 58 N.E. 686, 686 (1900) (Holmes, J.).

58. "[I]t is the prerogative of the patient to choose his treatment. A doctor may not withhold from the patient the knowledge necessary for the exercise of that right. Without it, the prerogative is valueless." Miller v. Kennedy, 11 Wash. App. 272, 283, 522 P.2d 852, 861 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

59. Aiken v. Clary, 396 S.W.2d 668, 673 (Mo. 1965). At one time, courts were divided as to whether an "informed consent" case should be tried on the theory of battery or negligence. The majority of courts now opt for the negligence theory. Downer v. Veilleux, 322 A.2d 82, 89-90 (Me. 1974). In Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970), the court distinguished battery from negligence in medical consent cases:

> Battery is an unlawful touching of another person without his consent. A

Under the modern doctrine of informed consent, the ultimate decision about treatment rests with the patient because of the potential invasion of his physical integrity.[60] The law will not permit a physician who believes that an operation or other treatment is desirable or necessary, "to substitute his own judgment for that of the patient by any form of artifice or deception."[61] The doctor must recognize the "ignorance and helplessness of his patient regarding his own physical condition,"[62] and "supply the patient with the material facts the patient will need in order to intelligently chart [his] destiny with dignity."[63] These facts include a "reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[64]

Although informed consent is the blending of the two concepts discussed above, the cornerstone of the doctrine is the patient's right to self-determination.[65] The doctor's duty to the patient[66] is the legal vehicle that

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> touching with consent, but of a different nature or scope from that to which consent was given, is also battery. [When there was no informed consent] the touching was with consent and was of the same nature and scope as that to which the consent was given, but involved an undisclosed collateral hazard. Cases such as this . . . are deemed to sound in negligence, as raising the question of a neglect of duty required to be observed by a physician in his relationship with his patient.

Id. at 190-91, 473 P.2d at 118-19 (citations omitted). *Accord*, Note, *supra* note 49, at 879-81. *See generally* Note, *supra* note 48, at 764-67.

See, e.g., Cobbs v. Grant, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 7, 104 Cal. Rptr. 505, 512 (1972); Hunter v. Brown, 4 Wash. App. 899, 903, 484 P.2d 1162, 1165 (1971); Trogun v. Fruchtman, 58 Wis. 2d 569, 595-600, 207 N.W.2d 297, 311-13 (1973). *See generally* Kessenick & Mankin, *Medical Malpractice: The Right to be Informed*, 8 U.S.F.L. REV. 261, 263-65 (1973); McCoid, *supra* note 51; Note, *supra* note 48, at 760-68. For a discussion of the difficulties with the negligence standard, see Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 589-92.

60. *See* Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124, 129-30.

61. Natanson v. Kline, 186 Kan. 393, 407, 350 P.2d 1093, 1104, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960) (decision explained).

62. Miller v. Kennedy, 11 Wash. App. 272, 282, 522 P.2d 852, 860 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 337 (1975).

63. *Id.*

64. Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972). *See* cases and articles cited in Dunham v. Wright, 423 F.2d 940, 944 n.6 (1970). "Consent, to be effective, must stem from an understanding decision based on adequate information about the therapy, the available alternatives and the collateral risks." Waltz & Scheuneman, *supra* note 54, at 629 (1970).

65. F. HARPER & F. JAMES, *supra* note 51, at 59; Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189, 189-90 (1961). *See generally* notes 48-51 *supra* and accompanying text. If the state interest in preserving life and health is overwhelming, a court may order compulsory treatment over objections. *See* W. PROSSER, *supra* note 43, § 18, at 102 & n.47.

66. There are two generally recognized exceptions to the full disclosure duty:

implements that policy.[67]

> The very foundation of the doctrine is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.[68]

III. THE CAUSE OF ACTION

In an informed consent action, as in other negligence actions, a plaintiff must prove three elements: that defendant breached his duty to the plaintiff; that defendant's breach of duty proximately caused plaintiff's injury; and that the injury resulted in damage to the plaintiff.[69] In informed consent actions these elements specifically translate to:

> (1) The defendant-doctor failed to inform the plaintiff-patient of alternative treatments, the reasonably foreseeable material risks of each alternative, and of no treatment at all. (2) The plaintiff-patient would have chosen no treatment or a different course of treatment had the alternatives and the material risks of each been made known. (3) The plaintiff has been injured as a result of submitting to the treatment.[70]

A patient who alleges a doctor treated her pregnancy without inform-

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emergency situations where the need for immediate medical treatment outweighs the consent requirement; and, therapeutic privilege where the doctor deems that disclosure would be detrimental to the patient's health. The doctor has the burden of proving the applicability of an exception. *See* Canterbury v. Spence, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Holt v. Nelson, 11 Wash. App. 230, 240-42, 523 P.2d 211, 218-19 (1974); 8 ST. MARY'S L.J. 499, 502-03 (1976).

67. "[The doctor's] duty is based upon the patient's right to information adequate for him to exercise an informed consent to or refusal of the procedure." Wilson v. Scott, 412 S.W.2d 299, 301 (Tex. 1967).

68. F. HARPER & F. JAMES, *supra* note 51, at 61.

69. 48 N.Y.U.L. REV. 548, 549 (1973). *Cf.* W. PROSSER, *supra* note 43, § 30. Prosser, however, divides the negligence action into four elements. First, a duty recognized by the law requiring an individual to conform to a certain standard; second, a failure to conform to that standard; third, a reasonable causal connection between the failure to conform to the standard and the resulting injury; fourth, damage or actual loss to another.

70. Holt v. Nelson, 11 Wash. App. 230, 235, 523 P.2d 211, 216 (1974) (citations omitted); 48 N.Y.U.L. REV. 548, 549 (1973). *See generally* Riskin, *supra* note 59 (difficulties of proof).

ing her about the abortion alternative, that she would have had an abortion if she knew it was available, and that as a result of not aborting she was injured, has stated a cause of action for medical malpractice. Although the ultimate success of the suit depends on evidence at the trial, it should not be dismissed for failure to state a cause of action.

A. *Breach of Duty: The defendant-doctor failed to inform the plaintiff-patient of alternative treatments, the alternative of no treatment, and the reasonably forseeable material risks of each alternative.*

The standard for measuring a physician's duty to disclose is in flux.[71] The traditional and majority rule is the "professional standard,"[72] under which the expert testimony of other physicians defines the customary community standard of disclosure.[73] If the doctor's disclosure meets the standard set by his professional colleagues and the treatment is performed properly, he has met his duty to the plaintiff and is not liable for any injuries to the patient. The rationale for expert testimony establishing the disclosure duty is clear: lay people do not have the expertise to evaluate a physician's conduct. Thus courts allow doctors to adopt their own custom as the standard of due care.[74]

A growing minority of courts,[75] however, skeptical as to whether a

71. The debate concerning which disclosure duty should prevail has been extensively documented elsewhere. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Ditlow v. Kaplan, 181 So. 2d 226 (Fla. 1966); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967); Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973); Plante, *supra* note 52; Waltz & Scheuneman, *supra* note 54; Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967) [hereinafter cited as *Informed Consent*]; Comment, *supra* note 46. *See also* 48 N.Y.U.L. REV. 548 (1973) (proposing a third disclosure standard).

72. *See, e.g.*, cases and jurisdictions cited in Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309, 309 n.1 (1976); DiFilippo v. Preston, 53 Del. 539, 549-50, 173 A.2d 333, 339 (1961). For a discussion criticizing *DiFilippo* and the medical standard, see 75 HARV. L. REV. 1445 (1962). The "professional standard" is also frequently called the "medical standard."

73. McCoid, *supra* note 42, at 606.

74. Although custom is usually no defense to a suit for negligence, the medical profession enjoys the privilege of adopting its own custom as the standard of due care. This is justified as being the only workable test in an area where the lay person is thought incapable of evaluating a doctor's conduct and where the courts want to allow doctors a great deal of discretion. Expert testimony is required because lay people do not know what the custom is.

Informed Consent, supra note 71, at 1401 (footnotes omitted).

75. *See, e.g.*, jurisdictions and cases cited in Seidelson, *supra* note 72, at 310 n.2.

community standard actually exists, cognizant of the "conspiracy of silence" among doctors, and concerned that physicians have too much discretion, have abandoned the professional standard.[76] The latter concern prompted the abandonment of the professional standard in the leading case of *Canterbury v. Spence*[77] in which the court adopted a "legal standard" of disclosure,[78] reasoning that a "standard set by law for physicians rather than one which physicians may or may not impose upon themselves" is necessary to preserve the patient's self-determination right.[79] The scope of the physician's duty in a legal standard jurisdiction is measured by the patient's need because the patient's right to self-decision "can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."[80]

Courts applying the legal standard have determined that the "patient's right to make up his mind should not be delegated to a local medical group—many of whom have no idea as to his informational needs. The doctor-patient relationship is a one-on-one affair."[81] This approach to the physician's disclosure duty radically alters the plaintiff's burden of proof in informed consent suits. The trier of fact can find the physician failed to make a *reasonable* disclosure even though the medical community may consider the disclosure adequate.[82]

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76. 1974 UTAH L. REV. 851, 853. *See* Cobbs v. Grant, 8 Cal. 3d 229, 238, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); *Informed Consent, supra* note 71, at 1404-06; Note, *Overcoming the "Conspiracy of Silence": Statutory and Common Law Innovations*, 45 MINN. L. REV. 1019, 1021-24 (1961); 8 ST. MARY'S L. REV. 499, 506-10 (1976).

77. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

78. Although *Canterbury* is the leading case rejecting the "professional standard," Seidelson, *supra* note 72, at 318 n.20, it is only the peak of a movement away from the professional standard. Four cases began the transition: Berkey v. Anderson, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969); Getchell v. Mansfield, 260 Or. 174, 489 P.2d 953 (1971); Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971); Hunter v. Brown, 4 Wash. App. 899, 484 P.2d 1162 (1971). Immediately after *Canterbury*, three other courts abandoned the professional standard. Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Fogal v. Genesee Hospital, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972). *See* Comment, *supra* note 46.

79. 464 F.2d at 784 ("[T]o safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.").

80. *Id.* at 786-87.

81. Wilkinson v. Vesey, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972).

82. Zeleznik v. Jewish Chronic Disease Hosp., 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (1975). *Accord*, F. HARPER & F. JAMES, *supra* note 51, at 6. New York's endorsement of *Canterbury* was short-lived. In informed consent cases that accrue after July 1, 1975 expert testimony is necessary to establish the standard of care. N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney Supp. 1976).

A reasonable disclosure must include an explanation of the proposed treatment or procedure and the material risks incident to it.[83] In *Canterbury*, the court ruled that a risk was material "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."[84]

For consent to be informed, a patient must also be advised of alternative treatments or procedures.[85] The importance of knowing the alternatives is obvious: the consent to taking risks incident to the proposed treatment is not informed if the patient does not know of any alternatives to taking the risks.[86] Because due care "may oblige the physician to advise the patient of the need for or the desirability of any alternative treatment promising greater benefit than that being pursued,"[87] the physician's inability to perform the alternative treatment does not obviate his duty to inform the patient of it.[88]

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83. Canterbury v. Spence, 464 F.2d 772, 787-88 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cooper v. Roberts, 220 Pa. Super. 260, 267, 286 A.2d 647, 650 (1971); Bucklin, *Informed Consent: Past, Present and Future* in LEGAL MEDICINE ANNUAL: 1975 (C. Wecht ed. 1975); 8 ST. MARY'S L. REV. 499, 504 (1976).

84. 464 F.2d at 787 (quoting Waltz & Scheuneman, *supra* note 54, at 639-40). *Accord*, Holland v. Sisters of St. Joseph of Peace, 270 Ore. 129, 522 P.2d 208, *vacated on other grounds*, 270 Ore. 129, 526 P.2d 577 (1974), commented on in 1974 UTAH L. REV. 851.

85. *See* sources cited note 83 *supra*; Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 434, 88 N.W.2d 186, 190 (1958); Gray v. Grunnagle, 423 Pa. 144, 157-58, 223 A.2d 663, 670 (1966). *Gray* is commented on in 41 DICK. L. REV. 675 (1967). *Gray's* emphasis on alternatives continues to be cited with approval by courts applying Pennsylvania law. *See, e.g.*, Harrigan v. United States, 408 F. Supp. 177, 187-89 (E.D. Pa. 1976).

86. Dunham v. Wright, 423 F.2d 940, 944 (3d Cir. 1970) (applying Pennsylvania law). *See also* Kessenick & Mankin, *supra* note 59, at 279-80; Note, *supra* note 48, at 771-72.

