# MORE THOUGHTS ON THE PHYSICIAN'S CONSTITUTIONAL ROLE IN ABORTION AND RELATED CHOICES

**Susan Frelich Appleton***

A few years ago, I advanced the hypothesis that the true focus of the Supreme Court's decisions protecting abortion has been the physician—not the patient, the pregnant woman, nor the individual seeking to assert what the Court calls "the right to privacy."[1] I explained how the Court's preoccupation with medical standards in resolving constitutional questions about abortion[2] and the Court's frequent portrayal of the physician as the ultimate decisionmaker in every abortion choice[3] create a tension that peaks in judicial reviews of state efforts to regulate informed consent to abortion.[4]

The informed-consent-to-abortion cases raise particularly troublesome problems because, outside the abortion context, the informed consent doctrine views physicians and patients as adversaries with separate and distinct roles, interests, and agenda. This vision conflicts sharply with the fusion of physician and patient depicted in current abortion jurisprudence. I concluded that a more coherent approach would address abortion restrictions as a form of sex-based discrimination, or more precisely, as laws that single out a class composed exclusively of female patients for different and often paternalistic treatment.[5] Under this approach, protection against inadequate disclosure by physicians to abortion patients would come not from criminal statutes, but rather from the state's provision of a forum for malpractice suits, just as it does when the question of

* Professor of Law, Washington University, St. Louis, Missouri. A.B. 1970, Vassar College; J.D. 1973, University of California, Berkeley.

This paper reworks a number of ideas that I originally presented at the Health Law Teachers' Conference of the American Society of Law and Medicine, on June 3, 1988, in Philadelphia, Pennsylvania. Carol Napier (Washington University School of Law, class of 1991) provided both careful and cooperative research assistance.

1. Appleton, *Doctors, Patients, and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U.L.Q. 183 (1985).

2. *See id.* at 189-97.

3. *See id.* at 197-207. For a more recent discussion of this theme, see R. GOLDSTEIN, MOTHER-LOVE AND ABORTION: A LEGAL INTERPRETATION 79-87 (1988).

4. *See* Appleton, *supra* note 1, at 207-26.

5. *See id.* at 226-35.

informed consent arises in the context of medical treatment other than abortion.[6] This alternative approach would properly emphasize abortion as a matter of profound and special importance for women. Further, it would allow for relatively easy solutions to questions, such as informed consent, that pose so many theoretical difficulties under the prevailing doctor-dominated privacy analysis.

Now, some years later, I look again at the main idea of my earlier work, that the physician is the real centerpiece of the Supreme Court's abortion doctrine. This time I consider two particular questions: First, have the courts continued to elevate the physician at the expense of the abortion patient in the recent assessments of "informed consent" regulations and in challenges to rules prohibiting abortion counseling, the newest restriction on the abortion patient's dialogue with her doctor? Second, despite its other difficulties, how might the doctor-focused regime contribute to an analysis of recent outgrowths of the abortion question, including fetal tissue transplants (the subject of John Robertson's and Nicholas Terry's papers[7]), "abortion pills," forced Caesarians and other maternal-fetal conflicts, and modern reproductive technology?

## I. REVISITING "INFORMED CONSENT" TO ABORTION: LAWS MAKING THE PHYSICIAN THE STATE'S MOUTHPIECE OR ITS SILENT PARTNER

When I examined the informed-consent issue earlier, the Supreme Court's last word on the subject was *City of Akron v. Akron Center for Reproductive Health, Inc.*[8] In this case the Court struck down a city ordinance purporting to insure "fully informed [written] consent" to abortion through three requirements. First, the ordinance required that the attending physician orally inform the patient of the status of the "unborn child" as a "human life from the moment of conception;" of the "characteristics of the particular unborn child," including its "appear-

6. *See id.* at 233:

> When the state singles out abortion patients or female birth-control patients for special protection from their physicians by mandating waiting periods and detailed disclosure requirements, the state perpetuates outmoded and pernicious stereotypes of woman as indecisive and incompetent health-care consumers, incapable of obtaining necessary information and time for reflection without paternalistic government intervention.

7. Robertson, *Fetal Tissue Transplants*, 66 WASH. U.L.Q. 443 (1988); Terry, *Politics and Privacy: Refining the Ethical and Legal Issues in Fetal Tissue Transplantation*, 66 WASH. U.L.Q. 523 (1988).

8. 462 U.S. 416, 442-51 (1983).

ance, mobility, tactile sensitivity, including pain;" of the physical and psychological risks of abortion; and of the availability of agencies providing assistance for birth control, adoption and childbirth.[9] Second, the ordinance required that the attending physician inform the patient of the "particular risks associated with her own pregnancy and the abortion technique to be employed," including instructions for appropriate post-abortion care and "such other information which in [the physician's] medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term."[10] Third, the ordinance required that the physician wait twenty-four hours after the pregnant woman signed the consent form before performing the abortion.[11]

In overturning all three parts of this ordinance, the *Akron* majority benefitted abortion patients, while further elevating the interests of physicians. The first part of the ordinance fell not only because it was a "parade of horribles" intended to discourage abortion[12] but also because it intruded upon the physician's discretion.[13] This invasion of physician discretion, unaccompanied by any demonstrated legitimate state interest, also invalidated the twenty-four hour waiting period.[14] The second provision, however, violated the Constitution not because of the content of the information to be communicated (which might advance patient knowledge and hence meaningful choice), but rather because of its insistence that the physician serve as the communicator.[15] Ultimately, as I have pointed out earlier, *Akron* teaches that the state may regulate what the patient hears but not what the doctor says.[16] Regardless of any benefits to patients from the information required by the second part of the ordinance, the physician must remain free of such state regulation. Even if the majority's result allows women less costly abortions as well as the opportunity to receive counseling from those better trained than physicians to perform this function,[17] the majority's reasoning still confirms the preeminence of the physician in Court's analysis.

---

9. *Id.* at 442-44.

10. *Id.* at 446.

11. *Id.* at 449.

12. *Id.* at 445. *See also* Appleton, *supra* note 1, at 216 nn.233-34 (noting Court's consideration of anti-abortion motives underlying this provision).

13. 462 U.S. at 445.

14. *Id.* at 450-51.

15. *Id.* at 448.

16. *See* Appleton, *supra* note 1, at 223-26.

17. *See id.* at 225.

Without reviewing *Akron*'s allocation of decisionmaking authority for abortions, the post-*Akron* literature on informed consent to all medical treatment has continued to advocate increased self-determination for patients and comparatively less paternalism and control by physicians. Jay Katz's, *The Silent World of Doctor and Patient*,[18] published in 1984, urges shared decisionmaking by doctor and patient as essential not only for patient liberty,[19] but also for effective therapy of any kind.[20] Though he does not mention abortion in particular, Katz explicitly rejects the fusion of doctor and patient emerging from the Court's early analyses of the abortion right[21] when he emphasizes "[p]hysicians' and patients' separate identities" and the "existence of inevitable conflict" between them.[22]

Along the same line, with respect to medical treatment in general, Marjorie Maguire Shultz has persuasively pressed for recognition of patient choice as an expressly protected interest[23] rather than as a by-product of the law's protection of bodily security and bodily well-being.[24] As Shultz sees this interest in patient choice and the physician's resulting duty, the physician's "possession of information rather than [any] proposed physical contact . . . ought to occasion . . . disclosure" to the patient,[25] who could then meaningfully participate in medical decisionmaking.[26] Further, Shultz concedes that abortion and other constitutional privacy cases about medical care fail to address the allocation of authority *between* physician and patient,[27] but argues that these cases do stress individual autonomy and decisionmaking.[28] Given her conces-

18. J. KATZ, M.D., THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

19. *See id.* at 84, 101-02.

20. *See id.* at 225.

21. *See* Appleton, *supra* note 1, at 197-204 (demonstrating how Court has depicted physician as speaking for and deciding for abortion patient).

22. Katz writes:

> The belief that doctors can act on behalf of patients denies the existence of inevitable conflict. Physicians' and patients' separate identities become obliterated. They collapse into one identity and one single authoritative voice emerges—the physician's. . . . The authority of the physician becomes virtually absolute.

J. Katz, *supra* note 18, at 99-100.

23. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

24. *Id.* at 219.

