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The “Gag Rule” Revisited: Physicians as Abortion Gatekeepers

M. Gregg Bloche

To the surprise of many and the dismay of some, the U.S. Supreme Court took it upon itself last term to proclaim a national compromise on the question of abortion.¹ The Court’s announced truce, an elaboration on Justice O’Connor’s “undue burden” idea, is pragmatic in design but unlikely to prove stable in practice. The three justices who spoke for the Court disparaged *Roe* with reluctant praise, then upheld its outer shell on the ground that social expectations and the need to sustain the appearance of the rule of law made it impolitic to do otherwise. This awkward doctrinal invention seems unlikely to yield a lasting peace. However artful as political brokerage, it is unpersuasive as principled jurisprudence. Its explicitly political calculus invites skepticism about its authors’ commitment to principled method even as it purports to preserve public regard for judicial legitimacy. Moreover, there is an unexplained “disconnect” between the opinion’s avowed preservation of *Roe*’s “essential holding” and its abandonment of *Roe*’s commitment to reproductive freedom as a compelling interest.

Should the “undue burden” approach nevertheless survive for a time, its “standardless”² character will encourage continuing cease-fire violations as abortion opponents probe its ill-marked limits. Its survival, though, is as uncertain as its substantive content. Not only were its three proponents unable to win over a majority; four justices proclaimed their commitment to frankly overruling *Roe*. The election of Bill Clinton is no guarantee that a fifth vote will not emerge in the future.³

Whatever the “undue burden” test’s prospects for survival, its ascension to the status of governing law has focused attention on the possibility of an American abortion compromise. The moment is thus opportune for a fresh look at another recent attempt at compromise—one pursued in a narrower legal context, without success so far. The context—discussion of abortion with patients at federally-funded family planning clinics—became widely

familiar to Americans a year ago, after the Supreme Court announced its decision in *Rust v. Sullivan*.⁴

Rust upheld federal regulations directing such clinics not to counsel or refer patients for abortion “as a method of family planning.”⁵ The regulations made compliance a prerequisite for federal funding under Title X of the Public Health Service Act. These bitterly controversial rules were presumed by activists on both sides of the abortion divide to impose a near-absolute ban on the discussion of abortion with clinic patients. This presumption quickly hardened into conventional wisdom as a broad coalition of medical and family planning organizations⁶ mobilized to persuade Congress to kill the regulations.⁷ Opponents of the rules characterized them as a flat ban on abortion counseling and referrals except in medical circumstances posing an immediate threat to a pregnant woman’s life. News reports presumed the validity of this interpretation, dubbing the regulations a “gag rule.” The American Medical Association,⁸ the American College of Obstetricians and Gynecologists,⁹ and other professional groups insisted that the regulations would force physicians to commit malpractice by withholding medically necessary information. Family planning leaders warned that unless Congress stopped the new rules from taking effect, their programs would be forced to make agonizing choices between refusing to discuss abortion and forgoing federal dollars.¹⁰

As I will explain below, this conventional wisdom was dictated neither by the “gag rule” itself nor the *Rust* opinion. On the contrary, the “gag rule” was artfully—some might say disingenuously—crafted to incorporate a potentially broad therapeutic exception, unrestricted by any regulatory definition of medical need. Partisans to the abortion controversy ignored this exception, thereby frustrating the Bush administration’s effort to exploit it to soften opposition to the “gag rule.” Instead, pro-choice and pro-life¹¹ activists framed the public debate over abor-

tion counseling in absolutist terms. Even medical and family planning leaders persisted in portraying the “gag” as fitting tightly, despite the therapeutic exception’s potential as an escape from the requirement that abortion information be withheld. The therapeutic exception thus failed politically as a compromise device in the abortion counseling context.

In this article, I explore this failure, with an eye toward its broader lessons about the social uses of medical discretion and the difficulty of achieving an abortion compromise in America. I begin by examining the legal underpinning beneath the widespread belief that the “gag rule” imposed a near-absolute ban on discussion of the abortion option. This conventional wisdom, I conclude, collapses on careful inspection. It fails utterly to account for the strong support to be found in the Title X regulations and their larger legal context for a therapeutic exception unconstrained by administrative or judicial definition.¹² Next, I observe that this legal unboundedness would have empowered Title X clinic physicians (and perhaps others who do counseling) to exercise broad discretion over abortion access, under the rubric of medical indication. The limits of this clinical discretion would have been self-imposed, explicitly or otherwise, by clinic administrators, professionally-accepted practice norms, and personal conscience.

By aggressively employing this therapeutic exception, family planning clinicians could have spoken freely about abortion, shielded by the law’s deference to medical authority. The legal contours of the exception allowed physicians (and perhaps others) to explore pregnancy termination with their patients and to refer them for care that could include abortion. By so doing, however, physicians would have become abortion gatekeepers. This would have raised difficult ethical and clinical questions about the extent to which medical judgment should be allowed to incorporate (and shield) socially-disputed moral choices. I briefly consider some of these questions, along with the countervailing appeal of preserving a measure of intimate freedom under medical cover.

I then conclude by positing some connections between the moral infirmities of medical gatekeeping and the political failure of the therapeutic exception. I suggest, in essence, that this failure was ensured by a strong resonance between the exception’s moral infirmities and the fears of the medical leaders, pro-choice activists, and abortion opponents who framed the public debate over the “gag rule.” The potential breadth of the therapeutic exception went unrecognized and unexplored because professional and popular understanding of the abortion counseling regulations was molded by the activists who framed the debate. Their most passionately felt fears and aspirations are sure to complicate the continuing search for a workable American compromise on abortion.