87. 464 F.2d at 781. *See* C. KRAMER, MEDICAL MALPRACTICE 13 (4th ed. 1976).

88. If a "physician knows that there is another mode of treatment that is more likely to be successful, which he does not have the facilities or the training to give, but which is available from specialists, it is his duty to advise his patient of these facts." Rahn v. United States, 222 F. Supp. 775, 780 (S.D. Ga. 1963) (quoting Annot., 132 A.L.R. 379, 394 (1941)). *See generally* Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 799 (1970); McCoid, *supra* note 42, at 597-98; Annot., 35 A.L.R. 3d 349 (1971).

The American Medical Association's principles of ethics provide: "A physician should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of medical services may be enhanced thereby." C. KRAMER, *supra* note 87, at 13 n.23 (quoting THE AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 8).

A physician treating a woman for pregnancy has a fiduciary duty to inform her about the proposed treatment and obtain informed consent before proceeding.[89] Pregnancy and childbirth have inherent risks,[90] and each method of delivery poses particular dangers.[91] The physician's duty to his pregnant patient includes the obligation to explain the material risks and alternatives to the proposed treatment.[92]

In either a professional[93] or legal standard[94] jurisdiction, the plaintiff has the burden of proving the doctor's disclosure was inadequate. Although a court using the professional standard might reject plaintiff's allegation that doctors in the community customarily inform pregnant patients of their abortion alternative, that determination must be based on expert testimony at trial concerning the custom of the local medical community.[95] It is not grounds for dismissing plaintiff's cause of action.[96]

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89. *See* notes 52-53 *supra* and accompanying text. "If disclosure sufficient to assure informed consent to therapy is the legal norm, then this principle should encompass the patient's right to receive information which will provide informed consent to non-therapy—that is, the carrying of the fetus to term." Friedman, *Legal Implications of Amniocentesis*, 123 U. PA. L. REV. 92, 147 (1974).

90. The Supreme Court did not dispute a lower court's finding

> that normal pregnancy, while not either a "disease" or an "accident," was disabling for a period of six to eight weeks, that approximately "[t]en percent of pregnancies are terminated by miscarriage, which is disabling," and that approximately 10% of pregnancies are complicated by diseases which may lead to additional disability.

General Elec. Co. v. Gilbert, 429 U.S. 125, 130 (1976) (citing 375 F. Supp. 367 (E.D. Va. 1974)) (footnotes omitted). *See generally* Douglas, *Prenatal Risks: An Obstetrician's Point of View* in RISKS IN THE PRACTICE OF MODERN OBSTETRICS (S. Adaljem ed. 1972). *See also* C. KRAMER, *supra* note 87, at 140-41 (there are certain procedures a doctor should follow to ensure that his patient gets proper predelivery care).

It can be argued that usual principles of medical jurisprudence should not apply to pregnancy because pregnancy is different from other medical conditions. One commentator has refuted this by pointing out that people go to doctors to have their former state restored, but that with a pregnant woman, society insists she will be damaged physically and psychologically if the treatment restores her former state, her bodily integrity. To a woman with an unwanted pregnancy, an abortion is the only treatment that will restore her former state of integrity. J. SALTMAN & S. ZIMERING, ABORTION TODAY 114 (1973).

91. *See, e.g.*, Shack v. Holland, 3 FAM. L. REP. (BNA) 2146 (N.Y. Sup. Ct. Kings County, Dec. 7, 1976).

92. *See* note 64 *supra* and accompanying text. *See generally* Annot., 69 A.L.R.3d 1250 (1976).

93. *See* notes 72-74 *supra* and accompanying text.

94. *See* notes 77-80 *supra* and accompanying text.

95. *See* note 73 *supra* and accompanying text.

96. When a motion is addressed to the sufficiency of the complaint, "the accepted rule [is] that a complaint should not be dismissed for failure to state a claim unless it

In a legal standard jurisdiction the plaintiff must allege that the doctor failed to disclose all the information relevant to her consent.[97] Dismissal of the complaint in a legal standard jurisdiction would be tantamount to finding that, as a matter of law, a physician does not have a duty to discuss abortion with his patient. That conclusion is unsupportable: Abortion is a feasible alternative to childbirth;[98] in many situations the abortion alternative is relevant to the patient; and, a physician's failure to discuss it infringes the patient's right of self-determination because it may lead her to believe she has no choice but to have the child.

In 1973, the Supreme Court recognized abortion as a lawful alternative to childbirth[99] and it is now a recognized, safe, and commonly employed medical procedure. Approximately 1.1 million abortions are performed annually in the United States.[100] Since 1969, one in fourteen women of childbearing age in this country not only considered abortion an alternative, but have chosen it over childbirth.[101] Abortion is as safe or safer than childbirth,[102] and is cheaper.[103] Because abortion is an alternative to pregnancy, a physician should include it in his comparative analysis of modes of treatment for pregnancy. Medical ethics,[104] the constitutional premise of the abortion decisions,[105] and the common law duty to inform[106] support this notion.

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appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46 (1957).

97. *See* note 80 *supra* and accompanying text.

98. 1974 UTAH L. REV. 851, 857-58. It has generally been assumed that only an expert could determine whether an alternative is feasible. Downer v. Veilleux, 322 A.2d 82, 92 (Me. 1974). But the present trend in medical malpractice cases is to require expert testimony only when the issue is beyond "ordinary human knowledge and experience." Canterbury v. Spence, 464 F.2d at 792. Expert testimony may be necessary if the doctor answers that in the particular case abortion was not feasible.

99. *See* section I *supra*.

100. St. Louis Post-Dispatch, Nov. 28, 1977, § B, at 4, col. 1.

101. ZERO POPULATION GROWTH, THE RIGHT TO CHOOSE: FACTS ON ABORTION (Dec. 1976) (reporting on Dept. of Health, Education, and Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1974 (May 1975)).

102. Roe v. Wade, 410 U.S. 113, 149 (1973). *See* St. Louis Post-Dispatch, Jan. 31, 1977, § A, at 6, col. 1. In 1972-74 there were 1.7 deaths per 100,000 first trimester abortions. There were 14.8 deaths per 100,000 live childbirths. *Id.* Doctors do not say abortion procedure is difficult, but complain that it is "boring." *See* J. SALTMAN & S. ZIMERING, *supra* note 90, at 103.

103. Butler, *supra* note 33, at 949 n.122.

104. *See* note 110 *infra* and accompanying text.

105. *See* notes 111-13 *infra* and accompanying text.

106. *See* notes 114-15 *infra* and accompanying text.

Many people, including physicians, have moral or religious convictions about abortion. The Supreme Court acknowledged this in the preface to *Roe v. Wade*,[107] but it nevertheless placed the responsibility on doctors—as professionals—to aid the patient's abortion decision.[108] Although statutes protect a physician's right to choose not to *perform* abortions,[109] a physician who will not *discuss* abortion as an alternative treatment because of his religious beliefs may be violating the American Medical Association's ethical canon that prohibits the practice of sectarian medicine.[110]

To allow the doctor effectively to veto the woman's abortion choice by not discussing abortion with her could also undermine the constitutional premise of *Roe* and *Doe*. Although those opinions emphasized the physician's role in the abortion decision, abortion was legalized because of the woman's privacy right. Professor Tribe, in analyzing *Roe*, criticized making the physician's opinion paramount in the abortion decision:

> To be sure, there is much in [*Roe* and *Doe*] that can be read to suggest a desire to make the ultimate decision that of a medical expert. . . . But any notion that the doctor, or some other disinterested expert, is in a better position than the woman and her family, *by virtue of such*

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107. 410 U.S. 113 (1973).

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.

Id. at 116.

108. *See* notes 19-22 *supra* and accompanying text.

109. *See* section IV *infra*.

110. Pilpel, *A Non-Catholic Lawyer's View* in 1 ABORTION IN A CHANGING WORLD 158-59 (R. Hall ed. 1970) (citing AMA CANONS OF ETHICS).

The irrelevance of a physician's religious beliefs in a medical malpractice action can be illustrated by a hypothetical. An obstetrician becomes a Christian Scientist, and, because of his personal aversion to surgery, neither performs Caesarean section deliveries nor refers patients to doctors who do. His patient, who needed a Caesarean delivery, is injured as a result of the normal delivery and she sues the doctor for damages arising from his alleged negligence. It is doubtful whether the physician could avoid liability by using his religious objections to Caesareans as a defense. Although a doctor who follows a course of treatment recognized by a legitimate school of medicine is not liable merely because another alternative might have been more successful, this "alternative treatment" doctrine would probably not protect a doctor whose judgment was based on religious, and not medical, grounds. *See* Note, *supra* note 3, at 577-78.

> *disinterest and expertise*, not only to provide advice and consultation but also to make the final choice with respect to whether the family should have and raise a child [is] a denial of the underlying first amendment premise that groups should ordinarily have the role of making their own ultimate associational choices informed and perhaps influenced, but not forced, by others.[111]

In light of *Planned Parenthood v. Danforth*,[112] which held that a woman's spouse or parents had no right to veto her decision to obtain an abortion, it would be unreasonable to allow a physician, who has no personal interest in either the potential life of the fetus or the woman carrying the child, to effectively exercise a veto by not presenting the abortion option to his patient. It is suggested here that the same privacy interest that prevents the state from enacting laws giving parents or spouses a veto over the woman's abortion decision prevents the state from sanctioning the physician's nondisclosure of the alternative by dismissing plaintiff's action against him.[113]

A physician in a legal standard jurisdiction has a common law duty to disclose all facts, risks, and alternatives that a reasonable person in the patient's situation would deem significant in determining whether to undergo treatment.[114] Most pregnant women desire to carry their pregnancies to term; a physician might determine a reasonable patient in that position would not consider the abortion option significant.[115] Then, if the patient is injured by childbirth, the physician can show he fulfilled his duty by disclosing all the risks and alternatives that his patient would

111. Tribe, *The Supreme Court, 1972 Term—Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 37 (1973); *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15.10 (1978).

112. *See* notes 27-32 *supra* and accompanying text.

113. The doctor's failure to disclose the abortion alternative can be distinguished in at least two ways from the parental and spousal vetoes outlawed in *Danforth*. First, *Roe* and *Doe* recognized the doctor's crucial role in the abortion decision (*see* note 21 *supra* and accompanying text), but did not discuss the role of the parents or spouse. Second, the doctor's non-disclosure affects the woman's decisionmaking process, whereas the parental or spousal provisions in the Missouri statute allowed for a veto of the woman's decision after it has been made.

114. Cooper v. Roberts, 220 Pa. Super. 260, 266, 286 A.2d 647, 650 (1971). *See also* Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Miller v. Kennedy, 11 Wash. App. 272, 282, 522 P.2d 852, 860, *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975); W. PROSSER, *supra* note 43, § 32, at 165-66 ; 48 N.Y.U.L. REV. 548, 553 (1973); 1974 UTAH L. REV. 851, 859.

115. "Disclosure of alternative treatment means disclosure of alternatives for the particular patient and not a recital of medical casebook theory." Dunham v. Wright, 423 F.2d 940, 946 (3d Cir. 1970).

have deemed significant although he did not discuss abortion. But a reasonable patient carrying an unwanted child would consider the option to abort significant. When a patient asks the physician about abortion,[116] tells him she does not want the child, or displays any distress about the pregnancy,[117] he has a duty to disclose information about the abortion alternative.[118]

No plaintiff has yet alleged that a physician breached his duty to inform her of the abortion alternative *per se.* Some courts, however, have upheld a cause of action against a physician who deprived his patient of information necessary for her to decide whether to exercise her abortion option, and thus recognized that abortion is a legally protected alternative.[119]

Parents have had mixed success when seeking damages for the "wrongful birth"[120] of a healthy baby.[121] In these suits, parents allege

116. A doctor who refuses to refer a patient requesting an abortion to a doctor who performs abortions may be violating his duty of due care. *See* notes 87-88 *supra*.

117. *Roe* said it was unconstitutional to consider maternal life and health the only medical justifications for abortion. *See* notes 19-20 *supra* and accompanying text. One commentator has suggested that the Court's guidelines were so broad that they were "apparently taking the position that every pregnant woman has the right to privacy to obtain an abortion independently of any *specific* physical, psychological, or social threat to her wellbeing because of her pregnancy." Ryle, *Some Sociological and Psychological Reflections on the Abortion Decisions*, 33 JUR. 218, 224 (1973). Another said: "[T]here are no clear medical indications for abortion in the vast majority of cases. Where there are no indications, there is no room for clinical judgment." Ely, *supra* note 11, at 922 n.22 (quoting Stone, *Abortion and The Supreme Court* in MODERN MEDICINE, Apr. 30, 1973).