25. *Id.* at 243, 246.

26. *Id.* at 247.

27. *Id.* at 277 n.243.

28. *Id.* at 277.

sion, however, perhaps she means that these cases ought to emphasize these values or that, even now, they use rhetoric purporting to do so. Shultz then urges private law to follow by adopting a similar focus on "intangible decisionmaking."[29]

Recent case law outside the abortion context has begun to creep in this same direction, although without achieving the velocity or the distance sought by Katz or Shultz. For example, recognition of "the patient's right of self-determination" recently persuaded New Jersey to join a number of other jurisdictions that had abandoned the "professional" standard for measuring a physician's duty to disclose information to a patient in favor of a "prudent patient" rule.[30] "The foundation for the physician's duty to disclose in the first place is found in the idea that 'it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.' "[31]

Despite the increasing prominence and clarity of patient autonomy in tort law's informed-consent doctrine and the corollary disfavor of physician paternalism in this area,[32] such values remain submerged and clouded in constitutional challenges to "informed-consent" regulations to abortion.[33]

In the most recent of such challenges to reach the Court, *Thornburgh v. American College of Obstetricians and Gynecologists*,[34] a majority struck down a Pennsylvania provision requiring the physician to commu-

29. *Id.*

30. Largey v. Rothman, 110 N.J. 204, 213, 540 A.2d 504, 509 (1988). Under the prudent patient rule, a physician has a duty to disclose a risk "when a reasonable patient, 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 to forego the proposed therapy or to submit to it." *Id.* at 211-12, 540 A.2d at 508 (citation omitted). The New Jersey Supreme Court lists the other jurisdictions following the prudent patient rule first adopted in Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). *Largey*, 110 N.J. at 212, 540 A.2d at 508.

Shultz would go further, proposing an individualized standard looking to whether a physician's failure to disclose encroached upon the patient's own right to choose. Shultz, *supra* note 23, at 251.

31. 110 N.J. at 214, 540 A.2d at 509 (quoting *Canterbury*, 464 F.2d at 781).

32. *See* 110 N. J. at 214, 540 A.2d at 509; J. KATZ, *supra* note 18, at 110, 128; Shultz, *supra* note 23, at 274-75. *See also* Appleton, *supra* note 1, at 221-22 & n.272 (criticizing possible paternalism in constitutional opinions about reproductive health care).

33. In other words, I disagree with Marjorie Shultz's claims that "in this instance the public law is somewhat in advance of the private" and that the "intangible decisionmaking focus of the constitutional privacy interest presages the change in private law" proposed by Shultz. Shultz, *supra* note 23, at 277.

34. 476 U.S. 747 (1986).

nicate the following to the patient twenty-four hours before procuring her consent to abortion:

> (a) the name of the physician who will perform the abortion, (b) the "fact that there may be detrimental physical and psychological effects which are not accurately foreseeable," (c) the "particular medical risks associated with the particular abortion procedure to be employed," (d) the probable gestational age, and (e) the "medical risks associated with carrying her child to term."[35]

The statute also required that the woman be told, although not necessarily by her physician, of the availability of medical assistance benefits for pregnancy and childbirth, child support from the father, and printed materials describing the fetus and state services providing help after birth.[36]

Citing *Akron*, the Court invalidated the entire provision because of its anti-abortion design and its invasion of physician discretion.[37] Improving upon the unsatisfactory explanation offered in *Akron*,[38] the Court in *Thornburgh* tried to explain precisely why such statutes pose problems from the perspective of the pregnant woman seeking to exercise her right to reproductive choice: The statute unconstitutionally imposes upon a woman "state medicine . . ., not the professional guidance she seeks. . . ."[39] According to the Court, such compelled information, which might heighten patient anxiety[40] and which in some cases, say, life-threatening pregnancies, would be cruel and destructive,[41] "is the antithesis of informed consent."[42] The majority opinion concludes with at least partly revisionist language asserting that, all along, the privacy right

---

35. *Id.* at 760.

36. *Id.* at 760-61.

37. *Id.* at 762.

38. In *Akron*, the Court sought to show the impact on the woman by stating that the ordinance placed "obstacles in the path of the doctor upon whom [the woman is] entitled to rely for advice in connection with her decision." 462 U.S. at 445 (quoting Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977)). It failed to explain, however, why such obstacles necessarily diminish rather than enhance the patient's choice.

39. 476 U.S. at 763 (footnote omitted).

40. The Court noted that heightening the patient's anxiety would contravene "accepted medical practice," *id.* at 762, in yet another reference to the physician-focused standard that controls these cases. *See* Appleton, *supra* note 1, at 189-97.

41. 476 U.S. at 763.

42. *Id.* at 764. *See also* Henderson, *Legality and Empathy*, 85 MICH. L. REV. 1574, 1634 (1987) (this part of majority's opinion in *Thornburgh* "appear[s] to illustrate an empathic understanding of the experience of women who have an unwanted—disastrous—pregnancy" in a way that *Roe* and other cases had ignored).

has belonged equally to women and men.[43]

Justice White's dissent, emphasizing the way in which the physician's disclosure of information is ordinarily thought to enhance patient choice, rejects the majority's conclusion that anxiety-producing or choice-influencing disclosures undermine liberty.[44] Similarly, Justice O'Connor's dissent, although conceding that disclosure requirements may interfere with the first amendment rights of physicians, notes that all informed-consent rules by their very purpose necessarily "intrude to some extent on the physician's discretion to be the sole judge of what his or her patient needs to know."[45]

In their appeal to patient self-determination all three opinions—the majority's, Justice White's and Justice O'Connor's—obscure an important point, which cannot be avoided once one confronts the even more seriously flawed reasoning of then-Chief Justice Burger's dissent. This opinion asks:

> Can anyone doubt that the State could impose a similar [disclosure] requirement with respect to other medical procedures? Can anyone doubt that doctors routinely give similar information concerning risks in countless procedures having far less impact on life and health, both physical and emotional than an abortion, and risk a malpractice lawsuit if they fail to do so?
>
> . . .Can it possibly be that the Court is saying that the Constitution *forbids* the communication of such critical information to a woman?[46]

The answers are, of course, yes, the state *could* impose a similar disclosure requirement on other medical procedures and, yes, doctors routinely give similar information while risking malpractice suits for failure to do so. (And certainly the Constitution does not forbid a doctor from communicating such information; indeed, a private physician's voluntary communication to his patient entails no state action and hence violates

---

43. 476 U.S. at 772:

> Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government. . . . That promise extends to women as well as men. Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision—with the guidance of her physician and within the limits specified in *Roe*—whether to end her pregnancy. A woman's right to make that choice freely is fundamental. Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all.

44. 476 U.S. at 801 (White, J., dissenting).

45. *Id.* at 830 (O'Connor, J., dissenting).

46. *Id.* at 783 (Burger, C.J., dissenting) (emphasis in original).

no constitutional right of the patient.[47]) But the point that gets lost in these arguments is that, despite its power, the state *does not* regulate disclosure to other medical procedures in the same way or with the same detail that it uses for abortion. Even in states that have codified the informed-consent requirement, the statutes merely identify a standard of care for judging claims of negligence in lawsuits brought by individual patients.[48] These statutes, which define informed consent in very general terms,[49] do not impose criminal penalties on non-complying physicians.[50] The result, then, is that the state has singled out abortion patients—a class composed entirely of women—as needing governmental supervision of their receipt of information from their physicians. Such unique treatment fosters a demeaning stereotype of women as incompetent health-care consumers.[51]

Failure to appreciate the unique way in which the state oversees abortion patients has produced strange reasoning in the lower courts. For example, relying on *Thornburgh*, the United States Court of Appeals for the Seventh Circuit recently invalidated an Illinois statute *solely* because of its intrusion upon the discretion of the abortion patient's physician.[52] This statute had in part prescribed the content of pre-abortion counseling[53] and in part constrained such counseling by prohibiting any person with a financial interest in the patient's decision from counseling her.[54]

---

47. *See* Appleton, *supra* note 1, at 212 and n.209. *See also, e.g.*, Planned Parenthood Ass'n—Chicago Area v. Kempiners, 531 F. Supp. 320, 329 (N.D. Ill. 1981) (counseling by health-care providers "on their own" "involves no state action and cannot offend the Constitution"), *vacated and remanded on other grounds*, 700 F.2d 1115 (7th Cir. 1983).