The “gag rule’s” therapeutic exception

In challenging the “gag rule’s” constitutionality, the plaintiffs in *Rust* asserted that the rule would bar abortion counseling and referral under all “medical circumstances”,¹³ including danger to a pregnant woman’s life. Popular accounts of the *Rust* decision announced this dire implication.¹⁴ But this consequence was hardly clear from the language of the regulation at issue. The regulation, part of a package of revisions to the Title X program promulgated by the Reagan administration in 1988, instructed clinics not to provide “counseling concerning” or “referral for” abortion “as a method of family planning.”¹⁵ The reference to “family planning” was drawn from a 1970 statute that the regulation purports to apply. This statute proscribes the use of federal funds “in programs where abortion is a method of family planning.”¹⁶

Were the qualifying phrase, “as a method of family planning,” to be read in accordance with health professionals’ understanding of “family planning,” the regulation would have little clinical significance. Family planning professionals advise *contraception*, not abortion, for the prevention of unwanted births.¹⁷ In family planning practice, abortion is at best a back-up measure, to be considered if contraception fails or is not used. From this clinical perspective, abortion in the event of inadequate contraception is not a *method* of family planning; it is a last resort when family planning *fails*.

Only if “abortion as a method of family planning” is understood more broadly, as encompassing abortion in the event that contraception fails or is not used, can the regulation be read to forbid a professionally-accepted practice. Abortion opponents generally advocate this broader interpretation; for most, abortion as a response to contraceptive failure is no more acceptable than abortion as a primary means of birth control. From this perspective (shared by the Bush administration and probably by sympathetic federal judges), abortion in either circumstance is “a method of family planning.”

Understood in this way, the regulation at issue restricts clinical speech and discretion to a greater degree than do current professional standards. Yet the qualifying phrase “method of family planning” still leaves room for exceptions to the regulation’s ban on abortion counseling and referral. The Supreme Court acknowledged as much in *Rust*, in a paragraph that received little notice. In dismissing First Amendment-related concerns, the Court said that it did not “read the regulations to bar abortion referral or counseling “when a woman’s pregnancy “places her life in imminent peril.”¹⁸ Writing for the majority, Chief Justice Rehnquist explained: “It does not seem that a medically necessitated abortion in such circumstances would be the equivalent of its use as a ‘method of family planning.’”¹⁹

The Court thus drew a distinction between abortion as a means of family planning and abortion as a medical necessity. In so doing, the Court characterized another provision in the *Rust* regulations—one requiring clinics to refer patients for needed emergency care²⁰—as a “specific exemption” from the ban on abortion counseling and referral.²¹ The regulations, the Court said, “contemplate that a [family planning] project would be permitted to engage in otherwise prohibited abortion-related activity in such circumstances.”²² The Court thus read the regulations to allow abortion counseling and referral on medical necessity grounds, at least in circumstances of emergency involving danger to a pregnant woman’s life

Moreover, the justices intimated that this medical necessity “exemption” might extend beyond medical emergency or danger to life. The Court noted that a pre-existing regulation, untouched by the 1988 revisions, requires family planning clinics to provide for “necessary referral to other medical facilities when medically indicated.”²³ The Court cited this provision as additional support for its conclusion that the regulations allowed “otherwise prohibited abortion-related activity” under some circumstances. The justices stopped short of explicit confirmation that this pre-existing requirement extends to medical indications other than life-threatening emergency. But judicial precedent, the history of the 1988 revisions, and Bush administration statements about the application of the 1988 regulations support a less circumscribed approach to medical indication.

In 1981, in *Valley Family Planning v. North Dakota*, a lower court held that the older provision requires family planning programs to refer pregnant women for “medically indicated” abortions.²⁴ Such referrals, the court said, are consistent with the 1970 statutory proscription against abortion as a “method of family planning.” Employing language similar to Chief Justice Rehnquist’s in *Rust*, the court explained: “where such a referral is necessary because of medical indications, abortion is not being considered as a method of family planning at all, but rather as a medical treatment possibility.”²⁵ Quoting a 1979 Department of Health and Human Services (HHS) interpretive opinion, the court added that abortion referral could be “medically indicated” based on either “the patient’s medical condition” or “the condition of the fetus.”²⁶

In 1987, HHS proposed the new restrictions at issue in *Rust*.²⁷ The HHS proposal made no change in the “medically indicated” referral requirement. During the comment period that preceded the Department’s promulgation of its final rules, antiabortion activists objected vehemently. Some insisted that the term “medically indicated” be explicitly limited to situations of imminent danger to a pregnant woman’s life. Others urged that the term be defined so as to bar abortion referrals under all circumstances.²⁸ But HHS refused to revise the rules to limit the scope of

permissible medical indications. In comments released with the final rules, HHS argued that to do so was “infeasible” since the term “refers to an infinite variety of physical conditions.”²⁹ Nor did the Department disavow the open-ended view of medical indication espoused in its 1979 interpretive opinion.

Moreover, HHS did not take the position, advocated by antiabortion forces,³⁰ that its new rules made *Valley Family Planning* irrelevant to the *current* meaning of “medically indicated” because *Valley* relied upon an HHS interpretation issued prior to the new rules. Abortion opponents asserted that the new regulations changed the meaning of “medically indicated” in the pre-existing referral rule, rendering the 1979 HHS opinion obsolete. The Department, however, adopted the position that the meaning of “medically indicated” was “unaffected” by the new rules.³¹ HHS noted that *Valley* did not limit the Department’s authority to issue *new* regulations. But HHS professed fealty to *Valley*’s construction of the older rule requiring “medically indicated” referrals.³²

On the other hand, in comments released with its final rules, HHS encouraged readers to do what it had refused to do in the regulations themselves—equate medical indication with danger to a pregnant woman’s life. For example, in purporting to square the 1988 regulations with *Valley*, the Department said that referral for possible abortion “was required under [*Valley*] when medically necessary, *such as* when the life of the mother is endangered”³³ (emphasis added). Some have read such comments to establish that danger to a woman’s life is the only allowable medical indication. But this is belied by HHS’s explicit refusal to write such a limit on the meaning of “medically indicated” into the regulations themselves. When federal regulations are plainly inconsistent with their accompanying administrative comments, the regulations are superior in legal authority. A policy plainly rejected when the regulations were written cannot be imported into the law through the back door, via accompanying comments.