118. The duty to inform can also arise when the woman wants the child, but has not been informed of the likelihood she is carrying a defective fetus: ignorance of the risks causes her lack of interest in abortion. *See* notes 131-78 *infra* and accompanying text.

119. *See* notes 120-78 *infra* and accompanying text.

120. There is a great deal of confusion in terminology concerning torts brought against a defendant for having "caused" the birth of an unwanted infant. "Wrongful birth," "wrongful pregnancy," and "wrongful life" are often used interchangeably by commentators and courts, but are distinct. *See generally* Kashi, *The Case of the Unwanted Blessing: Wrongful Life*, 31 U. MIAMI L. REV. 1409 (1977); Comment, *Busting the Blessing Balloon: Liability for the Birth of an Unplanned Child*, 39 ALB. L. REV. 221 (1975) [hereinafter cited as *Busting the Balloon*]; Comment, *Wrongful Birth: The Emerging Status of a New Tort*, 8 ST. MARY'S L.J. 140 (1976) [hereinafter cited as *Wrongful Birth*].

In this Note, "wrongful birth" indicates the plaintiff alleges that the defendant's breach of duty prevented plaintiff from terminating her pregnancy. The resulting birth is therefore characterized as "wrongful." *See, e.g.*, Rieck v. Medical Protective Co., 64 Wis. 2d 514, 219 N.W.2d 242 (1974), discussed in notes 122-27 *infra* and accompanying text.

"Wrongful pregnancy" is an action brought by the woman alleging that defendant's breach of duty "caused" her pregnancy, and therefore it was "wrongful." *See, e.g.*, Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967), discussed in notes 211-16 *infra* and accompanying text.

that a physician's negligent failure to diagnose the woman's pregnancy deprived them of their right to abort the child within a reasonable time.

The Wisconsin Supreme Court, in *Reick v. Medical Protective Co.*,[122] rejected the claim, and held that even when the chain of causation between the doctor's negligence and the patient's injury is complete and direct, recovery can be denied on public policy grounds.[123] The court did

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This Note is concerned with these two situations where either the mother or both parents bring suit. These are distinguished from "wrongful life" suits, where the plaintiff is the infant alleging defendant's breach of duty "wrongfully" caused the infant's birth. Courts have generally denied relief to infant plaintiffs for "wrongful life":

> [T]here is no remedy for having been born under a handicap, whether physical or psychological, when the alternative to being born in a handicapped condition is not to have been born at all. To put it another way, a plaintiff has no remedy against a defendant whose offense is that he failed to consign the plaintiff to oblivion. Such a cause of action is alien to our system of jurisprudence.

Stewart v. Long Island College Hosp., 58 Misc. 2d 432, 436, 296 N.Y.S.2d 41, 46 (Sup. Ct. 1968), *modified*, 35 App. Div. 2d 531, 313 N.Y.S.2d 502 (1970), *aff'd*, 30 N.Y.2d 695, 283 N.E.2d 616, 332 N.Y.S.2d 640 (1972).

Other courts have used the same reasoning to deny relief to infants who allege that their own life is "wrongful." *See, e.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976) (against doctor for negligent abortion resulting in plaintiff's birth); Pinkney v. Pinkney, 198 So. 2d 52 (Fla. Dist. Ct. App. 1967); Zepeda v. Zepeda, 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963), *cert. denied*, 379 U.S. 945 (1965) (against father for being born illegitimately); Gleitman v. Cosgrove, 49 N.J. 22, 227 A.2d 689 (1967) (against doctor who did not tell mother of risks of rubella that resulted in plaintiff's deformity); Williams v. State, 78 N.Y.2d 481, 223 N.E.2d 343, 276 N.Y.S.2d 885 (1966) (against state for not protecting mother from a sexual assault in a state institution that resulted in plaintiff's birth); Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975) (rubella). *But see* Jorgenson v. Meade Laboratories, Inc., 483 F.2d 237 (10th Cir. 1973) (action by mongoloid children for birth defects caused by drugs upheld); Renslow v. Mennonite Hosp., 67 Ill. 2d 348, 367 N.E.2d 1250 (1977) (infant with brain damage caused by negligent blood transfusion to his mother prior to conception has action against doctor); Sylvia v. Gobelle, 101 R.I. 76, 220 A.2d 222 (1966) (infant has action against doctor for improper treatment of mother's rubella during pregnancy). *Cf.* Arnoff v. Snider, 292 So. 2d 418 (Fla. Dist. Ct. App. 1974) (child has action against doctor when infant brother born after negligent sterilization of mother by doctor); Park v. Chessin, 88 Misc. 3d 222, 387 N.Y.S.2d 204 (1976), *modified and aff'd*, — App. Div. —, 400 N.Y.S.2d 110 (1977) (infant's action for damages, suffered after birth allowed). *See generally* Tedeschi, *Tort Liability for "Wrongful Life,"* 7 J. FAM. L. 465 (1967); Note, *"Wrongful Life"—A New Tort?*, Williams v. State, 17 HASTINGS L.J. 400 (1966); Annot., 22 A.L.R. 3d 1441 (1968).

121. *See* notes 122-30 *infra* and accompanying text. In these suits, the plaintiff did not discover that she was pregnant until the second trimester and second trimester abortion is a more risky medical procedure than first.

122. 64 Wis. 2d 514, 219 N.W.2d 242 (1974).

123. *Id.* at 517-18, 219 N.W.2d at 244. The court said that any one of six public policy grounds could bar recovery even when causation was established:

> (1) The injury is too remote from the negligence; or (2) the injury is too wholly out of proportion to the culpability of the negligent tort-feasor; or (3) in retro-

not discuss the illegality of abortion at the time of the alleged tort,[124] but did object to the anomaly recovery would create: the physician would support the child while the parents enjoyed the benefits of parenthood.[125] The amount of damages would also be disproportionate to the culpability involved.[126] Because the claim was based on the parents' intent to abort, the court feared that sustaining it, "would open the way for fraudulent claims and would enter a field that has no sensible or just stopping point."[127]

In *Ziemba v. Sternberg*,[128] a New York appeals court, faced with the same issue, denied defendant's motion to dismiss plaintiff's claim. The court, acknowledging a woman's abortion right under state law at the time of the alleged tort,[129] analyzed plaintiff's action like any other medical malpractice claim:

> When . . . as one of the consequences of defendant physician's lack of reasonable care, plaintiff was not advised of her pregnancy so that she could terminate it within a reasonable time, as she was entitled to do, . . . we believe the damages subsequently sustained by her and her

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spect it appears too highly extraordinary that the negligence should have brought about the harm; or (4) because allowance of recovery would place too unreasonable a burden (in the case before us, upon physicians and obstetricians); or (5) because allowance of recovery would be too likely to open the way for fraudulent claims; or (6) allowance of recovery would enter a field that has no sensible or just stopping point.

Id.

124. Prior to *Roe* and *Doe*, some courts said that the illegality of abortion barred recovery when the plaintiff claimed she would have had an abortion but for the doctor's breach of duty. *See, e.g.*, note 140 *infra* and accompanying text.

125. Rieck v. Medical Protective Co., 64 Wis. 2d 514, 519, 219 N.W.2d 242, 245 (1974). The Wisconsin court thus endorsed the "benefit" theory as a justification for denying the parents recovery despite the defendant's negligence. *See* notes 198-210 *infra*.

126. 64 Wis. 2d at 519, 219 N.W.2d at 245.

127. *Id.*

128. 45 App. Div. 2d 230, 357 N.Y.S.2d 265 (1975). *Accord*, Debora S. v. Sapega, 56 App. Div. 2d 841, 392 N.Y.S.2d 79 (1977); Chapman v. Schultz, 47 App. Div. 2d 806, 367 N.Y.S.2d 1018 (1975). *See generally* Fuchsberg & Fuchsberg, *Torts*, 26 SYRACUSE L. REV. 475, 481-82 (1975).

129. 45 App. Div. 2d at 232, 357 N.Y.S.2d at 268. The court rejected defendant's reliance on an earlier New York case, Stewart v. Long Island College Hosp., 58 Misc. 2d 432, 296 N.Y.S.2d 41 (Sup. Ct. 1968), *modified*, 35 App. Div. 2d 531, 313 N.Y.S.2d 502 (1970), *aff'd*, 30 N.Y.2d 695, 283 N.E.2d 616, 332 N.Y.S.2d 640 (1972), discussed in notes 140-44 *infra* and accompanying text. The court said a "substantially different legal environment" existed when the alleged tort in *Ziemba* occurred, because New York had legalized abortion. *See* Cox v. Stratton, 77 Misc. 2d 155, 161, 352 N.Y.S.2d 834, 841-42 (1974) (the reason for rejecting the cause of action in *Stewart* no longer exists).

husband may be the natural consequence of defendant's malpractice for which recovery will lie.[130]

Parents of children born with birth defects have also sought damages in "wrongful birth"[131] suits against physicians. In these cases, the parents' allegation is that the physician's negligence was his failure to tell them of the mother's risk—either because she contracted rubella during pregnancy[132] or because she had a high risk of carrying genetic defects[133]—of giving birth to a deformed child. Had they known of the risks, the plaintiffs claimed they would have aborted the fetus.[134]

In 1967, the New Jersey Supreme Court, in *Gleitman v. Cosgrove*,[135] said a deformed infant's parents had no cause of action against a doctor for failing to inform the pregnant mother, who had contracted rubella, of the dangers to the fetus. The court upheld the dismissal of the mother's claim for emotional distress caused by her son's condition and the father's claim for costs incurred in caring for the child.[136] The court said it was irrelevant whether the abortion, plaintiff was denied the opportunity of obtaining, would have been legal,[137] because the conduct complained of did "not give rise to damages cognizable at law; and, even if such alleged damages were cognizable, a claim for them would be precluded by the countervailing public policy supporting the preciousness of human life."[138] The dissent argued that the doctor was under a legal duty to tell

130. 45 App. Div. 2d at 233, 357 N.Y.S.2d at 269. The dissent argued that the "blessing concept" denied plaintiffs who wanted to keep the child from recovering damages. *Id.* at 234-35, 357 N.Y.S.2d at 270-71. *See* notes 198-210 *infra* and accompanying text.

131. It has been suggested that such suits should not be called "wrongful birth" because the parent is not complaining of the birth itself, but rather of the deformed life that resulted. *See Wrongful Birth*, *supra* note 120, at 151-52.

132. Rubella is commonly known as German measles. A woman who has rubella during pregnancy runs a 10-50% chance of having a deformed child. *See* Gleitman v. Cosgrove, 49 N.J. 22, 45, 227 A.2d 689, 701 (1967) (concurring opinion).

133. *See* note 157 *infra* and accompanying text.

134. *See* notes 135-54 *infra* and accompanying text.

135. 49 N.J. 22, 227 A.2d 689 (1967) (4 to 3 decision). For a discussion of the "rubella baby" cases, see Kashi, *supra* note 120, at 1426-29; *Wrongful Birth, supra* note 120, at 1151-54.

136. 49 N.J. at 29-31, 227 A.2d at 692-94. A claim on behalf of the infant was also dismissed. *See* note 120 *supra*. *See also* Smith v. United States, 392 F. Supp. 654 (N.D. Ohio 1975) (applying Texas law) (infant's case against doctor who failed to diagnose pregnant mother's rubella dismissed).

137. Gleitman v. Cosgrove, 49 N.J. 22, 31, 227 A.2d 689, 693-94 (1967). The *Gleitman* concurrence concluded that performing a eugenic abortion in this case would have been criminal. *Id.* at 40, 227 A.2d at 699.