48. *See* Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163 (1984).

49. *But see* Appleton, *supra* note 1, at 233 n.366 (noting one exception: a civil statute singling out breast cancer patients, who are virtually always female, for disclosure of "complete information on all alternative treatments which are medically viable").

50. *See generally*, Andrews, *supra* note 48. By contrast, the Pennsylvania statute subjected the physician to suspension or revocation of his license and others to criminal penalties. 476 U.S. at 759-60. The notably different message that the state communicates when it makes "informed consent" to abortion a matter of criminal law rather than simply providing a forum for a dissatisfied patient's civil claim reveals why Thomas Jipping's recent analysis misses the mark. *See* Jipping, *Informed Consent to Abortion: A Refinement*, 38 CASE W. RES. 329 (1988). *Cf. id.* at 377 (attempting to use a malpractice case about informed consent to abortion to establish the validity of the statute struck down in *Thornburgh*).

51. *See* Appleton, *supra* note 1, at 233-34 (elaborating on this argument).

52. Ragsdale v. Turnock, 841 F.2d 1358, 1372-73 (7th Cir. 1988).

53. *Id.* at 1372.

54. *Id.* at 1373. The statute also unconstitutionally required the physician who was to perform the abortion to perform a pregnancy test. *Id.* at 1372.

Even more disturbing, given what women have at stake in such challenges to abortion regulations, is a district court opinion that takes the Supreme Court's vision of doctor as decisionmaker to a new, although not really surprising, extreme.[55] This court struck down as unconstitutional a Missouri "informed consent" statute requiring, among other things, the abortion patient to be informed "according to the best medical judgment of her attending physician whether she is or is not pregnant."[56] Among the reasons the court cited for the unconstitutionality of this criminal provision was one specific way in which it invaded physician discretion. In the court's words, "it is clear that some physicians believe that it is in the best health interest of *many* patients seeking abortions not to be told definite results of pregnancy tests."[57] Because the court did not perceive the real vice in the statute—its suggestion that an exclusively female class of patients cannot be trusted to elicit on their own this important information from their doctors—the court embraced a view of physicians as "protecting" their patients from the difficult moral choice that abortion always presents.[58] Though I support the court's result, holding the statute unconsitutional, I am troubled by the court's explicit approval of patient ignorance and physician paternalism and its diminution of meaningful personal choice.

Most courts have done a better job, I think, with laws that present the mirror image of the forced-disclosure statutes. Instead of making the physician the state's anti-abortion mouthpiece,[59] these prohibited-disclosure provisions impose upon the physician the role of silent partner in the official campaign to minimize abortions. Such provisions, adopted by officials hoping to expand the constitutional protection the Supreme Court afforded to funding allocations that exclude abortions,[60] forbid abortion

55. Reproductive Health Servs. v. Webster, 662 F. Supp. 407 (W.D. Mo. 1987), *aff'd in part on other grounds*, 851 F.2d 1071 (8th Cir. 1988) (state did not appeal from district court's holding on this part of statute), *petition for appeal filed*, 57 U.S.L.W. 3296 (U.S. Sept. 11, 1988) (No. 88-605).

56. 662 F. Supp. at 414.

57. *Id.* at 415 (emphasis added). Relying on *Akron*, the court also found unconstitutional the provision's requirement that the *attending physician* apprise the woman of the statutorily listed facts. *Id.* at 414, 416.

58. Despite its emphasis on physicians and medical standards, even the early abortion opinions of the Supreme Court acknowledged that each abortion decision raises more than purely medical questions. *See* Appleton, *supra* note 1, at 198-200 (discussing Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973)); *see also* Jipping, *supra* note 50, at 374 (contrasting Court's differing definitions of "health" issues raised by each abortion choice).

59. *See Thornburgh*, 476 U.S. at 763 (informed-consent statute makes doctor "an agent of the State").

60. *See, e.g.*, Reproductive Health Servs. v. Webster, 851 F.2d 1071, 1080 (8th Cir. 1988) (cit-

counseling and referrals by physicians and other health-care workers receiving public support.[61]

Despite the argument that these are refusals to subsidize abortion which do not impinge upon the right to privacy,[62] almost every court that has considered such provisions on the merits has found them unconstitutional.[63] True, one court's constitutional analysis[64] focuses almost exclusively on the way in which these laws infringe the first amendment rights of the physician or family planning service,[65] and another court

---

ing Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977)). *Cf.* Bowen v. Kendrick, 108 S. Ct. 2562 (1988) (Adolescent Family Life Act, which provides federal grants to agencies, including religious organizations providing services related to teenage pregnancy, so long as such services do not include family planning and the promotion of abortion, does not on its face violate establishment clause of the first amendment).

61. *See* Reproductive Health Servs. v. Webster, 851 F.2d 1071 (8th Cir. 1988) (challenging Missouri statute prohibiting use of public funds or public facilities for purpose of performing, assisting, encouraging or counseling abortions not necessary to save woman's life and prohibiting public employees from performing, assisting, counseling or encouraging abortions not necessary to save woman's life); Planned Parenthood of Cent. and N. Ariz. v. Ariz., 789 F.2d 1348 (9th Cir.) (challenging footnote in appropriations bill forbidding state support of organizations that engage in abortions and abortion-related services), *aff'd sub nom.* Babbitt v. Planned Parenthood of Cent. & N. Ariz., 479 U.S. 926 (1986); State of N.Y. v. Bowen, 690 F. Supp. 1261 (S.D.N.Y. 1988) (challenging federal regulations that prohibit encouraging, promoting, or advocating abortion and counseling and referral for abortion by publicly funded family planning projects); Planned Parenthood Fed. of America v. Bowen, 680 F. Supp. 1465 (D. Colo. 1988) (same), 687 F. Supp. 540 (granting permanent injunction); Commonwealth of Mass. v. Bowen, 679 F. Supp. 137 (D. Mass. 1988) (same), *appeal docketed*, No. 88-1279 (1st Cir. ——, 1988); Planned Parenthood Ass'n—Chicago Area v. Kempiners, 531 F. Supp. 320 (N.D. Ill. 1981) (challenging statute that disqualifies state grant applicants providing abortion counseling and referral services), *vacated and remanded on other grounds*, 700 F.2d 1115 (7th Cir. 1983), *on remand*, 568 F. Supp. 1490 (N.D. Ill. 1983).

62. *See generally* Appleton, *Beyond the Limits of Reproductive Choice: The Contributions of the Abortion-Funding Cases to Fundamental-Rights Analysis and to the Welfare-Rights Thesis*, 81 COLUM. L. REV. 721 (1981).

63. These measures were found unconstitutional in all of the cases listed *supra*, note 61, except State of N.Y. v. Bowen, 690 F. Supp. 1261. *See also* Benshoof, *The Chastity Act: Government Manipulation of Abortion Information and the First Amendment*, 101 HARV. L. REV. 1916, 1917 (1988) (arguing unconstitutionality of "the largest federal domestic program to date that restricts speech about abortion").

64. The federal regulations have been held invalid on nonconstitutional grounds as well. *See* 680 F. Supp. at 1468-73 (regulations enacted without statutory authority), 687 F. Supp. 540 (granting summary judgment to plaintiffs challenging regulation and replacing preliminary injunction with permanent injunction); 679 F. Supp. at 140-44 (regulations conflict with congressional intent). *But see* 690 F. Supp. at 1265-72 (regulations do not offend controlling federal statute, do not violate legislative intent with such clarity that they should be set aside, and are neither arbitrary nor capricious).