Whatever the significance of the HHS comments at the time they were issued, subsequent directives from the White House and HHS suggested a less constrained view of medical indication. In a Nov. 5, 1991 memorandum, President Bush issued the following instruction to HHS Secretary Louis Sullivan regarding implementation of the abortion counseling regulations:

If a woman is found to be pregnant and to have a medical problem, she should be referred for complete medical care, *even* if the ultimate result may be the termination of her pregnancy.

An HHS directive sent to regional offices on March 20, 1992 repeated this instruction, citing the above-discussed “medically indicated” referral rule as its basis. This rule,

HHS said, “requires a physician to refer a pregnant woman with a health problem to medical care appropriate to her particular health problem, even if that referral ultimately results in an abortion.”

Nowhere in the President’s memorandum or the HHS directive were the open-ended terms “medical problem” or “health problem” equated with life-threatening emergency. Nor did these documents bar physicians from advising pregnant patients about the abortion option, so long as such advice could be characterized as “medical information” about a “health” problem. Both the President’s memorandum and the HHS directive called for the regulations to be applied so as not to “prevent a woman from receiving complete medical information about her condition from a physician.” Neither document imposed limits on the range of “health” or “medical” problems that might merit discussion of the abortion option.

The Bush administration thereby set the stage for medicalization of family planning patients’ access to abortion. The White House and HHS directives conditioned referral for possible abortion on a physician’s diagnosis of a “health problem.” Moreover, they required that such referrals be made to “full-service health care providers that perform abortions, but not to providers whose principal activity is providing abortion services.” Finally, physicians were the only health professionals *explicitly* allowed by the directives to discuss abortion with patients (although neither directive explicitly *barred* non-physician staff, e.g. nurses or social workers, from doing so).

These limitations posed substantial barriers to abortion access. Because family planning clinics rely heavily on non-physician counselors, failure to allow non-physicians to discuss abortion would hinder clinic patients’ access to “medically indicated” abortion. The requirement that referrals be made only to “full-service” providers represented a more certain impediment to abortion access. Relatively few “full service” providers perform abortions nowadays. Political pressures and financial disincentives have marginalized abortion practice to the specialty clinics that the Bush administration has put off-limits.³⁴ On the other hand, as I explain below, the Bush administration’s open-ended approach to medical indication allowed family planning physicians considerable latitude to advise their patients about the abortion option. That family planning clinics and the medical profession did not seize upon the therapeutic exception as a way to soften the “gag rule’s” impact cannot be explained as the product of regulatory constraint.

Physicians as abortion gatekeepers: the fluidity of the therapeutic exception

In empowering clinic physicians to make exceptions to the “gag rule” for health reasons, the Bush administration

invited the medical profession back into the business of abortion gatekeeping. Not since 1973, when *Roe v. Wade*³⁵ constitutionalized a woman’s right to an abortion, had American physicians been expected to perform this problematic function, except in the case of third trimester abortions.³⁶ (Under *Roe*, states may proscribe these except when “necessary to preserve the life or health of the mother.”³⁷) During the years preceding *Roe*, state legislatures and courts mediated the conflict between old laws that criminalized abortion and new demands for abortion access by liberalizing provisions that permitted abortion on therapeutic grounds. Provisions that allowed abortion to save a pregnant woman’s life were broadened in many states to incorporate maternal health and fetal defect.³⁸ An influential model statute proposed by the American Law Institute explicitly included the mother’s mental health.³⁹ The practical effect of such provisions was to put the issue of abortion access into the hands of physicians.

Roe transformed these provisions into historical curiosities. But the pre-*Roe* jurisprudence of medically indicated abortion offers some guidance as to the potential scope of the therapeutic exception to the Title X abortion counseling restrictions. The leading judicial construction of the pre-*Roe* therapeutic exception embraced an almost unbounded view of both “health” and physician discretion. In *United States v. Vuitch*,⁴⁰ the U.S. Supreme Court rejected the contention that a statute criminalizing abortion except in cases of danger to a woman’s “life or health” was unconstitutionally vague because the word “health” is ambiguous. Insisting that the term “health” “presents no problem of vagueness,” the Court characterized “the general usage and modern understanding of the word ‘health’” as “the [s]tate of being ... sound in body [or] mind”⁴¹ (quoting Webster’s Dictionary). The Court added: “whether a particular operation is necessary for a patient’s physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered.”⁴² The Court thus (1) equated health with global personal well-being⁴³ and (2) endorsed physician judgment as the law’s metric of medical need.

So interpreted, statutes legalizing abortions done to preserve women’s “health” encouraged sympathetic physicians to be liberal in granting medical dispensation. Some psychiatrists contended that unwanted pregnancy *per se* was detrimental to a woman’s mental health, justifying therapeutic abortion.⁴⁴ Others argued that the socioeconomic stress of unwanted childbirth was critically important in clinical assessment of a pregnancy’s effect upon a woman’s mental health.⁴⁵ Criminal prosecution of physicians who performed abortions on medical grounds was rare. Although the boundary between a woman’s health and her personal wants remained a matter of dispute,⁴⁶ physicians committed to expanding abortion access made growing use of the therapeutic exception through the early 1970s.

Roe relieved the pressure on American physicians to broaden abortion's therapeutic indications. Post-*Roe* medical thinking about abortion as therapy was influenced by women's access to abortion on request. Medical indication no longer served as a route of escape from the criminal abortion laws. It was relevant only to clinical complications that threatened women who wanted to bear children. Not surprisingly, abortions reported as having been performed for "therapeutic" reasons now comprise a small proportion of all American abortions.⁴⁷

In view of the low reported incidence of therapeutic abortion, the medical necessity exception to the family planning "gag rule" might at first seem impossible to apply in good faith to more than a small portion of pregnant clients. Were medical necessity a fixed notion, unresponsive to changes in the social context of clinical work, such might be the case. But medical need is a fluid concept. Like other socially recognized needs, it is reconceived as community and culture evolve.⁴⁸ Rising barriers to abortion access, engendered by the anti-abortion politics that gave rise to the "gag rule," could invite such a reconception with respect to abortion.