138. *Id.* at 31, 227 A.2d at 693. The *Gleitman* decision has been criticized because it denied recovery based on the difficulty of ascertaining damages and public policy. *See,*

the mother of the high incidence of abnormal births, and that releasing him from liability encouraged professional irresponsibility.[139]

Five years later, New York's highest court affirmed a decision that parents of a deformed child had no cause of action against a hospital that failed to perform a therapeutic abortion on the mother who contracted rubella during pregnancy.[140] The hospital had assured the mother she did not need a therapeutic abortion and should not seek one elsewhere, although two of four physicians on the hospital's abortion committee thought the procedure should be performed. The trial court had held that the hospital breached its duty to disclose the risks of the proposed treatment.[141] The appellate court overturned the jury verdict for the parents on two grounds:[142] first, public policy declared the proposed abortion to be illegal;[143] and, second, citing *Gleitman*, the court said it was impossible to evaluate the damages.[144]

In 1975, two state supreme courts recognized the right of action denied to parents in *Gleitman*. The Texas Supreme Court, in *Jacobs v. Theimer*,[145] held that parents of a rubella syndrome infant had a cause of action against a physician who failed to inform the pregnant mother that she had contracted rubella and might give birth to a deformed child, thus depriving her of an opportunity to have an abortion. The appellate court[146] had reasoned that because abortion was illegal in Texas when the alleged tort occurred, the physician had no duty to provide information giving the parents the option to choose abortion. To hold the physician to that duty would violate public policy and perhaps make him an accomplice to

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e.g., Capron, *Informed Decisionmaking in Genetic Counseling: A Dissent to the "Wrongful Life" Debate*, 48 IND. L.J. 581, 595-98 (1973); Kashi, *supra* note 120, at 1426-27; Note, *A Cause of Action For "Wrongful Life": [A Suggested Analysis]*, 55 MINN. L. REV. 58 (1970); 20 ME. L. REV. 143 (1968).

139. 49 N.J. at 49, 227 A.2d at 703.

140. Stewart v. Long Island College Hosp., 58 Misc. 2d 432, 296 N.Y.S.2d 41 (Sup. Ct. 1968), *modified*, 35 App. Div. 2d 531, 313 N.Y.S.2d 502 (1970), *aff'd*, 30 N.Y.2d 695, 283 N.E.2d 616, 332 N.Y.S.2d 640 (1972).

141. 58 Misc. 2d 432, 437-39, 296 N.Y.S.2d 41, 46-48 (Sup. Ct. 1968). The trial court dismissed the first cause of action brought for the infant. *See* note 120 *supra*.

142. 35 App. Div. 2d 531, 313 N.Y.S.2d 502 (1970).

143. *Id.* at 532, 313 N.Y.S.2d at 503.

144. *Id.* at 532, 313 N.Y.S.2d at 503-04. For criticism of *Stewart*, see sources cited in note 138.

145. 519 S.W.2d 846 (Tex. 1975). For an excellent analysis of the significance of *Jacobs*, see Kass & Shaw, *The Risk of Birth Defects:* Jacobs v. Theimer *and Parents' Right to Know*, 2 AM. J.L. & MED. 213 (1977).

146. The appellate court affirmed the trial court's granting of defendant's motion for summary judgment. 507 S.W.2d 288 (Tex. Ct. App. 1974).

criminal abortion.[147] The Texas Supreme Court reversed, and said that the physician had a duty to disclose his diagnosis and the "risk of the proposed treatment in continuing the pregnancy" as a reasonable medical practitioner would have done under the circumstances.[148] The fulfillment of his duty to inform—as opposed to either performing or telling the patient where to obtain an illegal abortion—would not expose the physician to criminal liability.[149] The parents' recoverable damages were the difference between raising a healthy child and raising a child with physical defects.[150]

A similar cause of action was recognized by the Wisconsin Supreme Court in *Dumer v. St. Michael's Hospital*.[15] The court upheld a damage claim[152] against a physician who had treated the pregnant plaintiff, in an emergency room, for a body rash. She alleged the physician failed to diagnose her rubella, fulfill his duty to inquire whether she was pregnant and, if she were, explain the risks of rubella syndrome to her.[153] The physician did not, however, have a duty to inform the patient about the abortion alternative because the decision to abort is a moral one for the parents to make free from the doctor's influence. The woman, said the court, did not have an unqualified right to an abortion at that time, thus the availability of abortion required a legal opinion "which the doctor was not required, or perhaps even competent, to give."[154]

147. *Id.* at 290-92.

148. 519 S.W.2d at 848 (Tex. 1975).

149. *Id.*

150. *Id.* at 849. The amount of recoverable damages after liability has been determined has been the subject of much controversy. *See* Kass & Shaw, *supra* note 145, at 227-39; Tedeschi, *On Tort Liability for Wrongful Life*, 1 ISRAEL L. REV. 513 (1966); 20 ME. L. REV. 143 (1968).

151. 69 Wis. 2d 766, 233 N.W.2d 372 (1975). The court distinguished this case from Reick v. Medical Protective Ass'n, 64 Wis. 2d 514, 219 N.W.2d 242 (1974), discussed in notes 122-27 *supra* and accompanying text. Parents in *Reick* sought the expenses of raising a healthy child, whereas parents in *Dumer* wanted only the expenses related to the child's deformed condition. 69 Wis. 2d at 774-75, 233 N.W.2d at 376.

152. *Dumer*, like *Jacobs*, limited the damages to the expenses incurred because of the child's deformity. Both courts said the difficulty of measuring damages when a healthy baby is born were not the same as measuring the damages parents of a deformed child incur. The difference in cost between raising a healthy baby and a deformed baby is ascertainable. Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975); Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975).

153. 69 Wis. 2d at 775, 233 N.W.2d at 377.

154. *Id.* at 775, 233 N.W.2d at 377. The court also found that the infant had no cause of action against the doctor because damages for wrongful life were not ascertainable. *Id.* at 771-73, 233 N.W.2d at 374-76. *See* note 120 *infra*.

Parents of genetically deformed infants have begun to bring suits analogous to the rubella baby cases.[155] Changes in public attitudes toward abortion, interest in family planning, and scientific advances have resulted in the growth of genetic counseling.[156] Genetic counseling enables parents to determine whether to carry pregnancies to term or terminate them due to the liklihood of genetic defects.[157] It has been suggested that a doctor has a duty to inform pregnant patients, who display traits indicating their fetus may be deformed, of the availability of genetic testing and counseling.[158] A physician who fails to disclose such information may be treating the patient under false pretenses and hence her consent to the treatment may be invalid. The patient reasonably expects to be "appraised of any information the physician has that the child might be defective and of the alternative ways to proceed so that the patient can determine what action to take."[159]

A New York appeals court considered this issue[160] in *Howard v. Lecher*[161] and dismissed the parents' complaint seeking damages from an obstetrician for emotional harm and mental distress caused by the birth and subsequent death of their deformed baby.[162] The parents alleged that the physician knew or should have known that they were potential

155. *See* notes 160-78 *infra*.

156. Approximately 1000 genetic counselors practice in the United States. Reilly, *Genetic Counseling and the Law*, 12 HOUS. L. REV. 640 (1975).

157. Capron, *supra* note 138, at 593, 603. Some types of genetic counseling occur before conception: interviews with and tests on the parents determine whether they might be carriers of certain hereditary diseases. Much genetic counseling, however, involves the interpretation of results of amniocentesis. Amniocentesis, performed about the fifteenth week of pregnancy, is the withdrawal of fluid from the amnion which surrounds the fetus. The fluid is then tested to determine various genetic traits. *See* Annas & Coyne, *Fitness for Birth and Reproduction: Legal Implications of Genetic Screening*, 9 FAM. L.Q. 463, 474 (1975). *See generally* P. REILLY, GENETICS, LAW, AND SOCIAL POLICY (1977); Friedman, *supra* note 89; Milunsky & Reilly, *The "New" Genetics: Emerging Medicolegal Issues in the Prenatal Diagnosis of Hereditary Disorders*, 1 AM. J. L. & MED. 71 (1975); Reilly, *supra* note 156; Waltz & Thigpen, *Genetic Screening and Counseling: The Legal & Ethical Issues*, 68 NW. U. L. REV. 696 (1973).

158. Annas & Coyne, *supra* note 157, at 480; Reilly, *supra* note 156, at 643-44.

159. Annas & Coyne, *supra* note 157, at 478.

160. For a discussion of this issue, see Birnbaum & Rheingold, *Torts*, 28 SYRACUSE L. REV. 525, 559 (1977); 41 ALB. L. REV. 162 (1977); 12 NEW ENG. L. REV. 819 (1977).

161. 53 App. Div. 2d 420, 386 N.Y.S.2d 460 (1976). *Accord*, Johnson v. Yeshiva Univ., 53 App. Div. 2d 523, 384 N.Y.S.2d 455 (1976); Greenberg v. Kliot, 47 App. Div. 2d 765, 367 N.Y.S.2d 966, *leave to appeal denied*, 37 N.Y.2d 707, 337 N.E.2d 618, 375 N.Y.S.2d 1026 (1975).

162. Plaintiffs also sought damages for the child's medical care and funeral expenses. That cause of action was not challenged on appeal. *Id.* at 422, 386 N.Y.S.2d at 461.

carriers of Tay Sachs disease,[163] and that tests were available to determine whether the fetus was genetically defective.[164] The parents claimed they would have sought a legal abortion had they known that the fetus had Tay Sachs. The court dismissed the suit,[165] pointing out the difficulty of measuring the damages of "wrongful life."[166] Public policy, said the court, also compelled dismissal because recognition of the cause of action would be an "unwarranted and dangerous extension of malpractice liability"[167] and perhaps would lead to fraudulent claims or entry into a field with no stopping point.[168]

The *Howard* dissent said that plaintiffs had alleged the elements of a negligence claim and, if they could establish these at the trial, the defendant should redress their injuries.[169] The plaintiffs had the "right to information adequate for [the woman] to exercise an informed consent or refusal of the continuation of her pregnancy."[170] The physician's breach of duty[171] deprived the plaintiffs of their legitimate option to abort.[172] The

163. Tay Sachs is one of the most devasting genetic diseases; children usually live a painful three to four years before dying. Jewish people of eastern European descent have a tenfold greater chance of carrying this disease than the general population. 12 NEW ENG. L. REV. 819, 829 n.73.

164. Plaintiffs also alleged that the doctor either failed to take or failed to analyze properly their genealogical history. 53 App. Div. 2d at 422, 386 N.Y.S. 2d at 461.

165. The court also pointed out that the parents were not directly injured by defendant's alleged breach. *Id.* at 424, 386 N.Y.S.2d at 462. Soon after the *Howard* decision, a New York trial court, in Park v. Chessin, 88 Misc. 2d 222, 387 N.Y.S.2d 204 (1976), ruled that parents, as the administrators of their deceased child's estate, had a cause of action on her behalf, against the defendant-doctor. The suit sought damages for the infant's pain and suffering that allegedly resulted from defendant's negligence in advising the parents to conceive and bear a child when it was foreseeable that the child would be congenitally defective. *Howard* was not controlling, said the court, because here the infant herself sought damages for pain suffered *after* birth based on a tort committed prior to conception. *Id.* at 229, 387 N.Y.S.2d at 209. This decision was modified and affirmed at — App. Div. 2d —, 400 N.Y.S.2d 110 (1977), where the court said that the physician's tort interfered with the woman's statutory right to abort and that the breach of the right "may also be said to be tortious to the fundamental right of a child to be born as a whole, functional human being." *Id.* at —, 400 N.Y.S.2d at 114. The parent's action for medical and support expenses was upheld. *Id.*

166. 53 App. Div. 2d at 424, 386 N.Y.S.2d at 462.

167. *Id.*

168. *Id.* at 425, 386 N.Y.S.2d at 462-63.

169. *Id.* at 426, 386 N.Y.S.2d at 463. The dissent said that defendants, by not moving for dismissal of plaintiff's action for expenses incurred as a result of defendant's alleged malpractice, had impliedly conceded that the sole issue was plaintiff's ability to establish the amount of damages due to their pain and suffering. *Id.* at 431, 386 N.Y.S.2d at 467.

170. *Id.* at 426, 386 N.Y.S.2d 460, 464.

171. The dissent rejected the notion that this created any new duty because the physician already owed a duty to the plaintiff-mother who was the "sole subject of the

parents' mental anguish—their injury—was the foreseeable consequence of the physician's preemption of plaintiffs' choice.[173] The dissent concluded:

> [The plaintiff mother] has been damaged by the denial to her of the option to accept or reject a parental relationship with the child. . . . Despite the genuine difficulty of ascertaining the amount of the injury, the trier of the facts must be permitted to affix the price of the loss of that option. The physician should not be allowed to escape liability on the basis of either his personal scruples or the *legal policy which requires him to inform a patient in other medical contexts* merely because the court feels unequipped to specifically determine the extent of the injury.[174]

In an analogous suit, *Karlsons v. Guerinot*,[175] another New York appeals court rejected the *Howard* reasoning and held the physician liable. The defendant's failure to inform the plaintiff of the danger, indicated by her medical history, of giving birth to a mongoloid child violated his duty of due care and precluded her decision to abort.[176] The plaintiff had argued, as did the dissent in *Howard*, that the physician was liable for failure to obtain informed consent to pregnancy treatment.[177] *Karlsons* rejected that basis for plaintiff's claim, however, saying an action based on informed consent "exists only where the injury suffered arises from an affirmative violation of the patient's physical integrity and, where nondisclosure of risks is concerned, these risks are directly related to such affirmative treatment."[178]

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defendant's treatment and was not an inadvertent, unknown and fortuitous observer." *Id.* at 430, 386 N.Y.S.2d at 446. This was in response to the majority's reliance on Tobin v. Grossman, 24 N.Y.2d 609, 249 N.E.2d 419, 301 N.Y.S.2d 554 (1969).

