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THE PHYSICIAN'S DECISION-MAKING ROLE IN ABORTION CASES

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I. JUSTICE BLACKMUN'S VIEW

The United States Supreme Court has, of course, severely restricted the power of states to regulate abortions. But in doing so, it has recognized a large and not well defined role for the physician—in the abortion itself, of course, but also in the abortion decision:¹

For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.²

and:

Up to those points [the end of the first trimester approximately], the abortion decision *in all its aspects* is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.³ [Emphasis added.]

Thus the Supreme Court has acknowledged that the abortion decision in all its aspects is inherently and primarily a medical

¹To decide to abort a fetus is an immense step, an enormity with grave medical, religious, and psychological implications. Who makes that decision? How is it made? What factors are taken into account when such a decision is made? What factors *ought* to be taken into account? These quite relevant questions have not yet received their due exploration. The legal authority in the wake of the Supreme Court's recent actions is that the abortion decision rests with the pregnant woman. But the physician, too, has a legal and obviously a medical share of that decision. This article (1) explores the physician's legal role, as seen through the words of Justice Blackmun, and the physician's medical role, as seen both empirically and in current medical literature, (2) assesses the current state of affairs in physician abortion counseling, and (3) suggests a synthesis which blends the physician's legal and medical roles with a proper regard for the enormity of the abortion decision.

²Roe v. Wade, 410 U.S. 113, 164 (1973).

³*Id.*, at 166.

decision. What aspects, then, comprise the abortion decision? Justice Blackmun, in his opinion for the majority in *Doe v. Bolton*, has given an answer of sorts:

... [M]edical judgment may be exercised in the light of all factors—*physical, emotional, psychological, familial, and the woman's age*—relevant to the well being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.⁴ [Emphasis added.]

What sort of physical, emotional, psychological, and familial factors did Justice Blackmun have in mind? In *Roe v. Wade*, Blackmun listed a sampling of “factors the woman and her responsible physician necessarily will consider in consultation”:⁵

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.⁶

Clearly the role of the physician in the abortion was seen by Blackmun as beyond that of the clinician. Indeed at another point, Blackmun fantasized over

the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called “error,” and needs. The good physician—despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are “good”—will have a sympathy and an understanding for the pregnant patient that probably is not exceeded by those who participate in other areas of professional counseling.⁷

⁴*Doe v. Bolton*, 410 U.S. 179, 191 (1973).

⁵*Roe v. Wade*, 410 U.S. 113, 153 (1973).

⁶*Id.*

⁷*Doe v. Bolton*, 410 U.S. 179, 196-97 (1973).

This judicial proclamation of near omniscience on the part of physicians is curious in light of Blackmun's clear recognition of "vigorous opposing views, even among physicians"⁸ concerning abortion:

One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.⁹

Thus Blackmun simultaneously upholds the physician's judgment in the abortion counseling setting and recognizes "vigorous opposing views . . . among physicians" in that same setting. The image created is a curious one: The only persons whose competence is seen as capable of resolving the difficult abortion decision dilemma are themselves acknowledged to be influenced by the same sociological factors that color everyone's thinking and conclusions about abortion. Is Blackmun too trusting or too candid? The choice is not a comfortable one, and one might hope for a third alternative, in the form of a common-sense fusion of Blackmun's images. To this fusion we shall presently return.

II. A MEDICAL PERSPECTIVE

We have seen Justice Blackmun's view of the physician's role in the abortion decision. The physician's own view of that role is not dissimilar.

The physician's initial task when confronted with a request for an abortion is, of course, to confirm the suspected pregnancy. An estimated twenty to thirty percent of criminal abortions performed prior to *Roe* and *Doe* were on non-pregnant women.¹⁰ To repeat or even approximate that figure today would obviously be poor medicine.

Beyond pregnancy confirmation, the physician may be expected to perform screening, counseling, decision-making, referral, and follow-up functions.¹¹

⁸*Roe v. Wade*, 410 U.S. 113, 116 (1973).

⁹*Id.*

¹⁰J. Butler, M.D., and B. Fujita, B.A., *Abortion Screening and Counseling: A Brief Guide for Physicians*, 50 *Postgraduate Medicine* 208 (1971). See also A. Margolis, M.D., *Some Thoughts on Medical Evaluation and Counseling of Applicants for Abortion*, 14 *Clinical Obstetrics and Gynecology* 1255 (1971).