Experience abroad confirms the potential flexibility of the therapeutic exception. In many other countries, medical justification is necessary (absent rape or incest) to obtain an abortion. This requirement tends to be interpreted broadly. Japanese law, which permits abortion "to protect the life and health of the mother," includes economic hardship as an abortion-justifying health consideration.⁴⁹ An Indian statute allows abortion when fetal abnormality is expected or pregnancy threatens a woman's physical or mental health. Liberal interpretation of the maternal health provision ensures easy access to abortion. Several European nations, including Spain, Portugal, and Switzerland, have enacted similar requirements; these have been applied with varying restrictiveness. In the United Kingdom, an Act of Parliament permits abortion when two physicians certify that continued pregnancy poses a greater risk to a woman's life or physical or mental health than does abortion. As applied, this statute has made abortion available upon request.⁵⁰

As I argue below, much of American abortion practice can potentially be redescribed in the language of medical indication. By engaging in such redescription, physicians could have broadly applied the "gag rule's" therapeutic exception,⁵¹ as some did in the face of criminal abortion laws a generation ago. Neither the Title X regulations nor judicial pronouncements on the permissible scope of medical need as a justification for abortion stood in the way. Indeed, *Vuitch* suggests a judicial inclination to defer to physician judgment as the measure of medical need.

To rein in physician judgment in the Title X abortion counseling context, HHS would have needed to limit the

allowed medical indications for discussion of abortion. As I noted above, HHS explicitly declined to do this. Moreover, the constitutionality of such limits would have been uncertain. The *Rust* majority suggested that medical judgment may "enjoy protection under the First Amendment from government regulation, even when subsidized by the Government."⁵²

The legal unboundedness of the therapeutic exception to the "gag rule" accorded considerable abortion gatekeeping authority to Title X clinic physicians, whether or not medical and family planning leaders acknowledge it. Critics of the "gag rule" were thus on target in observing that it disempowered poor women but incorrect in assuming that it shut the door to referrals for abortion. Rather, its therapeutic exception conferred a doorkeeping role on family planning physicians, analogous to that exercised by doctors with respect to state anti-abortion laws in the years before *Roe*. Under the "gag rule," Title X clinic patients had no right on their own to information about pregnancy options. However, clinic physicians had the authority to explore patients' feelings about pregnancy, offer information about options, and make referrals for possible abortion, all under the rubric of medical indication.

Re-medicalizing abortion: temptations and hazards

Had the "gag rule" lasted, three categories of medical indication for abortion might have been expected to expand—the condition of the fetus, the mother's physical health, and the mother's mental health. All would have posed the moral difficulties that inhere in determinations of whether someone's misfortune merits a medical response. Clinicians confronted by the distress of pregnant patients not wanting to give birth would have been tempted to broaden the domain of professionally-accepted medical indications for abortion. I turn now to a discussion of the attractions and hazards of so doing. Although my focus is on medical indication in the abortion counseling context, the discussion that follows applies to the medicalization of abortion access more generally.

Medical progress and moral authority

One influence that would have invited a widening of the scope of medical indication is scientific progress: we know much more today than we did a generation ago about the pitfalls of pregnancy for both mother and fetus. Our enhanced ability to predict and biologically explain these pitfalls makes their medicalization seem more plausible.

This effect would probably have been strongest for fetal indication. Popular and professional acceptance of fetal defect as a medical justification for abortion was catalyzed in the 1960s by grotesque images of fetal defor-

mity caused by maternal rubella infection and use of the tranquilizer Thalidomide.⁵³ In the years since, the teratogenic potential of myriad other drugs and environmental toxins has been recognized, knowledge of genetic determinants of fetal disease has proliferated, and sophisticated genetic and intrauterine diagnostic technologies have come into being. The resulting growth in medicine's ability to detect fetuses that are defective or at risk invites a corresponding expansion of fetal indications for abortion.

Awareness of the maternal health risks posed by pregnancy has also grown, creating a basis for the broadening of this indication for abortion. Advances in the management of high risk pregnancies are a countervailing influence: if prenatal care can reduce the risk, pregnancy termination may seem less justifiable. Had the "gag rule" survived, the principle of informed consent and its premise of patient autonomy would have weighed in favor of allowing the patient to choose between these two approaches to high-risk pregnancy—and in favor of preserving access to each option by empowering physicians to find that either was medically indicated. The Supreme Court's refusal to read *Roe* to require the federal government to pay for abortion⁵⁴ need not have constrained physician discretion to find that abortion was medically indicated.

Scientific advance could probably have had less influence on the scope of mental health indications for abortion. During the years immediately preceding *Roe*, the vast majority of abortions performed pursuant to the criminal law's therapeutic exception were done for psychiatric indications.⁵⁵ Sympathetic judges encouraged this use of psychiatry. In *Vuitch*, the Supreme Court construed the therapeutic exception at issue to permit abortion on mental health grounds "whether or not the patient had a previous history of mental defects."⁵⁶

Psychiatrists who evaluated women who wanted abortions purported to predict whether they would develop mental illness if forced to carry unwanted pregnancies to term. But such predictions stood up poorly to scientific scrutiny.⁵⁷ Psychiatry lacked the knowledge base needed to identify predisposing factors in pregnant women.⁵⁸ Today, a generation later, psychiatry is no more capable in this regard, despite remarkable advances in the biological understanding and treatment of major mental illnesses.

On the other hand, psychiatric judgments about the necessity of abortion could draw greater credibility today from organized psychiatry's recently-achieved consensus in support of a standardized, statistically reliable diagnostic system. By providing common terms for the reporting of clinical observations and conclusions, this system⁵⁹ empowers psychiatrists to convey their judgments with a new descriptive consistency that invites professional and popular confidence. Psychiatric predictions of the consequences of unwanted pregnancy may be no more accurate today than they were a generation ago, but they can

be stated in more standardized terms, enhancing their aura of scientific authority.

The Widening Domain of Health

Perceptions of whether a problem is medical are powerfully influenced by social and cultural developments that lie beyond the scope of this article.⁶⁰ Since World War II, western society (and its physicians) has evolved an expansive conception of health, encompassing physical, mental, and social well-being.⁶¹ This vision extends far beyond the physiologic effect of a prescribed drug or procedure. It has animated physician activism on behalf of such causes as international human rights⁶² and the prevention of nuclear war.⁶³ The broader the medical profession's view of health, the larger the domain of medically indicated action (and the smaller the realm of non-medicalized misfortune).