172. The dissent made numerous references to the parents' legal right to choose the abortion alternative.

173. 53 App. Div. 2d at 430, 386 N.Y.S.2d at 466.

174. *Id.* at 436-37, 386 N.Y.S.2d at 470.

175. 57 App. Div. 2d 73, 394 N.Y.S.2d 933 (1977). The court refused to recognize the infant's claim for "wrongful life." *Id.* at 79-80, 394 N.Y.S.2d at 937-38.

176. *Id.* at 78, 394 N.Y.S.2d at 936.

177. *Id.* at 81-82, 394 N.Y.S.2d at 938-39. *See* note 170 *supra* and accompanying text.

178. *Id.* at 82, 394 N.Y.S.2d at 939. The court cited no explicit authority for this position. There is no logical reason why an informed consent action can lie only when a risk directly related to the physician's affirmative treatment occurs. An informed consent action is appropriate whenever the plaintiff's injury would not have occured but for the doctor's failure to inform. *See* notes 228-30 *infra* and accompanying text. Although a plaintiff seeking damages from a physician who failed to inform her of the abortion alternative would have had the baby whether or not the doctor had treated her pregnancy, the inevitability of the "injury" would not shield a physician from liability in other

A few jurisdictions recognize that a plaintiff has a cause of action against a physician who fails to provide her with the necessary information for her to determine whether to carry to term or abort. Some courts that denied recovery noted the difficulty of ascertaining damages.[179] Others refused even to recognize the physician's duty to give the plaintiff information relevant to the abortion decision because of the public policy against abortion.

Many commentators argue that because abortion is now legal the precedential value of *Gleitman* and its progeny has been severely undermined.[180] *Gleitman* was based on a policy favoring the continuance of life and thus denying abortion because the court would not recognize that abortion "is such an 'available' alternative that denial of the opportunity to choose it constitutes an infringement of a legally protected interest."[181] Although the resistance of *Gleitman* and subsequent pre-*Doe* and *Roe* cases to recognize illegal abortions as medical alternatives is understandable, their reservations are no longer legally supportable. Because all first trimester abortions are now "justified" under state law, the availability of the abortion alternative gives rise to the physician's duty to advise his patient of that alternative.[182]

B. *Causation: The plaintiff-patient would have chosen no treatment or a different course of treatment had the alternatives and material risks of each been made known.*

Once the plaintiff proves the doctor breached his disclosure duty, the

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contexts. If a cancer patient died during surgery (although the surgery was properly performed) and his estate brought suit against the physician because he failed to obtain informed consent (he did not inform the patient of the risk of death during surgery), the court would not deny recovery merely because the patient eventually would have died of the cancer without the doctor's treatment.

179. For an expanded discussion, see section III, C *infra*.

180. *See, e.g.*, Duin, *New York's Abortion Reform Law: Unanswered Questions*, 37 ALB. L. REV. 22, 30-34 (1972); Kashi, *supra* note 120, at 1427; Kass & Shaw, *supra* note 145, at 220, 229-30; 41 ALB. L. REV. 102, 169 (1977); 12 NEW ENG. L. REV. 819, 837 (1977); 28 SYRACUSE L. REV. 143, 153 (1968).

181. 20 ME. L. REV. 143, 153 (1968).

182. [G]iven a situation in which the abortion would be justified under the laws of the state in which it is sought, a doctor's failure to discharge a duty of disclosure of the making of a statement that no abortion should be sought elsewhere should give rise to a malpractice cause of action.

Duin, *supra* note 180, at 33-34. Duin's article was written when abortion was permissible only in certain situations defined by state statutes. He said that a doctor who did not advise a pregnant patient that she could obtain a legal abortion under one of the statutory exceptions was liable in malpractice. Other commentators have expressed the same view. Note, *A Cause of Action for "Wrongful Life": [A Suggested Analysis]*, 55 MINN. L. REV. 58, 76-80; 6 WILLAMETTE L.J. 349, 353 (1970).

plaintiff must show proximate cause,[183] which requires that an act or failure to act contributed to or produced the events leading to the ultimate injury. "It is not necessary that the injury immediately follow the act or failure to act, but only that if the act or failure to act did not exist, the injury would not have occurred."[184] The plaintiff thus must show that "but for" the physician's breach of duty, she would not have submitted to the treatment in question.[185] Depending upon the jurisdiction, causation is determined by either an objective or subjective test.[186]

When causation is judged objectively, the jury determines whether a reasonably prudent person in the plaintiff's position would have undergone the treatment if there had been full disclosure.[187] Under the subjective standard, the determination hinges on the credibility of plaintiff's testimony that she would not have undergone the treatment if the disclosure had been made.[188]

The objective test is fairer to the physician because the patient's

183. W. PROSSER, *supra* note 43, § 41.

184. Note, *supra* note 49, at 886-87 (footnotes omitted). *See* Perdue, *The Law of Texas Medical Malpractice*, 11 HOUS. L. REV. 1075, 1090 (1974) (plaintiff need not show that defendant's negligence was *the* proximate cause, but must show it was *a* proximate cause of the injury); Waltz & Scheuneman, *supra* note 54, at 647 ("viewed from the point at which he had to decide, would the patient have decided differently had he known something he did not know?").

185. Kessenick & Mankin, *supra* note 59, at 265-67; Riskin, *supra* note 59, at 588-90; 48 N.Y.U.L. REV. 548, 549-50 (1973). *See, e.g.*, Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

186. *See generally* Canterbury v. Spence, 464 F.2d 772, 790-91 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Capron, *Informed Consent in Catastrophic Disease Research & Treatment*, 123 U. PA. L. REV. 340, 418-23 (1974); Kessenick & Mankin, *supra* note 59, at 265-67; Perdue, *supra* note 184, at 1090-92; Riskin, *supra* note 59, at 588-92; Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 DUQ. L. REV. 309 (1976); 10 SAN DIEGO L. REV. 913, 924-26 (1973).

187. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.) *cert. denied*, 409 U.S. 1064 (1972); Bowers v. Garland, 382 F. Supp. 503 (E.D. Pa.), *aff'd mem.*, 503 F.2d 1398 (3d Cir. 1974); Cobbs v. Grant, 8 Cal. 3d 229, 104 Cal. Rptr. 505, 502 P.2d 1 (1972); Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973). *See generally* Waltz & Scheuneman, *supra* note 54, at 646-48.

The establishment of a proximate cause (a reasonable person would not have undergone the treatment if he knew of the risk) makes the determination of the materiality of the risk unnecessary. 48 N.Y.U.L. REV. 548, 553 (1973).

188. *See, e.g.*, Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74, *modified*, 2 Ariz. App. 607, 411 P.2d 45 (1966); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973); ZeBarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, 499 P.2d 1 (1972). *See generally* Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639 (1968); *Informed Consent, supra* note 71.

unreasonable or idiosyncratic fears and concerns are irrelevant. The denial of the patient's right to make an unreasonable choice is deemed necessary to protect the physician from an embittered patient who, with the benefit of hindsight, claims she would not have undergone treatment that the jury finds the reasonable person would have undergone.[189]

The subjective test protects the individual's self-determination right, because it focuses on the individual's right to choose no matter how unreasonable that choice may be.[190] If a plaintiff is denied recovery when the jury believes she cared about a certain undisclosed factor that the reasonable person would not care about, the purpose of the informed consent rule is undermined.[191]

A woman seeking damages from a physician who failed to inform her about the abortion alternative, will allege that but for the physician's breach of his duty to inform she would have had an abortion. A defendant might allege that the necessary causal link is jeopardized if the plaintiff knew of the abortion alternative despite the physician's failure to discuss it with her.[192] Yet even if the woman knew that abortion was a technique to terminate pregnancy, she may not have known enough about abortion to make her consent to childbirth informed. The relative safety and economy of abortion compared to childbirth, the availability of abortion services in the community, and the technical aspects of the abortion procedure are unknown to many women.[193] The physician's duty is not fulfilled merely by informing the patient that alternatives exist; his duty is to give a comparative analysis of the alternatives.[194] Thus, although the woman may know or even ask about abortion (and obviously not all women of childbearing age know or ask about abortion), her lack of information about abortion may cause her to decide to bear the child that "but for" the physician's failure to disclose, she would have aborted.

189. Kessenick & Mankin, *supra* note 59, at 267.

190. Although the subjective test is consistent with the basis of informed consent—the patient's right to control his body—*Canterbury* followed the objective standard. The court recognized this inconsistency, but stated that it did not want the physician's liability to be determined by the patient's hindsight. Canterbury v. Spence, 464 F.2d 772, 790-91 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). *See* Seidelson, *supra* note 186, at 318-22.

191. Capron, *supra* note 186, at 420.

192. "It is reasonable that the physician should not have a duty to tell the patient what she already knows; the physician does not have the duty to inform the patient of risks or hazards of treatment the patient is aware of." Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); 75 HARV. L. REV. 1445, 1448 (1962).

193. *See generally* notes 100-03 *supra* and accompanying text.

194. *See* note 85 *supra* and accompanying text.

Because the plaintiff's allegations are assumed to be true when the legal sufficiency of her complaint is determined,[195] the patient's claim that she would have had an abortion if her physician had fulfilled his disclosure duty must be accepted at the pleading stage. At the trial, the plaintiff will have a better chance of proving causation in a jurisdiction in which it is determined by a "subjective" rather than "objective" standard.[196] Some women, such as unwed teenagers, may still prevail in an objective standard jurisdiction if they can convince the trier of fact that a reasonable person in their position would have chosen abortion over childbirth.

C. *Injury: The plaintiff-patient has been injured as a result of submitting to the treatment.*

In addition to breach of duty and proximate cause, the plaintiff must prove she was "injured" by submitting to the treatment. There are three grounds on which a court might dismiss a suit alleging a patient was injured by submitting to treatment for pregnancy that resulted in the birth of a healthy child. First, the birth of a child is not an injury. Second, even if the birth is an injury, it is not an undisclosed risk of the doctor's treatment. And finally, damages cannot be ascertained.

The first contention—that the birth of a healthy child is not an injury—is overbroad and naive. In a society where sterilization, birth control, and abortion are constitutionally protected rights, it is unreasonable to say that birth is beneficial as a matter of law. In his concurring opinion in *Doe*, Justice Douglas said: "Elaborate argument is hardly necessary to demonstrate that childbirth may deprive a woman of her preferred lifestyle and force upon her a radically different and undesired future."[197]

Although numerous jurisdictions have acknowledged that the birth of a child can be injurious,[198] traditionally courts considered the birth of a healthy child to be "inherently beneficial" or a "blessing" to the parents.[199] Most of the cases considering whether parents can recover

195. *See* note 96 *supra*.

196. Problems with proving intent to abort have not foreclosed recovery. *See* notes 128-30, 145-54, & 175-78 *supra* and accompanying text.

197. 410 U.S. at 214. Tribe says a woman's option to abort is crucial to family self-definition because contraception and adoption alone are not sufficient to control family size. Tribe, *supra* note 111, at 36 n.161 (1973).

198. *See* notes 210-23 *infra* and accompanying text.

199. *See* notes 203-10 *infra* and accompanying text.

from a defendant who "caused" a "wrongful pregnancy"[200] that culminated in the birth of a healthy unwanted child arise from similar facts. The plaintiff mother (or father) has been sterilized,[201] subsequently becomes pregnant (or impregnates), and then seeks damages from the performing physician.[202]

The first case to address the doctor's liability for a baby born subsequent to a negligent sterilization was *Christenson v. Thornby*.[203] Plaintiff lost his suit for "anxiety and expenses" incident to the birth,[204] because he failed to prove the elements necessary to his deceit action.[205] Although the court recognized that plaintiff's vasectomy did not violate public policy,[206] it indicated it would have denied relief even if plaintiff had sustained his burden of proof because plaintiff had been "blessed with the fatherhood of another child."[207]

Christenson established the "blessing concept" as a judicial obstacle to recovery for the birth of a healthy unwanted child.[208] It has been

200. *See* note 120 *supra*.

201. *See generally* Note, *Elective Sterilization*, 113 U. PA. L. REV. 415 (1965).