65. *See* 679 F. Supp. at 144-47 (extended analysis of why federal regulations violate first amendment rights of health-care providers followed by one paragraph noting impermissible burden on privacy right of pregnant patients).

treats the "physician's crucial role" as an independent protected right.[66] Further, the one court upholding such provisions overlooks the patient's interests entirely by simply contrasting the prohibition of speech with the failure to support it financially.[67] Still, one can find reasoning in these cases that effectively reveals what patients have at stake as well. While the physician's first amendment rights include competently counseling patients,[68] the patient's first amendment rights include "the opportunity to receive . . . information."[69] And a woman who cannot consult with her physician about the abortion option cannot exercise her freedom of choice.[70]

The statutes that prohibit abortion counseling or referrals present relatively easy cases, however. Physician and patient share a single goal that these laws inhibit: an opportunity for full disclosure. A successful challenge to these laws benefits both parties. Moreover, analyzed as issues of sex-based discrimination, these laws clearly disadvantage an all-female class of patients by singling out its members for an incomplete discussion of their medical options. No other patients are similarly restricted in their discussions with their health-care providers.[71]

---

66. *See* 680 F. Supp. at 1474-76 (court identifies regulations' intrusion into "physician's crucial role" as a constitutional flaw "in addition" to their restriction of flow of information to pregnant woman), 687 F. Supp. 540 (granting summary judgment to plaintiffs and permanently enjoining regulations).

67. *See* 690 F. Supp. at 1274 ("[The regulations] grant money to support one view and not another; but that is quite different from infringing on free speech.").

68. 662 F. Supp. at 426, *aff'd in part*, 851 F.2d 1071 (8th Cir. 1988); *see* 680 F. Supp. at 1476, 687 F. Supp. 540 (granting permanent injunction); *cf.* DKT Memorial Fund Ltd. v. Agency for Int'l Dev., 691 F. Supp. 394, 404-05 (D.D.C. 1988) (policy statement and implementing clause prohibiting governmental funding of foreign family planning organizations "promoting abortion" and similarly restricting subgrants from domestic organizations abridge freedom of speech). *But see* 690 F. Supp. 1273 (funding given "only to those who support particular views does not violate consitutional rights"); Planned Parenthood Ass'n—Chicago Area v. Kempiners, 531 F. Supp. 320, 324-25 (N.D. Ill. 1981) (grant ineligibility for organization that offers abortion counseling does not interfere with organization's protected rights), *vacated and remanded on other grounds*, 700 F.2d 1115 (7th Cir. 1983).

69. 662 F. Supp. at 426, *aff'd in part*, 851 F.2d 1071 (8th Cir. 1988); 680 F. Supp. at 1476-78, 687 F. Supp. 540 (granting permanent injunction); 531 F. Supp. at 330-33, *vacated and remanded on other grounds*, 700 F.2d 1115 (7th Cir. 1983).

70. 851 F.2d at 1080; 680 F. Supp. at 1476, 687 F. Supp 540 (granting permanent injunction); 662 F. Supp. at 427; *see* 679 F. Supp. at 147; 531 F. Supp. at 326-30, *vacated and remanded on other grounds*, 700 F.2d 1115 (7th Cir. 1983), *after remand*, 568 F. Supp. at 1496-99.

71. Although the state or federal government routinely bans or restricts the use, sale, or prescription of certain drugs or devices, *see* Whalen v. Roe, 429 U.S. 589, 603 n.30 (1977); People v. Privitera, 23 Cal.3d 697, 591 P.2d 919, 153 Cal. Rptr. 431, *cert. denied*, 444 U.S. 949 (1979), I know of no rule that prohibits the physician from *counseling* his patient on such matters—that is, *discuss-*

By contrast, in the "informed-consent" or forced-disclosure cases the statutes purport to guarantee the patient information that the physician may have elected not to reveal.[72] Physician's and patient's interests do not merge so easily here. This potential conflict between doctor and patient, which is the core of the tort doctrine of informed consent and its modern extensions, ought to trigger a separation of the patient's interests in self-determination from the physician's interests in the unrestricted practice of his profession. This separation would not only solidify abortion doctrine, but would also clarify how to approach several new questions about human reproduction that do not directly concern abortion.

## II. BEYOND ORDINARY ABORTION ISSUES

The constitutional protection that the Court has provided for abortion generates a number of new questions in which the confusion about doctors' and patients' interests becomes especially problematic. The discussion that follows will not attempt to analyze fully these issues; rather it will use them to illustrate the importance of the Court's failure to delineate the appropriate spheres of physician and patient.

### *A. RU 486 and Future "Abortion Pills"*

New developments in abortion technology require a clearer identification of the primary beneficiary of the Court's holdings. Abortion, as we

---

*ing* such subjects with his patient or *answering* a patient's questions thereon. *Compare* Young Women's Christian Ass'n. v. Kugler, 342 F. Supp. 1048 (D. N.J. 1972) (pre-*Roe* criminal abortion statute prohibited doctors from *prescribing, advising* or *directing* woman to take medication with intent to cause abortion; even these laws did not criminalize discussion of abortion or answering patient's questions thereon) *with* 680 F. Supp. at 1474 (under federal regulations "practitioners counseling women on how to manage an unintended pregnancy will not be able to mention abortion"), 687 F. Supp. 540 (granting permanent injunction) *and* 851 F.2d at 1079 (ban on "encouraging or counseling" abortion is unconstitutionally vague). In any event, abortion, unlike laetrile (the subject of *Privitera*), is not an illegal treatment, and, of course, physicians who communicate false, erroneous or misleading information to their patients may face civil or criminal liability. *See, e.g.*, Natanson v. Kline, 186 Kan. 393, 406, 350 P.2d 1093, 1103 (1960) (physician may be civilly liable for affirmative misrepresentation to patient); People v. Phillips, 64 Cal.2d 574, 578, 414 P.2d 353, 357, 51 Cal. Rptr. 225, 229 (1966) (grand theft), *on remand*, 270 Cal. App.2d 381, 75 Cal. Rptr. 720 (Dist. Ct. App. 1969)(second-degree murder), *cert. denied*, 396 U.S. 1021 (1970).

Theordore Hirt's recent attempt to defend abortion-counseling restrictions does not address the unique, gender-specific operation of such laws. *See* Hirt, *Why the Government Is Not Required to Subsidize Abortion Counseling and Referral*, 101 HARV. L. REV. 1859 (1988).

72. Shultz approves a standard under which a physician's possession of "significant knowledge about the medical condition of the patient," rather than a proposed physical contact with the patient, would trigger the duty to disclose. *See* Shultz, *supra* note 23, at 243.

know it today, is a mechanical or surgical procedure that entails the direct or active participation of the woman's physician.[73] The development of an "abortion pill," such as the currently experimental RU 486, which acts as a progesterone antagonist to terminate early pregnancies,[74] foretells a different vision in which the physician's involvement—for example, writing a prescription—precedes the actual abortion, perhaps by a significant interval.[75]

It is not difficult to imagine situations in which the physician might play, at most, a minimal role. For example, after the physician consults with and examines the patient, he prescribes an abortion pill, but after filling the prescription the patient decides not to use the medication and continues the pregnancy to term. Or this patient may use this pill to terminate a subsequent pregnancy without consulting a physician about this particular abortion. Finally, a physician might prescribe a substance like RU 486 for a patient to use in the event of a subsequent late menstrual period, without further physician consultation at the time the drug is ingested,[76] or to use regularly to prevent or interrupt unplanned pregnancies.[77]

As these hypothetical scenarios indicate, developments such as RU 486 allow increasing privatization of the abortion decision. These developments may not only shield the woman and her physician from the

73. *See* Roe v. Wade, 410 U.S. 113 (1973); Connecticut v. Menillo, 423 U.S. 9 (1975); Cahill, *'Abortion Pill' RU 486: Ethics, Rhetoric, and Social Practice*, HASTINGS CENTER REP., Oct.-Nov. 1987, at 5. *Cf.* Appleton, *supra* note 1, at 192 n.52 (noting menstrual extraction and other self-help techniques).

74. Cahill, *supra* note 73; Cousinet, LeStrat, Ulmann, Baulieu, & Schaison, *Termination of Early Pregnancy by the Progesterone Antagonist RU 486 (Mifepristone)*, 315 NEW ENG. J. MED. 1565 (1986). *See also* R. GOLDSTEIN, *supra* note 3, at 17 (RU 486, which "terminate[s] uterine receptivity," allows woman to assert her bodily integrity without invading bodily integrity of fetus); N.Y. Times, October 30, 1988, at 1, col. 1 (RU 486, removed from French market because of pressure from anti-abortion groups and ordered returned by French government, would face numerous obstacles in U.S.).