¹¹J. Butler, M.D., and B. Fujita, B.A., *Abortion Screening and Counseling: A Brief Guide for Physicians*, 50 *Postgraduate Medicine* 208 (1971). A. Margolis, M.D., *Some*

The screening function should include both medical and sociopsychological considerations.¹²

Medical Screening and Counseling

Good medical screening clearly involves the taking of a careful history, a physical examination, and laboratory tests.¹³ Beyond these screening activities, the physician will discuss several medical considerations with the patient: the type of procedure to be performed and the possible complications.¹⁴ The procedures most generally performed during the first trimester are vacuum aspiration, dilation and curettage, or both. Major complications of the first trimester abortion include hemorrhage of greater than 500 cc of blood, infection with febrile morbidity (defined as a temperature above 100.4°F persisting for more than 24 hours), and uterine perforation. Complications of the second trimester abortion include hemorrhage, infection, and failure of the primary induction, requiring a second procedure in cases of saline-induced abortions.¹⁵

Sociopsychological Screening and Counseling

The purpose of sociopsychological screening is to determine whether the patient wants the termination immediately and will be satisfied with the decision.¹⁶ If done properly, the screening will involve many elements of counseling. The physician will be aiming to discover whether the patient has any religious conflicts about

Thoughts on Medical Evaluation and Counseling of Applicants for Abortion, 14 *Clinical Obstetrics and Gynecology* 1255 (1971). R. Pasnau, M.D., *Contemporary Psychiatric Consultation: Evaluation or Rehabilitation?*, 14 *Clinical Obstetrics and Gynecology* 1258 (1971). J. Bragonier, M.D., Ph.D., and C. Ford, M.D., *Preabortion Evaluation: Selection of Patients for Psychiatric Referral*, 14 *Clinical Obstetrics and Gynecology* 1263 (1971). M. Bracken, M.P.H., G. Grossman, M.D., M. Hachamovitch, M.D., D. Sussman, M.S., D. Schieir, M.S.W., *Abortion Counseling: An Experimental Study of Three Techniques*, 117 *American Journal of Obstetrics and Gynecology* 10 (1973). N. West, M.D., and M. Walsh, *The Need for Pre-Abortion Counseling—Now More Than Ever*, 59 *Nebraska Medical Journal* 34 (1974).

¹²*Id.* See Butler and Fujita, at p. 210.

¹³MED-CHI Guidelines for Physician Performance of Induced Abortions, 1973 *Maryland State Medical Journal* 68.

¹⁴On complications, see F. Glenc, M.D., *Early and Late Complications After Therapeutic Abortion*, 118 *American Journal of Obstetrics and Gynecology* 34 (1974).

¹⁵D. Evans, M.D., and J. Gusdon, M.D., *Medical and Surgical Complications of Therapeutic Termination of Pregnancy*, 35 *North Carolina Medical Journal* 87 (1974).

¹⁶J. Butler, M.D., and B. Fujita, B.A., *Abortion Screening and Counseling: A Brief Guide for Physicians*, 50 *Postgraduate Medicine* 208, 210 (1971).

abortion, whether the patient has any unresolved doubts at all, who wants the abortion, whether there are any conflicts with parents or relatives about the abortion, whether the patient has received prior counseling on abortion, and whether the patient will want follow-up therapy (e.g., contraceptive advice or fitting).¹⁷ Sociopsychological screening is a delicate function because the patient being screened is almost by definition in a stressful dilemma.¹⁸ "Frequently the dilemma that encompasses the pregnant woman, be it social or economic, compels her to regard termination of the pregnancy as the only resolution. . . ."¹⁹ Almost never will she analytically assess her options, discarding the odious ones and weighing the acceptable ones. In theory, she has at least five or six options depending on her marital status: (1) attempt a self-induced abortion, (2) seek an illegal abortion, (3) request a legal abortion, (4) if single, marry and keep the child, (5) if single, remain so and keep the child, (6) if single, remain so and place the child for adoption, (7) if married, keep the child, (8) if married, place the child for adoption.²⁰