202. *See generally* Kashi, *supra* note 120; *Busting the Balloon, supra* note 120; Note, *Sterilization and Family Planning: The Physician's Civil Liability*, 56 GEO. L.J. 976 (1968); Comment, *Pregnancy After Sterilization: Causes of Action for Parent and Child*, 12 J. FAM. L. 635, 636-37 (1972-73); *Wrongful Birth, supra* note 120.

203. 192 Minn. 123, 255 N.W. 620 (1934). Plaintiff alleged that after the operation the physician told him that it had been successful and guaranteed sterility.

204. *Id.* at 125, 255 N.W. at 621.

205. *Id.* at 126, 255 N.W. at 622.

206. *Id.* at 125-26, 255 N.W. at 621-22.

207. *Id.* at 126, 255 N.W. at 622.

208. *Busting the Balloon, supra* note 120. *See, e.g.*, Bishop v. Byrne, 265 F. Supp. 460 (S.D. W.Va. 1967); Shaheen v. Knight, 11 Pa. D. & C. 2d 41 (1967); Terrell v. Garcia, 496 S.W.2d 124 (Tex. Ct. App. 1973), *writ ref'd n.r.e., cert. denied*, 415 U.S. 927 (1974); Hays v. Hall, 477 S.W.2d 402 (Tex. Ct. App. 1972), *rev'd on other grounds*, 488 S.W.2d 412 (Tex. 1973); Ball v. Mudge, 64 Wash. 2d 247, 391 P.2d 201 (1964) (dicta). The reasoning in *Shaheen* is typical of the reasoning in these cases. Plaintiffs were denied recovery of the expenses of raising and educating a child born subsequent to a vasectomy performed for family planning purposes. The court said:

> To allow damages in a suit such as this would mean that the physician would have to pay for the fun, joy and affection which plaintiff Shaheen will have in the rearing and educating of this, defendant's [plaintiff's] fifth child. . . . He wants to have the child and wants the doctor to support it. In our opinion to allow such damages would be against public policy.

Id. at 45-46. The court also noted that plaintiff refused to give the child up for adoption and thereby mitigate the "damages." *Id. See* note 225 *infra*.

Some cases decided shortly after *Christenson* did allow recovery. *See, e.g.*, West v. Underwood, 132 N.J.L. 325, 40 A.2d 610 (1945) (allowed plaintiff's claim for pain and suffering and loss of service in action based on negligence); Milde v. Leigh, 75 N.D. 418, 28 N.W.2d 530 (1947) (recovery for loss of wife's services allowed in action based on wrongful interference with marital rights).

suggested that courts denying relief on the theory that parents of a healthy unwanted child suffer no damages as a matter of law have implicitly applied the "benefit rule" of tort liability. The rule provides that a plaintiff's damages will be offset by the amount that defendant's tortious act benefited plaintiff's interest that was harmed.[209] The courts recognized the parents' actual financial injury, but categorically assumed that the birth of a child conferred a substantial benefit to its parents that clearly outweighed the financial costs incurred in the birth and support of the child.[210]

In 1967, the judicial erosion of the "blessing" concept began. In *Custodio v. Bauer*,[211] the California Court of Appeals said plaintiffs could recover their provable economic loss incident to the birth of a healthy baby conceived after plaintiff-mother had a therapeutic sterilization.[212] The mother survived delivery uninjured, but the birth meant that she "must spread her society, comfort, care, protection and support over a larger group. If this change in the family status can be measured economically it should be [compensated]."[213] Damages, said the court, were not awarded to compensate plaintiffs for an unwanted child,[214] but to "replenish the family exchequer so that the new arrival will not deprive the other members of the family of what was planned as their just share of the family income."[215] By rejecting the *Christenson* reasoning,

209. THE RESTATEMENT (SECOND) OF TORTS § 920 (Tent. Draft No. 19, 1973) states:
> When the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred a special benefit to the interest of the plaintiff which was harmed, the value of the benefit conferred is considered in mitigation of damages, to the extent this is equitable.

210. 47 TUL. L. REV. 225, 228 (1972). The invalidity of this assumption when applied to parents who have made the choice not to have children and to practice birth control is apparent. *Id.* at 228-29. *See* notes 214 and 222 *infra*.

211. 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967).

212. The court said a sterilization operation, when not prohibited by statute, was a matter of individual conscience. The court questioned whether the state could control sterilization because under Griswold v. Connecticut, 381 U.S. 479 (1965), "the means of preventing contraception is now clothed in a cloak of constitutional protection." 251 Cal. App. 2d at 317-18, 59 Cal. Rptr. at 473 (1967). *See* note 220 *infra* and accompanying text.

213. *Id.* at 323-24, 59 Cal. Rptr. at 476. *See* 9 UTAH L. REV. 808, 811 n.21 (1965). The court in *Custodio* chose not to rule on the parents' claim for child support. 251 Cal. App. at 326, 59 Cal. Rptr. at 478.

214. The court said that *Christenson* and *Shaheen* erroneously considered this the purpose of damages, and misapplied the torts "benefit" rule. 251 Cal. App. 2d at 323, 59 Cal. Rptr. at 476. *See* notes 209-10 *supra* and 222 *infra*. *See generally* Kashi, *supra* note 120, at 1414-15; *Busting the Balloon*, *supra* note 120, at 225-26; 47 TUL. L. REV. 225, 228-29 (1972).

215. 215 Cal. App. 2d at 324, 59 Cal. Rptr. at 477.

the court explicitly recognized, as have other jurisdictions,[216] that the birth of a healthy baby is not a blessing as a matter of law.

The most complete discussion of damages arising from the birth of an unwanted healthy child was in *Troppi v. Scarf*.[217] Plaintiff conceived after defendant-druggist negligently substituted tranquilizers for birth control pills in plaintiff's prescription. The court rejected defendant's argument that public policy and the overriding benefits of parenthood relieved him of the liability that wrongdoers in other contexts incur, and expressly authorized recovery of child support for the "wrongfully" born child.[218] Public policy, the court reasoned, favored family planning and birth control.[219] After discussing *Griswold v. Connecticut*,[220] which held that the Constitution protects the right to practice contraception, the court said: "Since the state may not infringe upon this right [of contraception], it may not constitutionally denigrate the right by completely denying protection provided as a matter of course to like rights."[221]

Troppi said recoverable damages could be determined by applying the benefit rule of torts,[222] but unlike *Christenson*, the court concluded that

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216. Many courts now award damages to parents of unwanted children if a causal connection between the pregnancy and defendant's breach of duty is established. *See, e.g.*, Coleman v. Garrison, 327 A.2d 757 (Del. Super. Ct. 1974) (damages limited to expenses and pain and suffering related to pregnancy and delivery); Jackson v. Anderson, 230 So. 2d 503 (Fla. Dist. Ct. App. 1970); Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971); Sherlock v. Stillwater Clinic, — Minn. —, 260 N.W.2d 169 (1977); Betancourt v. Gaylor, 136 N.J. Super. 69, 344 A.2d 236 (N.J. Super. Ct. 1975); Cox v. Stretton, 77 Misc. 2d 155, 352 N.Y.S.2d 834 (1974); Bowman v. Davis, 48 Ohio St. 2d 41, 356 N.E.2d 496 (1976); *cf.* Doerr v. Villate, 74 Ill. App. 2d 332, 220 N.E.2d 767 (1966) (wife has breach of contract action against doctor who negligently sterilized her husband). *See also* Bishop v. Byrne, 265 F. Supp. 460 (S.D. W. Va. 1967) (rejects doctor's defense that father was an intervening cause). *But see* Clegg v. Chase, 89 Misc. 2d 510, 391 N.Y.S.2d 966 (1977).

217. 31 Mich. App. 240, 187 N.W.2d 511 (1971). *See generally* Kashi, *supra* note 120, at 1415-18; 52 B.U.L. REV. 189 (1972); 47 TUL. L. REV. 225 (1972).

218. 31 Mich. App. at 246, 187 N.W.2d at 514.

219. *Id.* at 253, 187 N.W.2d at 516-17.

220. 381 U.S. 479 (1965). *See* note 212 *supra*.

221. 31 Mich. App. at 253, 187 N.W.2d at 517 (footnotes omitted). *See* Sherlock v. Stillwater Clinic, — Minn. —, —, 260 N.W.2d 169, 175 (1977).

222. *See* notes 209-10 & 214 *supra*. In applying the benefit rule, the court concluded that defendant's conduct conferred a benefit on the same interest his conduct harmed. Commentators have suggested that this conclusion may be erroneous because the interest benefited is emotional or psychological, while the interest harmed is economic. Kashi, *supra* note 120, at 1414-15; *Busting the Balloon, supra* note 120, at 226 n.19; 47 TUL. L. REV. 225, 232-33 (1972). *See* RESTATEMENT (SECOND) OF TORTS § 920, comment b (Tent. Draft No. 19, 1973).

the benefit of parenthood did not outweigh the damages as a matter of law. The benefit of birth was a question of fact that depended on the plaintiff's circumstances.[223] Under the flexibility of the benefit rule, courts can consider a variety of factors including family size and income as well as parents' age and marital status, and make an ad hoc determination of the damages.[224]

Even though a court may accept the view that the birth of a healthy baby can be injurious,[225] it might deny plaintiff relief because the birth of a child is not an undisclosed danger of treatment for pregnancy.[226] While injury in informed consent cases generally means the occurrence of an undisclosed risk,[227] it is suggested here that a plaintiff can be injured by treatment that she consented to other than by the materialization of an undisclosed risk.[228] In a case where the plaintiff was treated for pregnan-

223. 31 Mich. App. at 253-57, 187 N.W.2d at 517-19.

224. *Id.* at 257, 187 N.W.2d at 519.

225. *Id.* at 257, 187 N.W.2d at 519. The court rejected defendant's argument that the plaintiff had a duty to mitigate by abortion or adoption: "While the reasonableness of the plaintiff's efforts to mitigate is ordinarily to be decided by the trier of fact, we are persuaded to rule, as a matter of law, that no mother . . . can reasonably be required to abort (even if legal) or place her child for adoption." *Id.* at 260, 187 N.W.2d at 520. *See generally* Comment, *supra* note 202, at 640-41. The notion that a plaintiff in a "wrongful pregnancy" suit has the duty to mitigate has been rejected by other courts. *See, e.g.*, Custodio v. Bauer, 251 Cal. App. 2d 303, 324, 59 Cal. Rptr. 463, 476 (1967); Troppi v. Scarf, 31 Mich. App. 240, 260, 187 N.W.2d 511, 519-20 (1970); Sherlock v. Stillwater Clinic, — Minn. —, —, 260 N.W.2d 169, 176 (1977); Ziemba v. Sternberg, 45 App. Div. 2d 230, 233, 357 N.Y.S.2d 265, 269 (1974).

226. It should be noted that in many cases, plaintiff is not claiming that the birth itself was the injury. Rather, the injury was the occurrence of a risk incidental to the birth that the doctor knew about but did not disclose to the patient. The plaintiff claims her consent to treatment was not informed, and that the doctor is liable for the injuries. *See* the rubella and genetics cases discussed in notes 131-78 *supra* and accompanying text.

227. Karp v. Cooley, 493 F.2d 408, 422 (5th Cir. 1974); Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Waltz & Scheuneman, *supra* note 54, at 646; *Informed Consent, supra* note 71, at 1409.

228. One commentator has suggested that a weakness in informed consent actions is the requirement that an undisclosed risk materialize, because requiring the occurrence of an undisclosed risk means that there is no compensation for violation of the patient's dignity interest. *See* Riskin, *supra* note 59, at 589 n.52.

The following hypothetical illustrates an injury arising from treatment not consented to, other than by the occurrence of an undisclosed risk. A woman has a malignant breast tumor, and the doctor advises her to undergo a radical mastectomy. The physician informs her of the risks incidental to the procedure. The operation is successful and no undisclosed risks materialize. After surgery, however, the woman discovers that an alternative procedure would have been medically feasible: The tumor alone could have been removed. Although this procedure has inherent risks, and was perhaps more dangerous than

cy and an unwanted healthy baby is born, she is claiming that although she consented to carrying to term and knew of the risks involved, her consent was not informed because it was induced by a lack of knowledge of the alternatives.[229] She is injured because the non-disclosure distorts her judgment: her injury is not the happening of an undisclosed risk; it is the occurrence of a known "risk"—an unwanted child[230]—that she would not have had but for the doctor's breach of his duty to inform her of alternatives.[231]

The third potential obstacle to plaintiff's claim is the difficulty of ascertaining damages. In a malpractice action, "the person responsible [for the injury] must respond for all the damages resulting directly from and as a natural consequence of the wrongful act according to common experience and in the usual course of events, whether the damages could or could not have been foreseen by him."[232] The damages a patient who was not fully advised of alternative treatments should recover is the difference between the patient's actual condition and her probable condi-

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the radical mastectomy, the woman can prove she would have chosen to have the tumor removed if the doctor had informed her of the alternative. Thus, despite the nonoccurrence of an undisclosed risk, the patient has been injured (she has had a breast instead of a tumor removed) as a result of treatment she would not have undergone but for the doctor's failure to disclose.