75. Those conducting studies of RU 486, however, state: "The occurrence of failed abortions [in 15 out of 100 subjects] and prolonged uterine bleeding in some subjects mandates that this drug be used only under close medical supervision." Cousinet et al., *supra* note 74, at 1569. The subjects in this study received oral doses of RU 486 as outpatients, with follow-up visits scheduled for days 4, 6, 9 and 13 and still later visits for some subjects. *Id.* at 1566.

76. Follow-up consultation may well be necessary. *See supra* note 75.

77. *See* Cahill, *supra* note 73, at 5, 8; Nieman, Choate, Chrousos, Healy, Morin, Renquist, Merriam, Spitz, Bardin, Baulieu, & Loriaux, *The Progesterone Antagonist RU 486: A Potential New Contraceptive Agent*, 316 NEW ENG. J. MED. 187, 190 (1987) (study concludes that RU 486 "holds promise as a safe and effective form of fertility control that can be administered once a month").

scrutiny that "surgical" abortion invites,[78] but may also insulate the woman's choice from the direct and immediate involvement of the physician. Such abortion decisions increasingly resemble contraception, conception, and continuation-of-pregnancy decisions in which the physician's participation, attenuated at best, often occurs well before or after the fact.[79] Only a constitutional framework premised on the independent right of the woman, rather than on the physician's participation in each abortion determination, can accommodate such developments.[80]

In addition, developments like RU 486 underscore the previously examined need for a coherent approach to informed consent to abortion, under which tort remedies available to all, rather than gender-specific state intervention, encourage appropriate communication between physician and patient.[81] Whether a physician describes a drug like RU 486 to his patient as a method of birth control or abortion (or as a method of contraception or "contragestation"[82]) may have a significant impact on her decisionmaking process and her own moral resolutions.[83] Such choices ought to belong to *her*, free from the protective paternalism of either her physician or the state,[84] and the constitutional analysis ought to reflect this goal.

### *B. Fetal Tissue Transplants*

On June 20, 1988, Missouri became the first state to ban medical transplantation of fetal tissue from abortions known to be procured for that reason and abortions of fetuses known to be conceived for such pur-

78. Cahill, *supra* note 73, at 5.

79. In other words, although the physician may render medical assistance, as he does when he prescribes oral contraceptives or provides prenatal care, his consultation with the woman ordinarily occurs before or after she makes her decision to avoid conception or to conceive and carry to term.

80. The Court's habitual deference to accepted medical practice, *see supra* text accompanying note 2, cannot resolve such issues any more than it could resolve challenges to, say, state regulation of family size or state determination of the "right" time for a woman to conceive a child. Although state interests in population control might enter such analysis, *see, e.g.*, Griswold v. Connecticut, 381 U.S. 479, 496-97 (1965) (Goldberg, J., concurring), accepted medical practice would not be an issue.

81. *See supra* note 6 and accompanying text.

82. *See* Cahill, *supra* note 73, at 7.

83. *See id. See also* Appleton, *supra* note 1, at 219-23 (considering requirement that physicians prescribing "abortifacients" so inform their patients).

84. *Cf. supra* text accompanying notes 55-58 (criticizing Reproductive Health Servs. v. Webster, 662 F. Supp. 407, 415 (W.D. Mo. 1987), *aff'd in part on other grounds*, 851 F.2d 1071 (8th Cir. 1988)).

poses.[85] John Robertson, whose article explains fully the diseases that fetal transplants may alleviate,[86] reads *Roe v. Wade* to protect a decision to abort to obtain fetal tissue for transplantation.[87] He would conclude that a law like Missouri's violates the Constitution because "state laws that conditioned abortion on particular motivations would be invalid."[88]

I wonder whether the right recognized in *Roe* reaches so far. It is true that *Roe*'s protection of the abortion choice did not discriminate among the reasons a woman might have for making this decision,[89] even if Justice Douglas's concurrence identified this facet of the right to privacy more explicitly than the majority's opinion.[90] The *Roe* majority did, however, list a number of burdens or detriments that unwanted

---

85. On June 20, 1988, the following amendment to Chapter 188 of the Revised Statutes of Missouri was signed into law:

> 188.036. 1. No physician shall perform an abortion on a woman if the physician knows that the woman conceived the unborn child for the purpose of providing fetal organs or tissue for medical transplantation to herself or another, and the physician knows that the woman intends to procure the abortion to utilize those organs or tissue for such use for herself or another.
>
> 2. No person shall utilize the fetal organs or tissue resulting from an abortion for medical transplantation, if the person knows that the abortion was procured for the purpose of utilizing those organs or tissue for such use.
>
> 3. No person shall offer any inducement, monetary or otherwise, to a woman or a prospective father of an unborn child for the purpose of conceiving an unborn child for the medical, scientific, experimental or therapeutic use of the fetal organs or tissue.
>
> 4. No person shall offer any inducement, monetary or otherwise, to the mother or father of an unborn child for the purpose of procuring an abortion for the medical, scientific, experimental or therapeutic use of the fetal organs or tissue.
>
> 5. No person shall knowingly offer or receive any valuable consideration for the fetal organs or tissue resulting from an abortion, provided that nothing in this subsection shall prohibit payment for burial or other final disposition of the fetal remains, or payment for a pathological examination, autopsy or postmortem examination of the fetal remains.
>
> 6. If any provision in this section or the application thereof to any person, circumstance or period of gestation is held invalid, such invalidity shall not affect the provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared severable.

1988 Mo. Legis. Serv. —— (Vernon).

A more extended review of this legislation appears in Terry, *supra* note 7, at 537-41.

86. *See* Robertson, *supra* note 7, at notes 5-9 and accompanying text.

87. *Id.* at notes 142-46 and accompanying text.

88. *Id.* at text accompanying note 144.

89. *See* 410 U.S. at 153-54.

90. Doe v. Bolton, 410 U.S. 179, 215 (1973) (Douglas, J., concurring in an opinion applicable to *Roe* and *Doe*):

> Georgia's [abortion] enactment has a constitutional infirmity because, as stated by the District Court, it "limits the number of reasons for which an abortion may be sought." I agree with the holding of the District Court, "This the State may not do, because such action unduly restricts a decision sheltered by the Constitutional right to privacy."

[citation omitted]

pregnancies impose.[91] As one might expect, this 1973 list does not include any reference to the sorts of "detriments" that transplanting fetal tissue to oneself or to another might alleviate. Yet to the extent that the Missouri statute prohibits *abortions* that could relieve the burdens on *Roe*'s list, whatever their motiviation,[92] it violates the Constitution, absent a compelling state interest. On the other hand, to the extent that such statutes might simply prohibit a certain reason for aborting (tissue transplantation) while still allowing a woman to terminate the same pregnancy for other reasons (or for no particular reason at all),[93] then I doubt such statutes, though difficult to enforce, violate the constitutional right to choose "whether or not to terminate [a] pregnancy."[94] The woman remains free to decide to terminate her pregnancy and to act on her

---

91. 410 U.S. at 153:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. 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 the 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, as in this one, 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.

92. In other words, subsection 1 of the Missouri statute prohibits physicians from performing abortions when certain conditions obtain; the statute does not exclusively address post-abortion disposition of fetal tissue. *See supra* note 85.

93. The Missouri statute allows tissue transplantation so long as the person "utilizing" the tissue (presumably the physician performing the transplantation—or perhaps the recipient) does not know that the abortion was procured for such purpose. Thus, the statute allows transplantation of tissue from "family-planning abortions" and transplantation from abortions performed for transplantation purposes so long as the woman conceals this reason from the "utilizer." *See supra* note 85.

94. 410 U.S. at 153. *See id.* (Court disagrees that woman is "entitled to terminate her pregnancy . . . for whatever reason she *alone* chooses") (emphasis added). This statement probably reflects the physician's crucial role in the Court's analysis rather than a limitation on the permissible reasons for abortion.