Physicians who take both a broad view of health and a dim view of denying women access to abortion may be inclined to see the adverse consequences of unwanted childbirth as medical problems and abortion as medically indicated in many situations. Today, in contrast to a generation ago,⁶⁴ most physicians support the right to abortion on request.⁶⁵ In tandem with an expansive conception of health, this sea-change in medical opinion could favor growth of the therapeutic exception beyond its pre-*Roe* bounds in the face of highly restrictive abortion regulations.

Moral and clinical dangers

For now, at least, the threat of regulation so restrictive as to render the therapeutic exception critical to women's access to abortion has eased. The election of President Clinton and *Roe*'s survival, albeit in weakened form, have tilted the political landscape toward the pro-choice position. Yet this landscape remains seismically active. A future shift in the opposite direction could confront American physicians with pressure to make abortion widely accessible on "medical necessity" grounds.

Should this occur, the moral and clinical dangers of abortion doorkeeping ought to give physicians pause. A physician's finding that abortion is medically indicated is a subjective moral choice presented in scientific guise. This alone is not of particular note—every medical recommendation has subjective content, e.g., a tradeoff between competing risks or between risks and cost.⁶⁶ What merits concern is that an abortion referral involves a moral choice that is the subject of bitter social dispute. A finding of medical necessity could provide a path of escape from a state-decreed moral preference fervently supported by many people. The moral content of medical necessity is vividly illustrated in Switzerland: abortion-seekers from Catholic areas commonly travel to Protestant regions, where the requirement that a woman's

health be at risk is interpreted more broadly.⁶⁷ When strong evidence indicates that pregnancy imminently threatens a woman's survival, use of the medical necessity escape route is likely to be tolerated even by many abortion opponents. But the lower the severity or immediacy of the threat (and the less convincing the medical evidence), the more vulnerable this escape will be to challenge.

Where the medical indication for abortion is a confirmed or suspected fetal defect, the moral content of medical judgment will be openly exposed to social and political attack. The Reagan administration's challenge to medical discretion to withhold treatment from defective newborns⁶⁸ illustrates the vulnerability of physician discretion to political attack in an analogous context.

Mental health indications for abortion are even more problematic. The standardized language of current psychiatric diagnosis provides poor cover for psychiatrists' inability to predict accurately whether a woman will develop major psychiatric illness if forced to carry her pregnancy to term. Without valid grounds for making such predictions, psychiatrists called upon to make these determinations will be left to their prejudices,⁶⁹ as they were a generation ago.⁷⁰ Confronted with a woman's anguish over the prospect of an unwanted child, a clinician may be tempted to invent the necessary prediction.⁷¹ The implausibility of these predictions as a scientific enterprise invites skepticism about their legitimacy—and about the integrity of psychiatric evaluation in general.

Moreover, the boundary between psychiatric symptoms and non-medicalized misery remains ill-defined.⁷² By broad social consensus, psychosis and some other profoundly disabling mental states today lie within the medical domain, but other inner experiences and behaviors abide in disputed territory. American psychiatric diagnosis incorporates sadness and anxiety, impulsivity and cruelty, disappointment at work and in relationships, and other feelings and behaviors that many people see as the province of morality or fate. Abortion referrals based on such symptoms could strike many as an illegitimate assertion of clinical authority outside the social jurisdiction of medicine.

Thus the business of determining the medical necessity of abortion is sure to be hazardous. It is a moral activity for which physicians lack clear moral authority. It usurps authority that both "pro-choice" and "pro-life" adherents believe should be exercised by others, either pregnant women themselves or morally interventionist government.

This moral awkwardness poses clinical dangers. Skepticism about the legitimacy of medical judgment in the abortion context could undermine physicians' credibility more generally. Credibility is essential in clinical work—it engenders patient confidence in a physician's diagnostic conclusions, treatment recommendations, counseling, and reassurance. It is important for treatment compliance and

for attenuating fear and uncertainty. Erosion of citizen confidence in medical judgment poses additional dangers at the public health level. Popular suspicion that public health admonitions cloak moral aims behind disingenuous science can lead to disregard of empirically well-supported recommendations that save lives or protect disadvantaged groups (e.g. HIV-infected persons) from irrational prejudice.

Moreover, for some pregnant women, securing an abortion referral on medical grounds could be personally damaging. In some social settings, it may carry stigma, especially if a psychiatric diagnosis or prediction is involved. Whether or not it carries a social stigma, it invites a woman to understand her experience as evidence of defective femininity, not the sexual self-mastery connoted by abortion obtained as of right. Abortion on medical grounds also entails an experience of being excused from a purported social duty. The therapeutic exception presupposes and reinforces the norm that a woman should carry her child to term. In obtaining a medical excuse, a person is encouraged to see illness as an escape from personal and social responsibilities.⁷³ In addition, the availability of a medical excuse invites patients to invent or distort symptoms in order to qualify. Whether deliberate or unconscious, such deceit is likely to undermine the quality of clinical care, particularly for psychiatric and other syndromes that present through patients' self-reporting.

For physicians who favor abortion rights, the granting of medical dispensation for abortion may have an undesirable political effect: it could function as a "safety valve" for social pressure that might otherwise express itself through pro-choice activism.⁷⁴ It also legitimates legal barriers to abortion access by implicating the medical profession in their enforcement. From the "pro-life" physician's perspective, the very notion of medically necessary abortion is morally oppressive. It pits private conviction against professional duty; if abortion is medically indicated in some circumstances, then abortion counseling and referral when they arise constitute an ethical obligation.