229. *See* Note, *supra* note 48, at 771.

230. The resulting injury is the same as that in the negligent sterilization cases. *See* notes 211-24 *supra* and accompanying text. In those cases, the doctor breached his duty of due care by negligently performing the sterlization; here the doctor breached his duty of due care by not making a full disclosure and obtaining informed consent before proceeding with treatment.

This Note has analyzed plaintiff's claim under the informed consent theory rather than as an action alleging that the physician's nondisclosure was a failure to meet the standard of care. In informed consent suits, at least in some jurisdictions, the plaintiff can prevail if she shows the disclosure was not reasonable. If the action alleged that the doctor failed to meet the standard of care in the community, the plaintiff would have to introduce expert testimony establishing that standard. Because it is unlikely that plaintiff could carry the burden of showing that physicians customarily inform their patients of the abortion alternative, the informed consent suit is more likely to be successful. An informed consent suit is also philosophically consistent with the interest plaintiff is attempting to vindicate. *Roe* and *Doe* were based on the woman's right to choose; informed consent actions protect individual choice. The physician's nondisclosure of the abortion alternative interferes with this right.

231. *See* note 86 *supra* and accompanying text. The policy of informed consent is undermined if a court finds a patient's consent was informed when she knew the risks but not the alternatives to taking those risks.

232. Steitz v. Gifford, 280 N.Y. 15, 20, 19 N.E.2d 661, 663 (1939).

tion had her choice of treatment been made after being properly informed of the alternatives.''[233] If the plaintiff has convinced the trier of fact that she would have aborted but for the doctor's breach of duty, the court must measure the difference between having and aborting an unwanted child.

Some damages the plaintiff may claim can be reasonably ascertained: the medical and hospital expenses of the pregnancy and delivery, wages lost, and the pain and anxiety incident to the pregnancy and delivery.[234] These damages should be offset to the extent they would have been incurred if the plaintiff had an abortion.

A more difficult question of damages arises if the plaintiff seeks expenses for raising the child.[235] Because the benefit rule of torts is the just method for ascertaining damages, the trier of fact[236] must offset the ascertainable damages the plaintiff incurred by having the child by the benefits of parenthood. The expenses of rearing a child, though speculative, are reasonably ascertainable. Although measuring the benefits of a child's services and companionship is difficult, such determinations are routinely made in wrongful death suits[237] and, therefore, should not prevent plaintiff's recovery here.[238] Failing to hold the wrongdoer liable merely because of the difficulty of ascertaining damages is not only an injustice to the plaintiff, but undermines legal enforcement of the doctor's duty to inform.[239]

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233. 48 N.Y.U.L. REV. 548, 550 (1973).

234. *See* Troppi v. Scarf, 31 Mich. App. 240, 260-61, 187 N.W.2d 511, 520-21 (1971); Sherlock v. Stillwater Clinic, — Minn. —, —, 260 N.W.2d 169, 175 (1977). *See generally* Note, *supra* note 202, at 992-93.

235. The possible defense that plaintiff should have mitigated her damages by placing the child up for adoption is not discussed here because of its virtually uniform rejection. *See* note 225 *supra*.

236. Whether legally compensable damages have been incurred in a tort action is a question of law for the court, but the trier of fact, with the court's guidance, determines the amount of damages. *See* RESTATEMENT (SECOND) OF TORTS §§ 328B(f), 328C(d) (1965).

237. Troppi v. Scarf, 31 Mich. App. 240, 260-61, 187 N.W.2d 511, 520-21 (1971); Sherlock v. Stillwater Clinic, — Minn. —, —, 260 N.W.2d 169, 176 (1977). *See generally* Note, *supra* note 202, at 994-95.

238. The wrongdoer is not entitled to complain that damages cannot be precisely measured. Story Parchment Co. v. Peterson Parchment Paper Co., 282 U.S. 555, 567 (1931); Karlsons v. Guerinot, 57 App. Div. 2d 73, 78-79, 394 N.Y.S.2d 933, 937 (1977).

239. Sherlock v. Stillwater Clinic, — Minn. —, —, 260 N.W.2d 169, 175 (1977); Howard v. Lecher, 53 App. Div. 2d 420, 435, 386 N.Y.S.2d 460, 469-70 (dissenting opinion); W. PROSSER, *supra* note 43, § 4, at 23.

IV. CONSCIENCE CLAUSES

Since the 1973 legalization of abortion, Congress[240] and most state legislatures[241] have enacted conscience clauses. These statutes provide legal protection for individuals and institutions who have moral or religious objections to performing abortions.[242] The individuals and institutions are protected primarily in three ways: individuals and institutions cannot be compelled to perform abortions; individuals and institutions are not liable to patients who have been denied abortions; and, individuals employed in institutions performing abortions cannot be discriminated against because of their refusal to participate in abortions.

The federal conscience clauses were enacted as a response to the pre-*Roe* and *Doe* decision in *Taylor v. St. Vincent's Hospital*,[243] in which a federal district court enjoined a denominational hospital from prohibiting sterilizations. The hospital's receipt of Hill-Burton funds[244] intertwined it sufficiently with the state so that the hospital's deprivation of sterilization constituted state action and the fourteenth amendment applied.[245] Plaintiffs, deprived of a fourteenth amendment right, could sue under section 1983.[246] Because the elevation of abortion to a federally protected right meant that private hospitals receiving Hill-Burton funds[247] could be

240. *See* notes 243-50 *infra* and accompanying text.

241. *See* note 251 *infra*.

242. *See generally* Note, *supra* note 3.

243. No. 1090 (D. Mont. Nov. 1, 1972), *reconsidered and rev'd*, 369 F. Supp. 948 (D. Mont. 1973), *aff'd*, 523 F.2d 75 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976) (private hospital had the town's sole obstetrics facility). *Accord*, Chrisman v. Sisters of St. Joseph of Peace, No. 70-430 (D. Ore. July 2, 1971), *aff'd*, 506 F.2d 308 (9th Cir. 1974).

Section 401(b)(c) of the Health Programs Extension Act of 1973, 42 U.S.C. § 300a-7 (Supp. V 1975), was enacted after the court found jurisdiction to hear *Taylor*. The reversal was in response to the enactment of § 401. 369 F. Supp. at 950. Congress was clearly responding to the first *Taylor* decision when it passed 401(b). *See* H.R. REP. 227, 93d Cong., 1st Sess. 11 (1973); [1973] U.S. CODE CONG. & AD. NEWS 1464, 1473.

244. The Hill-Burton Act, 42 U.S.C. § 291 (1970), authorizes joint federal-state aid for the construction of public and private health care facilities.

245. *See* United States v. Price, 383 U.S. 787, 794-95 (1966); United States v. Guest, 383 U.S. 745, 753-57 (1966); Evans v. Newton, 382 U.S. 296, 299 (1966).

246. 42 U.S.C. § 1983 (1970) provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State . . . subjects . . . any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law . . . or other proper proceeding for redress.

247. Under this reasoning, a hospital that did not receive Hill-Burton funds, but did receive tax exemptions, medicaid, medicare, or welfare funds might be found to be acting under color of state law. *See*, Note, *supra* note 3, at 576-77.

compelled to perform abortions, Congress acted to overrule the implications of *Taylor* after the 1973 decisions.

The primary federal conscience clause, the Church Amendment,[248] provides that receipt of Hill-Burton or other federal funds by an individual or entity does not authorize any court or public official to require any individual "to perform or assist in the performance of any . . . abortion," or any entity to provide facilities or personnel for abortions if the individual or entity objects to abortion because of "religious beliefs or moral convictions."[249] The clause also prohibits entities receiving federal funds from discriminating against employees who either "performed or assisted" or refused to "perform or assist" an abortion.[250]

Over forty states have enacted conscience clauses.[251] The typical

248. Health Programs Extension Act of 1973, § 401(b)-(c), 42 U.S.C. § 300a-7 (Supp. V 1975). It has been suggested that insofar as the conscience clauses "permit public facilities or private facilities whose activities legally constitute 'state action' to be free of constitutional restrictions, they are clearly ineffective and unconstitutional." Pilpel & Patton, *Abortion, Conscience and the Constitution: An Examination of Federal Institution Conscience Clauses*, 6 COLUM. HUMAN RIGHTS L. REV. 279, 289 (1974-75). Other commentators have agreed with this position. *See, e.g.*, Note, *supra* note 3, at 602; Note, *Hill-Burton Hospitals After* Roe *and* Doe: *Can Federally Funded Hospitals Refuse to Perform Abortions*?, 4 N.Y.U. REV. L. & SOC. CHANGE 83, 97 (1974); 2 FORDHAM URB.L.J. 611, 619 n.55 (1974). *See also* Note, *Section 401(b) of the Health Programs Extension Act: An Abortive Attempt by Congress to Resolve a Constitutional Dilemma*, 17 WM. & MARY L. REV. 303, 331 (1975) (§ 401(b) has been read so broadly it is unconstitutional). Prior to the enactment of the federal conscience clauses, the Seventh Circuit held that receipt of Hill-Burton funds was insufficient to make a hospital's action "state action." Doe v. Bellin Memorial Hosp., 479 F.2d 756 (7th Cir. 1973), commented on in 62 GEO. L. J. 1783 (1974) and 18 ST. LOUIS U.L.J. 440 (1974). The conflict over the constitutionality of Congress' attempt to say that receipt of Hill-Burton funds is not enough to make a hospital's action state action may be moot. The Court's approval of St. Louis' prohibition of abortion in city hospitals in Poelker v. Doe, 432 U.S. 519 (1977), *see* note 34 *supra* and accompanying text, may be broad enough to allow any hospital to make a policy decision not to perform abortions.

249. 42 U.S.C. § 300a-7(a) (Supp. V 1975).

250. 42 U.S.C. § 300a-7(b) (Supp. V 1975). A year after the Church Amendment, Congress enacted a second conscience clause, 42 U.S.C. § 300a-7(b)(2) (Supp. V 1975), that provides that no entity receiving Department of Health, Education, and Welfare research grants may discriminate in employment because of an individual's performance or non-performance, on religious or moral grounds, of a medical procedure. Other federal legislation has incorporated conscience clause principles. *See generally* Pilpel & Patton, *supra* note 248, at 287-89.

251. ALASKA STAT. § 11.15.060 (1970); ARIZ. REV. STAT. ANN. § 36-2151 (1974); ARK. STAT. ANN. § 41-2560 (1977); CAL. HEALTH & SAFETY CODE § 25955(c) (Deering Supp. 1975); COLO. REV. STAT. § 18-6-104 (1973); DEL. CODE tit. 24, § 1791 (1975); FLA. STAT. ANN. § 458.22(5) (West Supp. 1977); GA. CODE ANN. § 26-1202(e) (Supp. 1977); HAW. REV. STAT. § 453-16(d) (Supp. 1975); IDAHO CODE § 18-612 (Smith-Hurd Supp. 1977); ILL.

statute provides that no hospital has to permit abortions, and no physicians or medical personnel are obliged to perform or participate[252] in abortions if they object for moral or religious reasons. The refusal is not grounds for either civil liability or employment discrimination.[253]

Although many statutes require an individual refusing to perform or participate in abortions to state his objection in writing,[254] the notice is generally given to the hospital but not the patient.[255] California[256] and Nebraska[257] provide that hospitals not performing abortions must inform patients of that policy; the California statute specifies that the notice be posted in an area of the hospital open to patients and prosepctive admittees. Illinois[258] requires that patients be promptly notified if their request for abortion is denied.