As my student, Kathryn Case (Washington University School of Law, class of 1989), has pointed out, in several other situations a woman may seek an "abortion" for reasons other than to avoid pregnancy itself. *See* seminar paper on file with *Washington University Law Quarterly*. Consider, for example, abortion of a fetus with chromosomal anomalies revealed by prenatal testing, followed by a completed pregnancy of a "normal" fetus (*see generally* Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618, 656 (1979) (discussing "replacement" theory as method of measuring damages in wrongful life cases)), abortion of a fetus of the undesired gender, followed by a completed pregnancy of a fetus of the desired gender (*see, e.g.*, Note, *Sex Selection Abortion: A Constitutional Analysis of the Abortion Liberty and a Person's Right to Know*, 56 IND. L.J. 281 (1981)), or selective abortion of one or more fetuses in a multiple-fetus pregnancy (*see, e.g.*, N.Y. Times, Jan. 25, 1988, § 1 at 1, col. 6).

decision.[95]

Similarly, if such statutes simply ban post-abortion transplantation, but do not ban the abortions themselves, then the right articulated in *Roe* would not be implicated.[96] In other words, nothing in *Roe* suggests protection for a woman's ownership of the fetal tissue removed from her uterus[97] or her control over its disposition following the abortion.[98] Rob-

95. Robertson's elaboration of the "subtle point," *see* Robertson, *supra* note 7, at 487 n.145, underlying his conclusion is not convincing. First, the consequences of foregoing an abortion because the state has banned the pregnant woman's motive for aborting are vastly different from an individual's decision to forego publication of protected material because the state has removed the profit-motive. When a woman decides to bear a child because the state has outlawed tissue transplantation, the one reason for which she would have terminated the pregnancy, the consequence is palpable and life-altering; this woman must have chosen to bear the child—otherwise, she could have obtained an abortion for other ("family planning") reasons. But the individual who, without prospect of a profit, foregoes publication faces no such consequence and, indeed, may later reconsider. *Cf.* Bellotti v. Baird, 443 U.S. 622, 642 (1979) (pluralilty opinion) (abortion decision cannot be postponed). In short, the pregnant woman who does not abort and the would-be publisher are not in parallel positions. Second, another comparison weakens Robertson's analogy. With respect to another aspect of the fundamental right to privacy or liberty, divorce, *see* Boddie v. Connecticut, 401 U.S. 371, 382-83 (1971) (due process guarantees access to courts for this "exclusive precondition to the adjustment of a fundamental human relationship"); *see also* Karst, *The Freedom of Intimate Association*, 89 Yale L.J. 624, 671-72 (1980) (suggesting no-fault divorce is constitutionally required), states have long specified the grounds and have disallowed the exercise of the right for other "motives," even in the current no-fault era. Finally, it may well be that if Robertson's hypothetical law directing the profits from certain speech to charity uncontitutionally burdens speech, it does so because such laws may result in the disappearance of certain speech from the market—to the detriment of the first amendment rights of those who would read or hear such publications (recipients). *Cf.* N.Y. EXEC. LAW § 632-a (McKinney 1982) (New York's "Son of Sam" law directing to the victims of a crime the profits that the criminal might earn from publications about his or her crime). This extension of Robertson's analogy may reinforce the emphasis that he ultimately places on the fetal-tissue recipient's constitutional rights. *See* Robertson, *supra* note 7, at notes 154-56 and accompanying text.

96. *See* Wynn v. Scott, 449 F. Supp. 1302, 1322 (N.D. Ill.) (ban on fetal research does not infringe on fundamental right recognized in *Roe*), *appeal dismissed sum nom.* Carey v. Wynn, 439 U.S. 8 (1978), *aff'd on other grounds sub nom.* Wynn v. Carey, 599 F.2d 193 (7th Cir. 1979). *But see* Note, *State Prohibition of Fetal Experimentation and the Fundamental Right to Privacy*, 88 COLUM. L. REV. 1073 (1988).

97. I agree with Robertson's conclusion that the "woman has no inherent right to dispose of fetal tissue or designate the recipient." *See* Robertson, *supra* note 7, at 487 n.145. *But see id.* at note 65 and accompanying text. Though the fetus is not a person, *Roe*, 410 U.S. at 158, and although it depends on the woman's body for survival at least until viability, it has its own unique identity, reflected in its own genetic structure, which differs from that of the woman. The fetus occupies her body but is not part of it. The point is not that the woman therefore should lose all say about the tissue disposition (compare how the next of kin may control the donation of cadaveric organs) but is simply that the tissue is not "hers." *Cf.* Moore v. Regents of the Univ. of Cal., no. BO 21195 (July 21, 1988) (because persons have property right in their bodily tissues, patient may sue for conversion physician and others who, without patient's consent, used cells removed from his body to develop profitable pharmaceuticals).

ertson concedes this point when analyzing bans on the use of tissue obtained for "family planning abortions" but reaches a different result for bans on donor designation of the tissue recipient.[99]

This discussion overlooks two important points, however. First, in the Supreme Court's informed-consent opinions, *Akron* and *Thornburgh*, examined earlier, the legislature's anti-abortion design played a "decisive" role in invalidating the statute.[100] Prohibitions on the use of fetal tissue or statutes like Missouri's—with its "unborn child" language,[101] its inclusion in Missouri's criminal abortion restrictions,[102] and its post-abortion transplantation ban[103]—may well fall for this reason even if a woman remains free to terminate her pregnancy and thereby to avoid all

98. The Court has held unconstitutional regulation of post-abortion disposition when the vagueness of the statute failed to give fair warning to the physician. *See* City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 451-52 (1983). This example, however, simply supports my later point—that these issues are better considered as encroachments on the physician's discretion rather than state invasions of the patient's privacy right. *See infra* note 109 and accompanying text. In addition, the Court has upheld post-abortion record-keeping requirements, *see* Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 81 (1976) ("no legally significant impact or consequence on the abortion decision or on the physician-patient relationship"), and post-abortion pathology test requirements that comport with accepted medical practice, *see* Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 462 U.S. 476, 486-90 (1983) (opinion of Powell, J., announcing result supported by majority); similarly, states constitutionally can require physicians to provide care for an infant born alive following an abortion, *id.* at 483-84, even if they cannot require abortion methods that protect the fetus at the expense of maternal health, *see, e.g.*, Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 768-69 (1986). In Margaret S. v. Edwards, 794 F.2d 994 (5th Cir. 1986), the court refused to decide whether a Louisiana law requiring a physician to inform the patient *after* the abortion about the dispositional alternatives for the fetus did or did not significantly burden or chill the patient's privacy right; the court struck down the statute because it imposed the disclosure duty on the attending physician, contrary to the rule announced in *Akron*. *Id.* at 997-98; *see supra* notes 15-17 and accompanying text. This court also found Louisiana's ban on fetal experimentation unconstitutionally vague. *Id.* at 998-99. One can readily imagine, however, how a pre-abortion disclosure requirement concerning post-abortion legal consequences might chill the right to choose abortion. *Cf., e.g.*, Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978) (invalidating former Missouri statute requiring physician to inform patient that live-born infant resulting from abortion automatically becomes ward of state), *aff'd*, 440 U.S. 941 (1979); Leigh v. Olsen, 497 F. Supp. 1340, 1351 (D.N.D. 1980) (regulation conditioning abortion on woman's selection for disposal of fetus directly and unreasonably burdens abortion decision).

99. *See* Robertson, *supra* note 7, at notes 131-36 and accompanying text (bans on use of fetal tissue); *id.* at notes 142-46 and accompanying text (bans on designation of donees).

100. *See Thornburgh*, 476 U.S. at 762; *Akron*, 462 U.S. at 444-45.

101. *See supra* note 85.

102. *See* MO. REV. STAT. § 188.075 (1986) (person knowingly violating any provisions of sections regulating abortion guilty of class A misdemeanor). *See also* MO. REV. STAT. § 188.065 (1986) (revocation of license for health personnel who willfully and knowingly violate such provisions).

103. *See supra* note 85.

of the burdens listed in *Roe*. True, the state may through its statutes "speak" in favor of respecting fetal life, as Robertson argues;[104] but the abortion-funding cases[105], which he notes,[106] together with the treatment of anti-abortion design in *Akron* and *Thornburgh*, make plain that such expressions of governmental value judgments will survive only when the state fails to subsidize abortion (or fetal research), not when it actively regulates or restricts abortion and thus evokes strict judicial scrutiny.[107]

To say that a statute is invalid because of its anti-abortion design, however, does not require one to identify precisely whose constitutional right, physician's or patient's, the statute disturbs.[108] This observation suggests the second important point. Statutes like Missouri's, as well as narrower measures directed solely at post-abortion disposition or transplantation,[109] necessarily interfere with the exercise of medical discretion and the physician's professional judgment in the treatment of disease. The pre-eminence of the doctor in the Court's constitutional analysis and the Court's consistent deference to medical standards and discretion would call for strict judicial scrutiny.[110] And as *Roe* and subsequent cases establish, neither a state's moral objections to abortion[111] (or fetal tissue transplantation) nor its health concerns that fail to mirror prevailing practice[112] meet this test.