Justifying the medical gatekeeper: Private space versus public preferences

Medical indication is thus deeply problematic as a basis for abortion access. Yet a case can be made for medical dispensation as a means for shielding private decisions about abortion from the force of anti-abortion politics. A primary function of law is the mediation of inevitable conflict between private and political choices.⁷⁵ Societies devise myriad legal and social mechanisms for the preservation of separate and conflicting spheres of personal and political preference.⁷⁶ Such mechanisms succeed in large measure by sheltering private choices from public visibility.⁷⁷ Deference to physician authority does this for reproductive choice to the extent that it obscures the subjectivity of the

decision to abort. If legal protection for reproductive choice erodes, ways to reduce the public visibility of the decision to abort will become more important for the preservation of private choice.

To be sure, the concept of medical necessity is an imperfect shield for private choice about abortion. The enclave of private discretion it preserves is the physician's, not the patient's: the patient's preferences are protected only insofar as the physician incorporates them into his or her gatekeeping decision. Moreover, the medical veil over the subjective core of this decision is translucent, not opaque. For reasons discussed earlier, the physician-gatekeeper's exercise of discretion in this area is likely to engender skepticism. The profession's moral legitimacy and scientific credibility may be at risk. Physician control of abortion access is not what either "pro-life" or "pro-choice" advocates have in mind.

Conclusion

Under the rubric of medical indication, the "gag rule" allowed family planning physicians considerable discretion to discuss pregnancy termination with their patients and to make referrals that could have resulted in abortion. Yet neither abortion rights leaders nor medical organizations acknowledged this prior to the "gag rule's" demise. Rather, their advocacy efforts on behalf of the rule's repeal ignored the possibility (or at least the significance) of a therapeutic exception. In so doing, they presented the abortion counseling regulations in a maximally oppressive visage, thereby strengthening the case for repeal. The resistance of abortion opponents to the emergence of loopholes in the regulations contributed ironically to the persuasiveness of this portrayal.

Had President Bush been reelected, the success of this portrayal would have come at a cost. The dire message directed to those with the power to repeal the "gag rule" also reached the clinics and physicians who were expected to conform to it. This message governed clinic doctors' understanding of the regulations, effectively foreclosing liberal use of the therapeutic exception on behalf of pregnant women in distress. To a degree that should provoke disquiet among physicians, professional leaders who portrayed the regulations in these unnecessarily dire terms risked engaging in self-fulfilling prophecy. The failure of family planning physicians to employ the therapeutic exception broadly would have been a product of professional reluctance, not legal command.

What accounted for this reluctance? The serious moral and clinical problems posed by medical management of abortion access were surely important factors. They weighed in favor of the conclusion that the medical escape route around barriers to abortion access should be followed, if at all, with serious misgivings. Yet these problems

have not prevented physicians in Europe and elsewhere from employing the therapeutic exception liberally to avert legal proscriptions against abortion. I conclude by positing some reasons for the therapeutic exception's failure to thrive in America in the abortion counseling context. The key to this failure, I suggest, lies in the resonance between the moral and clinical infirmities of medical gatekeeping and the interests of the activists who shaped the profession's and the public's understanding of the "gag rule."

Most obviously, abortion opponents had no interest in the emergence of a significant therapeutic exception. Having fought (unsuccessfully) for its elimination when the abortion counseling regulations were being written, they were not likely to defer to its professionally-mediated expansion. On the contrary, when the Bush administration pointed publicly to the medical escape path in an effort to reduce the fury of "gag rule" opponents, some anti-abortion activists alleged that the administration was sidling away from its pro-life position.⁷⁸ From their absolutist perspective, even this modest gesture toward accommodation represented a failure of moral commitment, rather than a pragmatic attempt to placate a powerful opposition. Any visible effort by the medical profession to expand the accepted medical indications for abortion would have probably aroused these activists' bitter opposition.

The therapeutic exception had no more appeal for pro-choice advocates. The feminist concerns that animate pro-choice activism in America center on women's autonomy with respect to intimate matters and women's right to take part in society as equals.⁷⁹ The medicalization of abortion access in the Title X context would have implicated both of these concerns. Most basically, medical gatekeeping denies women's claim to sexual autonomy by placing reproductive choice within the domain of physician authority. Additionally, because the medical authority it confers governs women's reproductive decision-making while leaving men beyond its ambit, making abortion available only on medical grounds disregards feminist aspirations for equal treatment and respect. For feminists old enough to recall how women obtained legal authorization to abort in the years before *Roe*, the memories of male-dominated medical boards passing judgment upon traumatized women still rankle.

From a feminist perspective, equal regard for women in society is further compromised by the therapeutic exception's invidious normative implication—that the ideal woman is a well-functioning reproductive vessel, and that failure to carry a pregnancy to term bespeaks biological or psychological inadequacy. This implication—and its consequences for women's self-perceptions and socio-economic prospects—ensured that the medicalization of abortion access in federally-funded family planning clinics would meet an unwelcome feminist reception. For the pro-choice activists who publicly defined the case against the

“gag rule,” these concerns eclipsed the therapeutic exception’s potential to make a humane difference in the lives of some pregnant women.

From the perspective of medical leaders, the prospect of an open-ended therapeutic exception was anathema because of its implications for professional credibility. The dissonance between the thinly-veiled moral content of the abortion gatekeeping role and the aura of science that inspires Americans’ regard for medicine would have undermined the cultural authority of medicine more generally. American physicians already face a rising tide of skepticism. As health care costs continue to soar, the reasoning behind medical decisions is increasingly being questioned. Moreover, the clinical autonomy so cherished by physicians is rapidly eroding as health care payers strive to contain costs via “managed care.” In this context, it is hardly surprising that the leaders of American medicine had little stomach for the skepticism that would surely have resulted from the medicalization of abortion access.

The therapeutic exception did not produce a pragmatic accommodation in the abortion counseling controversy because it was not responsive to the most passionately-felt concerns of the controversy’s partisans. Because of this empathic failure, the potential breadth of the exception went unrecognized and unexplored by the activists who framed the “gag rule” debate. A broader lesson to be drawn from this experience is that compromise on the abortion question cannot be dispassionately engineered and imposed, by regulators (or courts) emotionally disconnected from the parties to the struggle. The principal infirmity of such disengagement is that it blocks appreciation of the attitudes that drive the struggle. Compromises uninformed by such appreciation risk leaving the parties with the sense of having been disregarded.