State conscience clauses that refer to the performance or participation in the performance of abortions do not, it is argued here, alleviate the doctor's common law duty to inform the patient of alternative treat-

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ANN. STAT. ch. 38, §§ 81-16, 81-33 (1977); IND. CODE § 35-1-58.5-8 (1975); IOWA CODE ANN. § 146.1-146.2 (West Supp. 1977); KAN. STAT. ANN. § 65-443 (Vernon Supp. 1977); KY. REV. STAT. ANN. § 311.800(1) (Baldwin Supp. 1974); LA. REV. STAT. ANN. §§ 40.1299.31-.33 (West Supp. 1975); ME. REV. STAT. tit. 22, § 1572 (Supp. 1974); MD. ANN. CODE art. 43, § 556E (Supp. 1977); MICH. STAT. ANN. § 14.57 (Supp. 1976); MINN. STAT. ANN. § 145.42 (Supp. 1978); MO. ANN. STAT. § 197.032 (Vernon Supp. 1978); MONT. REV. CODES ANN. § 69-5223 (Supp. 1977) (applies to sterilizations only); NEB. REV. STAT. §§ 28-4,156 to 28-4,160 (Supp. 1973); NEV. REV. STAT. § 499.191 (1973); N.J. STAT. ANN. §§ 2A:65A-1 to 65 A-4 (West 1975); N.M. STAT. ANN. § 40A-5-2. (1972); N.Y. CIV. RIGHTS LAW § 79-i (McKinney Supp. 1976); N.C. GEN. STAT. § 14.45.1(f) (Supp. 1977); N.D. CENT. CODE § 23-16-14 (Supp. 1977); OHIO REV. CODE ANN. § 4731.91 (Page 1977); OR. REV. STAT. §§ 435.475 to .495 (1975); PA. STAT. ANN. tit. 43, § 955.2 (Purdon Supp. 1977); R.I. GEN. LAWS § 23-16-10.1 (Supp. 1974); S.C. CODE §§ 32-684 to 32-685 (Supp. 1974); S.D. COMPILED LAWS ANN. §§ 34-23A-12 to 34-23A-15 (Supp. 1977); TENN. CODE ANN. § 39-304 (Supp. 1974); UTAH CODE ANN. § 76-7-306 (Supp. 1974); VA. CODE § 18.2-75 (1975); WASH. REV. CODE §§ 9.02.060 to .090 (1977); WIS. STAT. ANN. § 448.06(8) (West Supp. 1974); WYO. STAT. § 6-77.2 (Supp. 1975).

252. Many statutes use either the word "perform" or "participate." *See, e.g.*, FLA. STAT. ANN. § 458.225) (West Supp. 1977) (participate); HAW. REV. STAT. § 453-16(d) (Supp. 1975) (participate); MINN. STAT. ANN. § 145.42 (West Supp. 1978) (perform); N.J. STAT. ANN. §§ 2A:65A-1 to 65A-4 (West 1975) (perform).

253. *See, e.g.*, DEL. CODE tit. 24, § 1791 (1975); IND. CODE § 35-1-58.5-8 (1975); KAN. STAT. ANN. § 65-443 (Vernon Supp. 1977); OHIO REV. CODE ANN. § 4731.91 (Page 1977).

254. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-2151 (Supp. 1974); GA. CODE ANN. § 26-1202(e) (Supp. 1977); PA. STAT. ANN. tit. 43, § 955.2 (Purdon Supp. 1977).

255. Note, *supra* note 3, at 584.

256. CAL. HEALTH & SAFETY CODE § 25955(c) (Deering Supp. 1975).

257. NEB. REV. STAT. § 28-4,156 (Supp. 1973).

258. ILL. ANN. STAT. ch. 38, §§ 81-16, 81-33 (Smith-Hurd 1977).

ment.[259] Only four state conscience clauses offer broader protection for the physician, and arguably insulate him from his common law duty to inform.[260] Maryland's conscience clause provides that no doctor shall be required to "refer to any source for any medical procedure that results in termination of pregnancy,"[261] but fails to address the duty to *discuss* abortion. Louisiana provides that no physician is liable for "his refusal for any reason to recommend [or] counsel" an abortion.[262] The conscience clauses of Michigan[263] and Oregon[264] explicitly state that a physician is not required to give a patient advice about abortion if he informs the patient of his refusal.

If a court concluded that a physician breached his duty to his patient by not informing her about the abortion alternative, only the conscience clauses of Michigan and Oregon (and possibly Maryland and Louisiana) would provide a defense. States seeking to shield physicians from liability for their failure to advise about abortion must enact statutes similar to these. Whether such statutes will withstand constitutional scrutiny will depend on the balance struck between the physicians right to exercise his conscience and the woman's right to choose abortion.[265] Although the

259. The Abortion Act of England, Abortion Act, 1967, c.87, § 4-(1), at 203 (1967), is similar to most state statutes. One commentator has suggested that the Act's recognition that a physician who has a conscientious objection to abortion does not have to participate in their performance does not mean that the physician is relieved from his general obligations to his patient. A physician should send a patient to another doctor if "he considers that it might be lawful to recommend or perform an abortion if he did not have a conscientious objection, or . . . he feels that he cannot form an opinion in good faith because of his conscientious objection." COMBINED TEXTBOOK OF OBSTETRICS AND GYNAECOLOGY 796 (9th ed. J. Walker, I. MacGillivray, & M. Macnaughton 1976).

260. Other states offer more protection than the majority of states, but the language is still too narrow to imply that the doctor has no duty to inform. *See, e.g.*, IDAHO CODE § 18-612 (Supp. 1977) ("to assist or participate in the performance or provision"); KY. REV. STAT. ANN. § 311.800(1) (Baldwin Supp. 1974) ("performing, participating in, or cooperating in").

261. MD. ANN. CODE art. 43, § 556E (Supp. 1977). *Cf.* S.D. COMPILED LAWS ANN. § 34-23A-11 (1977) (social workers and counselors not liable for helping or refusing to arrange abortions).

262. LA. REV. STAT. ANN. § 40:1299.31 (West Supp. 1975).

263. MICH. STAT. ANN. § 14.57(53) (Supp. 1976) reads: "A physician who informs a patient that he refuses to give advice concerning, or participate in an abortion shall not be liable to the hospital . . ., or the patient for the refusal." *Cf.* MONT. REV. CODES ANN. § 69-5223 (Supp. 1977) (physician does not have to advise about sterilization).

264. OR. REV. STAT. § 435.485(1) (1975) reads: "No physician is required to give advice with respect to or participate in any termination of a pregnancy . . . if his refusal to do so is based on an election not to give such advice or to participate in such terminations and he so advises the patient."

265. A physician whose objection is founded on religious beliefs will be able to assert

constitutionality of statutes protecting physicians who choose not to *perform* abortions seems certain,[266] the balance may tip in the patient's

that his explicit first amendment right to exercise his religion freely outweighs the woman's implicit privacy right to choose abortion. *See* Note, *The Michigan Abortion Refusal Act*, 8 U. MICH. J.L. REF. 659, 664 (1975). A physician whose objection is founded on purely moral or philosophical grounds probably can not avail himself of first amendment protections. Wisconsin v. Yoder, 406 U.S. 205, 215-16 (1972) ("[T]o have the protection of the Religion Clauses, the claims must be rooted in religious belief . . . . [T]he very concept of ordered liberty precludes allowing every person to make his own standards on matters of conduct in which society as a whole has important interests."). A physician whose objection is based on moral grounds but who argues that his moral beliefs are his religion, may be able to claim the first amendment protects his right not to advise patients about abortion. *See* Welsh v. United States, 398 U.S. 333 (1970); United States v. Seeger, 380 U.S. 163 (1965) (conscientious objector cases interpreting meaning of "religious training and belief" in selective service statute). *See also* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 14-6 (1978) (for purposes of the free exercise clause, religion should be broadly defined). *See generally* Pilpel & Patton, *supra* note 248, at 285-303; Note, *supra*, at 674.

266. *See* Doe v. Poelker, 515 F.2d 541, 546 (8th Cir. 1975), *rev'd on other grounds*, 432 U.S. 519 (1977); Doe v. Hale Hosp., 500 F.2d 144, 147 (1st Cir. 1974), *cert. denied*, 420 U.S. 907 (1975); Hodgson v. Anderson, 378 F. Supp. 1008, 1017 (D. Minn. 1974), *appeal dismissed*, 420 U.S. 903 (1975). *See also* Horan, *Abortion and the Conscience Clause: Current Status*, 20 CATH. LAW. 289 (1974); Pilpel & Patton, *supra* note 248, at 284; Note, *supra* note 265.

It is inconsistent with basic notions of liberty to compel an individual to perform an abortion against his will. Gutman, *Can Hospitals Constitutionally Refuse to Permit Abortions and Sterilizations?*, 2 FAM. PLAN. POPULATION RPTR. 146 (1973). Any doubts about the constitutionality of statutes that allow individuals to refuse to *perform* abortions have probably been quashed by Poelker v. Doe, 432 U.S. 519 (1977). *See* note 34 *supra* and accompanying text. If it is constitutionally permissible for a city hospital to refuse to perform abortions, certainly an individual physician can refuse.

The constitutionality of entity clauses has also been questioned. Justice Blackmun, in dictum in Doe v. Bolton, 410 U.S. 179, 197-98 (1973), recognized the validity of the conscience clause then in effect in Georgia. That clause read:

> Nothing in this section shall require a hospital to admit any patient . . . for the purpose of performing an abortion . . . . A physician, or any other person who is a member of or associated with the staff of a hospital, . . . in which an abortion has been authorized, who shall state in writing an objection to such abortion on moral or religious grounds shall not be required to participate in the medical procedures which will result in the abortion, and the refusal of any such person to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person.

Id. at 205. While this can be read as a Supreme Court validation of institutional conscience clauses, this provision was not challenged in *Doe* and the Court's dictum discussed denominational hospitals only. Pilpel & Patton, *supra* note 248, at 301. At least two federal courts have suggested that non-denominational hospitals cannot constitutionally refuse to perform abortions. *See* Hodgson v. Anderson, 378 F. Supp. 1008, 1017-18 (D. Minn. 1974), *appeal dismissed*, 420 U.S. 903 (1975) (entity conscience clause invalidated

favor when the physician's minimum duty to inform the patient about the abortion alternative is at issue.[267]

V. CONCLUSION

Courts are beginning to grapple with the many questions legalization of the abortion alternative raises in the physician-patient relationship. One question not yet considered by the courts is whether a physician has the duty to inform his pregnant patient about the abortion alternative. It is suggested here that the purpose of the informed consent requirement—the protection of individual autonomy in health care decisions—is undermined if the law allows a physician who objects to abortion for moral or religious reasons to breach his duty to inform his patient about the abortion alternative.

The constitutionality of conscience clauses and other legislation that seeks to override the common law duty to inform is unclear. Courts confronted with the task of balancing the physician's right to exercise his conscience and the woman's right to choose abortion may adopt a workable solution: The physician, protected by law from liability for not performing abortions, must inform the pregnant patient that abortion is a medically feasible alternative that he, for personal reasons, does not perform but which other competent physicians do.

The law should not encourage abortions or suits alleging a failure to inform about the abortion alternative. The decision to abort is a difficult and controversial one.[268] The parent-child relationship may be destroyed if a child learns that his parents brought a suit alleging they would have aborted the child had they been informed of that option.[269] Courts that

as applied to public hospitals); Doe v. Rampton, 366 F. Supp. 189, 193 (D. Utah 1973) (invalidated Utah's all-inclusive conscience clause). The validity of these opinions is questionable under Poelker v. Doe, 432 U.S. 519 (1977). *See* note 248 *supra* and accompanying text.

267. It has been suggested that requiring a Catholic doctor merely to tell his patient that he does not perform abortions may be "counseling" abortion patients contrary to the tenets of the church. Note, *supra* note 3, at 584.

268. Developing a body of case law that governs the patient-physician relationship and protects the right to abort requires judges and juries to recognize that "cases are not decided in a vacuum; rather, decisional law must keep pace with expanding technological, economic, and social change. Inherent in the [legalization of abortion] . . . is a public policy consideration which gives potential parents the right, within certain statutory and case law limitations, not to have a child." Park v. Chessin, — App. Div.2d —, —, 400 N.Y.S.2d 110, 114 (1977). *See* note 165 *supra*.

269. In Sherlock v. Stillwater Clinic, — Minn. —, 260 N.W.2d 169 (1977), a negligent sterilization case, the court warned parents and lawyers to give "serious reflection to the

recognize a cause of action against a physician who refused or neglected to inform a woman pregnant with an unwanted child that abortion was an alternative, however, would not be advocating abortion or encouraging such suits; they would be encouraging professional responsibility and protecting the constitutional right to freedom of choice in reproductive decisions.

Shelly C. Shapiro

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silent interests of the child and, in particular, the parent-child relationships that must be sustained long after controversies have been laid to rest." *Id.* at —, 260 N.W.2d at 177. Justice Rehnquist recently pointed to the *Stillwater* case as an example of cases that, because they pit parent against child, should not be the subject of an adversary hearing. Wash. Post, Feb. 4, 1978, § A, at 6, col. 1.