---

104. *See* Robertson, *supra* note 7, at text accompanying notes 135-36.

105. Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977).

106. *See* Robertson, *supra* note 7, at 484 n.135.

107. In the funding cases, the Court determined that abortion is a negative right and that governmental refusals to subsidize abortions evoke the rational-basis test, not the strict scrutiny applicable to state-created obstacles to abortion. *See* Appleton, *supra* note 62. *Cf.* H.L. v. Matheson, 450 U.S. 398, 413 (1981) (in applying less than strict scrutiny to parental notification requirement for minors' abortions, Court says state may encourage childbirth).

108. *Akron*'s examination of the two reasons for the invalidity of the forced-disclosure requirement might be read to suggest that a statute's anti-abortion design violates the patient's rights while the intrusion upon the physician's discretion constitutes a separate flaw. *See* 462 U.S. at 444-45. But if the Court has given physicians a protected interest in the exercise of medical discretion in abortion, then a statute *designed* to have a negative impact on abortion practice would fail for that reason as well.

109. *See, e.g.*, Margaret S. v. Edwards, 794 F.2d 994, 998-99 (5th Cir. 1986) (Louisiana statute prohibiting nontherapeutic fetal experimentation is unconstitutionally vague).

110. *See, e.g.*, Roe v. Wade, 410 U.S. 113 (1973); Doe v. Bolton, 410 U.S. 179 (1973); *see also* People v. Privitera, 23 Cal. 3d 697, 730, 591 P.2d 919, 939, 153 Cal. Rptr. 431, 451 (Bird, C.J., dissenting) (compelling state interest test required for intrusions upon physician's right to administer medical care), *cert. denied*, 444 U.S. 949 (1979).

111. *See, e.g.*, *Thornburgh*, 476 U.S. at 771-72.

112. *See, e.g.*, *Akron*, 462 U.S. at 434-39.

### C. *The Physician and Patient as Real Adversaries*

The jurisprudence of reproduction has produced constitutional litigation in which the physician and patient are real adversaries. Doctrine that treats these two parties as one or that defers to the doctor as a means of protecting the patient's rights cannot satisfactorily resolve these cases.

#### 1. *Forced Caesareans and other Maternal-Fetal Conflicts*

In a small but growing number of cases[113] (examined in a much more quickly growing body of scholarship[114]) physicians or other health care

113. *See* Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.) (upholding order granting hospital's application for permission to administer blood transfusions to emergency patient, over her religious objections, because she was "hardly *compos* mentis" and she was the mother of a young child), *cert. denied*, 377 U.S. 978 (1964); *In re* A.C., 533 A.2d 611 (D.C. 1987) (denying stay of court-ordered Caesarean section because 26-week-old fetus' interests outweigh terminally ill and heavily sedated mother's right to bodily integrity), *vacated for reh'g en banc*, 539 A.2d 203 (D.C. 1988); Jefferson v. Griffin Spalding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981) (relying on *Roe v. Wade*, court refuses to stay order giving custody of almost-full-term fetus to the state and requiring pregnant woman with complete placenta previa to submit to sonogram and Caesarean section, despite her religious objections); Raleigh Fitkin-Paul Morgan Memorial Hosp., v. Anderson, 42 N.J. 421, 201 A.2d 537 (authorizing, over patient's religious objections, blood transfusions necessary to preserve her life and that of her fetus after 32nd week of pregnancy), *cert. denied*, 377 U.S. 985 (1964); *but see* Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983) (vacating judgment in favor of husband who sought to compel wife, over her religious objection, to submit to cervical sutures to prevent miscarriage of four-month pregnancy). *See also In re* Steven S., 126 Cal. App. 3d 23, 178 Cal. Rptr. 525 (1981) (fetus cannot be a dependent child within juvenile court's jurisdiction); *In re* Dittrick Infant, 80 Mich. App. 219, 263 N.W.2d 37 (1977) (fetus is not a neglected child within court's jurisdiction even after parental rights to older child had been permanently terminated for abuse); People v. Stewart, No. M50819 (San Diego County, Cal. Feb. 26, 1987) (dismissing prosecution for conduct during pregnancy, including drug use and failure to follow prenatal medical advice, allegedly causing infant to be born brain-dead), *as cited by* Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1963 n.79 (1986). *Cf.* Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1980) (summary judgment for mother whose prenatal ingestion of Tetracycline caused son to have discolored teeth reversed; child may recover damages for injuries caused by mother's unreasonable prenatal conduct); *In re* Baby X, 97 Mich. App. 111, 293 N.W.2d 736 (1980) (mother's narcotics ingestion during pregnancy makes newborn, who exhibited withdrawal symptoms after birth, a neglected child warranting state intervention).

114. *See* Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987) (opposing forced intervention); Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599 (1986) (opposing forced intervention); Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1 (1984) (favoring limited forced intervention); Nelson, Buggy & Weil, *Forced Medical Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest,"* 37 HASTINGS L.J. 703 (1986) (opposing forced intervention); Rhoden, *supra* note 113 (opposing forced intervention); Robertson, *The Right to Procreate and In Utero Fetal Therapy*, 3 J. LEGAL MED. 333 (1982) (advocating forced intervention); Shaw, *Conditional Prospective Rights of*

providers have challenged the reproductive choices of their pregnant patients by initiating intervention, purportedly on behalf of the fetus. Whether the physician seeks judicial approval of a blood transfusion[115], a Caesarian section,[116] a prescribed diet or course of medication,[117] or surgery in utero,[118] the underlying issue remains the same: Should the woman's interests in bodily integrity, autonomy, and privacy prevail over the fetus's interests in life and health or the state's interests in fetal protection?

No matter how one might prefer to resolve this difficult question, these cases reveal the absurdity of the assumption that the physician shares the interests of his patient in reproductive decisions.[119] Physicians who initiate these cases ordinarily disagree with the woman's choice and seek a court order to avoid a subsequent claim of battery or malpractice. Certainly these physicians are not the "rascals" that the Supreme Court excepts from its generalization of shared interests.[120] Nor can we presume that all of these physicians are pursuing results that their patients "really" want, whatever the patients' asserted objections.[121] The adversity

---

*the Fetus*, 5 J. LEGAL MED. 63 (1984) (advocating forced intervention and the availability of criminal sanctions and punitive damages for prenatal misconduct); *Constitutional Limitations on State Intervention in Prenatal Care*, 67 VA. L. REV. 1051 (1981) (allowing some forced intervention based on a balancing of interests); *The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention*, 14 PAC. L.J. 1065 (1983) (advocating forced intervention only for medically accepted treatments that clearly benefit fetus and do not result in serious harm to mother). *See also* Beal, *"Can I Sue Mommy?" An Analysis of a Woman's Tort Liability for Prenatal Injuries to her Child Born Alive*, 21 SAN DIEGO L. REV. 325 (1984) (canvassing existing law with a view toward whether mothers should be liable in tort for prenatal harm that they cause their children).

115. *See, e.g.*, Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 337 U.S. 978 (1964); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 337 U.S. 985 (1964).

116. *See, e.g., In re* A.C. 533 A.2d 611 (D.C. 1987) (hospital sought order), *reh'g granted en banc*, 539 A.2d 203 (D.C. 1988); Jefferson v. Griffin Spaulding County Hosp. Auth., 247 Ga. 86, 274 S.E.2d 457 (1981).

117. *Cf., e.g.*, People v. Pointer, 151 Cal.App. 3d 1128, 1141, 199 Cal. Rptr. 357, 365 (1984) (intensive prenatal treatment program would be less intrusive than prohibition of conception as condition of probation for woman whose dietary practices had endangered children and would endanger future fetuses).

118. *See, e.g.*, Nelson, Buggy & Weil, *supra* note 114, at 709-11.