Greater engagement, on the other hand, cannot insure successful accommodation. Given the bitter feelings that drive the abortion conflict, it may be more realistic to expect merely that our political leaders not disconnect themselves from the passions felt by both sides. Perhaps, if political leaders committed themselves to such an obligation, our ongoing differences over this bitter question would seem less venomous than they do today.

References

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1. Planned Parenthood of Southeastern Pennsylvania v.

Casey, 112 S. Ct. 2791 (1992).

2. *Id.* at 2878 (Scalia, J., dissenting).

3. During a one-term Clinton presidency, the replacement of 83-year-old Justice Blackmun by a reliable *Roe* supporter may reasonably be anticipated. Prospects for the departure of one or more *Roe* opponents are much more speculative, as is the election of a Democratic (or pro-choice Republican) president in 1996.

4. *Rust v. Sullivan*, 111 S. Ct. 1759 (1991).

5. *Id.* at 1769.

6. American College of Obstetricians and Gynecologists, “12 National Medical and Nursing Organizations Call for Overturn of ‘Gag Rule,’” News Release, June 13, 1991.

7. Prior to President Clinton’s repeal of these regulations, the campaign for Congressional repeal came closest to its goal in November 1991, when the House and Senate passed legislation that would have barred their enforcement. E. Pianin, “House Votes to Shield Abortion Counseling but Fails to Muster a Veto-proof Majority,” *Washington Post*, November 7, 1991, sec. A16. President Bush vetoed this legislation, and its supporters fell 12 votes short of the 288 needed in the House of Representatives for an override. E. Pianin, “House Affirms Ban on Abortion Advice,” *Washington Post*, November 20, 1991, sec. A1.

8. R. Scalettar, Statement of the American Medical Association to the Subcommittee on the Constitution, Judiciary Committee, U.S. Senate, re: the impact of *Rust v. Sullivan* on medical communications (July 30, 1991).

9. Statement by Richard H. Schwarz, President of the American College of Obstetricians and Gynecologists (June 13, 1991).

10. L. Feldmann, “U.S. Abortion Clinics Await Policy Signal by Congress,” *Christian Science Monitor*, June 18, 1991, at 7.

11. I employ the term “pro-life” not because I believe it is the best characterization of the anti-abortion position, but rather because respecting abortion opponents’ self-labeling preference may contribute in a small way to reducing the bitterness that infects public discourse about abortion.

12. In stating this conclusion, I do not mean to suggest that repeal of the regulations sustained in *Rust* served no purpose. Even accompanied by a therapeutic exception, they chilled conversation between patients and health professionals to a degree that made their repeal desirable, from the perspectives of both patients and providers. J. Sugarman & M. Powers, “How the Doctor Got Gagged: The Disintegrating Right of Privacy in the Physician-Patient Relationship,” *JAMA*, 266 (1991): 3323-3327.

13. Petitioners’ Brief for a Writ of Certiorari to the United States Court of Appeals, Second Circuit, *Rust v. Sullivan*, 889 F.2d 401 (1989), *aff’d* 111 S.Ct. 1759 (1991).

14. R. Marcus, “Abortion-Advice Ban Upheld for Federally Funded Clinics,” *Washington Post*, May 24, 1991, sec. A1.

15. 42 C.F.R. § 59.8(a)(1) (1989).

16. 42 U.S.C.A. § 300a-6 (West 1991).

17. H.W. Jones, *Nowak’s Textbook of Gynecology* (Baltimore: Williams and Wilkins, 11th ed., 1988): 236.

18. *Rust v. Sullivan*, 111 S. Ct. 1759, 1773 (1991).

19. *Id.*

20. 42 C.F.R. § 59.8(a)(2) (1989).

21. 111 S. Ct. at 1773.

22. *Id.*

23. 42 C.F.R. § 59.5(b)(1) (1991).

24. *Valley Family Planning v. North Dakota*, 661 F.2d 99, 101 (8th Cir. 1981).

25. 661 F.2d at 101, n.2 (quoting a 1979 HHS interpretive opinion).

26. 661 F.2d at 101.

27. 52 Fed. Reg. 33210 (1987).

28. 53 Fed. Reg. 2922, 2926 (1988).
29. *Id.*
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.*
34. T. Lewin, "Hurdles Incease for Many Women Seeking Abortions," *New York Times*, March 15, 1992, sec. 1:1.
35. *Roe v. Wade*, 410 U.S. 113 (1973).
36. *Id.* at 163. The U.S. Supreme Court's ruling in *Planned Parenthood of Southeastern Pennsylvania v. Casey* sets the stage for medical gatekeeping in another abortion-related context—state laws imposing obstacles to abortion access that survive the "undue burden" test. In upholding Pennsylvania's 24-hour waiting period and parental consent provisions, the Court said that the Pennsylvania law's medical exemption from these requirements is "central" to their constitutional validity. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S. Ct. 2791, 2822 (1992). "[T]he essential holding of *Roe*," the Court reasoned, "forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Id.* at 2822.
- Despite the Pennsylvania statute's use of the term "medical emergency" to narrowly frame its medical exemption, the Court insisted on a broad view of the exception. Quoting from the Third Circuit's opinion, the Court stated: "We read the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman." *Id.* at 2822. This construction was essential, according to the Court, to bring the exemption into line with *Roe*'s proscription against interference with abortion choice where continued pregnancy threatens a woman's health. In so construing the exemption, the Court rejected *Planned Parenthood*'s attempt to do what it had tried without success in *Rust*—to cast a medical necessity exception in sufficiently narrow terms to foreclose the constitutionality of a barrier to abortion access.
37. *Roe v. Wade*, 410 U.S., at 163.
38. E. Pfeiffer, "Psychiatric Indications or Psychiatric Justification of Therapeutic Abortion?" *Arch. Gen. Psychiat.*, 23 (1970):402-407.
39. Model penal code § 230.3(2) (1962).
40. *United States v. Vuitch*, 402 U.S. 62 (1971).
41. *Id.*
42. *Id.*
43. The Court's opinion last term in *Planned Parenthood v. Casey* ironically echoed this sweeping view of health in addressing Pennsylvania's requirement that women opting for abortion be given information about their "unborn child." The opinion justified this requirement by (1) discerning a government interest in apprising women of abortion's "health risks," (2) declaring that "psychological well-being is a facet of health," and (3) warning that failure to instruct women about abortion's "impact on the fetus" contributes to "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed." 112 S. Ct. at 2823.
44. H.I. Levene & F.J. Rigney, "Law, Preventive Psychiatry, and Therapeutic Abortion." *J. Nerv. and Mental Dis.*, 1970; 151:51-59.
45. R.B. Sloane, "The Unwanted Pregnancy," *New Eng. J. Med.*, 280 (1969):1206-1213; E.C. Senay, "Therapeutic Abortion: Clinical Aspects," *Arch. Gen. Psychiat.*, 23 (1970):408-15.
46. H.G. Whittington, "Evaluation of Therapeutic Abortion as an Element of Preventive Psychiatry," *Am. J. Psychiat.*, 126 (1970): 58-63.
47. F.G. Cunningham, *Williams Obstetrics* (Norwalk, Conn: Appleton and Lange, 18th ed., 1989): 501.
48. M. Walzer, *Spheres of Justice* (New York: Basic Books, 1983):86-91.
49. L. Tribe, *Abortion: The Clash of Absolutes* (New York: W.W. Norton, 1990):60.
50. *Id.* at 63.
51. Without acting disingenuously, physicians could accomplish this by taking a broad view of health and a liberal view of the "necessity" of clinical interventions aimed at achieving health. Only if medical necessity is misapprehended as a fixed, timeless measure, unresponsive to evolving social perceptions of need, must such behavior be judged disingenuous and therefore ethically dubious.
52. 111 S. Ct. at 1776.
53. K. Luker, *Abortion and the Politics of Motherhood* (Berkeley: University of California Press, 1984):62-65, 78-83.
54. *Harris v. McRae*, 448 U.S. 297 (1980).
55. L. Marder, "Psychiatric Experience with a Liberalized Therapeutic Abortion Law," *Am. J. Psychiat.*, 126 (1970): 1230-1236).
56. 402 U.S. at 72.
57. A. Heller, H.G. Whittington, "The Colorado Story: Denver General Hospital Experience with the Change in the Law on Therapeutic Abortion," *Am. J. Psychiat.*, 125 (1968):809-816.
58. Whittington, *supra* note 47, at 1224-1229.
59. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington, D.C.: American Psychiatric Press, 3rd ed., 1980).
60. M. Foucault, *Madness And Civilization* (New York: Random House, Inc., 1965).
61. D. Callahan, *What Kind of Life: The Limits of Medical Progress* (New York: Simon and Schuster, 1990):34-40.
62. E.O. Nightingale, E. Stover, "A Question of Conscience: Physicians in Defense of Human Rights," *JAMA*, 255 (1986): 2794-2797.
63. B. Day, H. Waitzkin, "The Medical Profession and Nuclear War: A Social History," *JAMA*, 254, (1985):644-651.
64. A. Peck, "Therapeutic Abortion: Patients, Doctors, and Society," *Am. J. Psychiat.*, 125 (1968):797-804.
65. ACOG poll, "Ob-gyns' Support for Abortion Unchanged Since 1971," *Family Planning Perspectives*, 17(6) (Nov/Dec 1985):275.
66. R. Veatch, *The Physician-Patient Relation* (Bloomington, Indiana: Indiana University Press, 1991): 54-62.
67. Tribe, *supra* note 50, at 75.
68. *Bowen v. American Hospital Association*, 476 U.S. 610 (1986); U.S. Commission on Civil Rights, *Medical Discrimination Against Children with Disabilities* (Washington: U.S. Government Printing Office, 1989).
69. A. Stone, *Law, Psychiatry, and Morality* (Washington, D.C.: American Psychiatric Press, 1984):242-244.
70. Whittington, *supra* note 47, at 1224-1229.
71. S. Halleck, *The Politics of Therapy* (New York: Science House, 1971):144-146. Such invention need not be consciously disingenuous. Clinicians commonly form beliefs, influenced by their prejudices and ambitions, in the face of empirical uncertainty. Jay Katz, *The Silent World of Doctor and Patient* (New York:First Press, 1986). Indeed, the omnipresence of empirically unsettled questions in medical practice would make clinical decision-making impossible without such beliefs.
72. Whittington, *supra* note 47, at 1224-1229.
73. Halleck, *supra* note 71, at 146.

74. *Id.* at 146-147.

75. C. Sunstein, "Legal Interference with Private Preferences," *Univ. Chi. L. Rev.*, 53 (1986):1129-1174.

76. Michael Seidman suggests that much of American constitutional law can be understood as a means for preserving a barrier between our contradictory private and public lives:

Any theory about what constitutes the good life must recognize that people are both private and public regarding. We are all ... entitled to equality of concern and respect, but we also need lovers, families, and friends for whom we care specially. Any effort to resolve this contradiction is fundamentally misguided.

M. Seidman, "Public Principle and Private Choice: The Uneasy Case for a Boundary Maintenance Theory of Constitutional

Law," *Yale L.J.*, 96 (1987):1006-1059. Law, this model holds, mediates between enclaves of private choice and contrary assertions of public morality. It explicitly protects some spheres of personal preference from state intervention, and it develops mechanisms to shield other realms of private choice from public visibility. Although Seidman focuses on constitutional interpretation, the model can be applied to law more broadly.

77. G. Calabresi & P. Bobbitt, *Tragic Choices* (New York: W.W. Norton, 1978).

78. P. Hiltz, "White House Eases Stand on Abortion Counseling," *Houston Chronicle*, March 21, 1992, Sec. A:1 (byline *New York Times*).

79. A. Allen, "Tribe's Judicious Feminism," *Stanford Law Review* 44 (1991):179-203 (discussing complementary roles of privacy and equal protection arguments for abortion rights).