119. *Cf.* Appleton, *supra* note 1, at 203-04 (Court says physicians speak for patients' interests).

120. *See, e.g.*, Doe v. Bolton, 410 U.S. 179, 197 (1973) ("The good physician—despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are 'good'—will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling."). *See also Roe*, 410 U.S. at 166 (intra-professional remedies for physicians who abuse exercise of medical judgment).

121. There is little more than speculation that these patients would prefer medical intervention if only they could disclaim responsibility for choosing it. *Cf.* C. FOOTE, R. LEVY & F. SANDER,

between physician and patient is real and reveals the distortion worked in the abortion opinions. If not, then it reveals the complete irrelevance of the abortion cases for other questions of reproductive self-determination.

By contrast, examining these cases as problems of "samaritan law," in which the issue becomes the patient's duty to aid her fetus in the face of risks to her own autonomy and bodily integrity, reveals the otherwise ignored questions of gender-based discrimination that any satisfactory resolution must address.[122]

### 2. *Access to Modern Reproductive Technology.*

Still further from classic abortion questions, the increasing use of a variety of noncoital methods of reproduction also creates potential adversity between physician and patient. These noncoital methods include artificial insemination and in vitro fertilization, which can circumvent problems of infertility and genetic disease.[123]

California, for example, statutorily requires a physician to participate in a woman's artificial insemination in order for certain legal protections to apply. Specifically, without the physician's participation a woman is not guaranteed the absence of all parental rights for the semen donor in the resulting child.[124] Other statutes also compel physician participation in artificial insemination[125] even though the process can easily be accomplished without medical assistance.[126] In vitro fertilization, which does

---

CASES AND MATERIALS ON FAMILY LAW 491-92 (3d ed. 1985) (asking whether religious objectors might really want medical treatment for their children). Put another way, the court cannot substitute its judgment for that of a competent patient. *Cf.* Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Conn. Super. Ct. 1972) (using "doctrine of substituted judgment," court approves parental consent to removal of kidney from healthy seven-year old daughter and transplantation to her gravely ill identical twin).

122. *See Rhoden, supra* note 113, at 1976-82 (principles of samaritan law protect individual from forced interventions to save another); *see also* Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569 (1979) (rationalizing result in *Roe v. Wade* as protecting, under the equal-protection clause, a woman's right to be a "bad Samaritan").

123. *See generally* L. ANDREWS, NEW CONCEPTIONS (1984).

124. CAL. CIV. CODE § 7005 (West 1983); *see* Jhordan C. v. Mary K., 179 Cal. App.3d 386, 224 Cal. Rptr. 530 (1986).

125. *E.g.*, GA. CODE ANN. § 43-34-42 (1984) (felony for non-physician to artificially inseminate a woman); WASH. REV. CODE ANN. § 26.26.050 (1986) (inseminated woman's husband treated as father of resulting child if insemination performed "under supervision of a licensed physician and with the consent of her husband").

126. *See, e.g.*, Jhordan C. v. Mary K., 179 Cal. App. 3d 386, 391, 394, 224 Cal. Rptr. 530, 532, 535 (1986) (self-insemination by nurse); C.M. v. C.C., 152 N.J. Super. 160, 161, 377 A.2d 821, 821-22 (Cumberland County Ct. 1977) (self-insemination using glass syringe and glass jar); Hornstein,

require considerable medical assistance, necessarily involves physicians or other health-care professionals in the reproductive process.[127]

Given these facts, a state-employed physician[128] who refuses to assist, say, a single woman seeking artificial insemination or in vitro fertilization, because he will only provide such treatment for married women, arguably inhibits her exercise of reproductive autonomy.[129] A successful challenge by this woman requires at least[130] that the right of privacy elaborated in *Roe* (even if not first articulated there) belongs to her, not to her physician.[131] If, on the other hand, the *Roe* line of cases essentially establishes a constitutional protection for the medical and moral discretion of doctors, as I have suggested in the past, then the physician must prevail in this challenge. In any event, an analysis that fuses physician's and patient's interests provides no help in resolving such instances

---

*Children by Donor Insemination: A New Choice for Lesbians*, in TEST-TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD 373, 375 (R. Arditti, R. Klein, & S. Minden eds. 1984) (turkey baster).

127. *See* Smith v. Hartigan, 556 F. Supp. 157, 159 n.4 (N.D. Ill. 1983) (describing procedure which requires, *inter alia*, surgical removal of ovum); L. Andrews, *supra* note 123, at 121 (same).

128. For example, a physician at a state medical facility, such as the state university's teaching hospital or clinic, would fit this description.

129. Litigation based on precisely such facts was settled out of court in Michigan. *See* L. Andrews, *supra* note 123, at 194-95 (single woman sued Wayne State University artificial insemination clinic which restricted its services to married couples). *See also id.* at 194 (recommending that single women seek services from state-affiliated clinic to permit reliance on constitutional right to privacy); Kern & Ridolfi, *The Fourteenth Amendment's Protection of a Woman's Right to Be a Single Parent Through Artificial Insemination by Donor*, 7 WOMEN'S RTS. L. REP. 251 (1982) (examining arguments supporting claim that barring single women from artificial insemination violates fundamental rights to privacy and procreation); Kritchevsky, *The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family*, 4 HARV. WOMEN'S L.J. 1, 26-28 (1981) (legislation restricting artificial insemination to married women violates constitutional right of unmarried women to choose pregnancy through artificial insemination); Note, *Reproductive Technology and the Reproductive Rights of the Unmarried*, 98 HARV. L. REV. 669 (1985) (due process and equal protection clauses protect right of unmarried person to procreate through reproductive technology).

130. Even a successful assertion of her right to privacy would not guarantee the woman the insemination she seeks, for no physician can be compelled to provide treatment against his judgment. *See* McCabe v. Nassau County Med. Cen., 453 F.2d 698, 705-09 (2d Cir. 1971) (Moore, J., dissenting) (federal court cannot substitute its judicial judgment for physician's medical judgment when woman asserts constitutional right to sterilization). Indeed, Lori Andrews's description of the Michigan case, *see supra* note 129, concludes by noting that the litigation settled "with the university's agreement to drop its marriage requirement and *to consider* the woman for its [insemination] program." L. Andrews, *supra* note 123, at 195 (emphasis added).

131. This analysis assumes that *Roe* and related cases protect reproductive choices, not just abortion, and that *Roe*'s recognition of "artificial means" to terminate pregnancies supports protection of "artificial means" to initiate pregnancies. *See also* Skinner v. Oklahoma, 316 U.S. 535 (1942) (strict scrutiny of classifications infringing right to procreate); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632 (1974) (mandatory maternity leave unconstitutionally penalizes protected decision to bear a child).

of true doctor-patient adversity.[132]

## III. CONCLUSION

Legal developments in the years since I last examined the physician's role in private reproductive decisions have produced little substantive change although the language of the Supreme Court's most recent opinion acknowledges a woman's right to privacy in forceful terms.[133] Because these developments fail to recognize the sex-based discrimination produced by all abortion-specific restrictions, the informed-consent cases remain highly problematic. Though more satisfactorily resolved, the prohibited-disclosure cases also fail to separate the distinct interests of doctors and patients. Finally, new questions, growing out of the abortion controversy but reaching well beyond our ordinary understanding of this term, including questions raised by "abortion pills," fetal tissue transplantation, failure to treat fetal disease or distress, and medically assisted methods of noncoital reproduction, all underscore the need to identify clearly in both substance and language the patient—the woman—as the center of the analysis.

---

132. Again, the underlying problem may well be properly viewed as one of discrimination, here based on marital status, *see* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child."), rather than on gender—notwithstanding the suggestion that the latter basis is established by comparing the state's treatment of artificial insemination and surrogacy. *See In re* Baby M., N.J. Super. 313, 388, 525 A.2d 1128, 1165 (1987), *rev'd*, 109 N.J. 306, 537 A.2d 1227 (1988). Even under this questionable approach, one could find gender-based discrimination only if the hypothesized state-sponsored physician assisted single men wishing to reproduce via "surrogate mothers" while refusing to assist single women seeking to bear children for themselves via artificial insemination or in vitro fertilization.

133. *See supra* note 43 (quoting Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 772 (1986)); Henderson, *supra* note 42, at 1634.