There is a dilemma involved in the physician's role in sociopsychological screening and counseling, not unlike the curious double-image of the physician painted by Justice Blackmun. The curiosity of Blackmun's simultaneous near deification of the physician's judgment and recognition of vigorous opposing views among physicians did not escape Bernard N. Nathanson, M.D., who wrote of the physician's role in the abortion decision in the November 18, 1974, issue of the *New England Journal of Medicine*.²¹

Dr. Nathanson's story began in 1969 when he became an organizer of the National Association for Repeal of Abortion Laws (now known as the National Abortion Rights Action League). NARAL was successful in its efforts to persuade the New York State Assembly to pass a "liberalized" abortion law in 1970. With the enactment of

¹⁷J. Bragonier, M.D., Ph.D., and C. Ford, M.D., Preabortion Evaluation: Selection of Patients for Psychiatric Referral, 14 *Clinical Obstetrics and Gynecology* 1263, 1269 (1971).

¹⁸Bragonier and Ford would question the general applicability of this statement.

¹⁹N. West, M.D., and M. Walsh, The Need for Pre-Abortion Counseling—Now More Than Ever, 59 *Nebraska Medical Journal* 34 (1974).

²⁰Butler and Fujita list only seven options, omitting the last—i.e., if married, place the child for adoption. 50 *Postgraduate Medicine* 208, 211 (1971).

²¹B. Nathanson, M.D., Sounding Board—Deeper into Abortion, 291 *New England Journal of Medicine* 1189 (1974).

that law, Dr. Nathanson became director of the Center for Reproductive and Sexual Health, described by him as "the first—and largest—abortion clinic in the Western world."²² Dr. Nathanson's recent fame no doubt results from his own published assessment of his work at the Center—this subsequent to his resigning the directorship:

The Center had performed 60,000 abortions with no maternal deaths—an outstanding record of which we are proud. However, I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths.

There is no longer serious doubt in my mind that human life exists within the womb from the very onset of pregnancy, despite the fact that the nature of the intrauterine life has been the subject of considerable dispute in the past.²³

Dr. Nathanson's radical reassessment of when human life begins does not, however, affect us directly in this inquiry. It is to his views on abortion consultation and the abortion decision that we turn:

Somehow, we must not deny the pervasive sense of loss that should accompany abortion and its most unfortunate interruption of life. We must not coarsen our sensitivities through common practice and brute denial.²⁴

Dr. Nathanson differed from Justice Blackmun in his assessment of the physician's ability to counsel directly on the emotional, moral, and sociological aspects of the abortion decision:

I offer no panacea. Certainly the medical profession itself cannot shoulder the burden of this matter. The phrase "between a woman and her physician" is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion. The decision is the most serious responsibility a woman can experience in her lifetime, and at present it is hers alone.²⁵

If physicians do not usually delve into the emotional, moral, and sociological aspects of the abortion decision in their consultations with pregnant women seeking abortions, who usually does? Dr.

²²*Id.* See 286 *New England Journal of Medicine* 403-407 (1972) for an account of the Center's activities.

²³291 *New England Journal of Medicine* 1189 (1974).

²⁴*Id.*

²⁵*Id.*

Nathanson's empirical observation was that those aspects of the decision are usually entrusted to "the narrow partisanship of committed young women who have had abortions and who typically staff the counselor ranks of hospitals and clinics now."²⁶ Dr. Nathanson's suggestion?

Can there be no help for the pregnant woman bearing the incalculable weight of this moral tension? Perhaps we could make available to her—though it should by no means be mandatory—a consultative body of unique design, much like Saint Simon's Council of Newton. To meet the new moral challenges of the Abortion decision, we may very well need specialists, some of new kinds, to serve on such a body—a psychohistorian, a human ecologist, a medical philosopher, an urbanologist-clergyman. The counseling that such a body could offer a pregnant woman would be designed to bring the whole sweep of human experience to bear on the decision. . . .²⁷

Thus the incongruity—Justice Blackmun certainly recognized the "physical, emotional, psychological, [and] familial"²⁸ awesomeness of the abortion decision, but in relegating those formidable considerations to consultation between "the woman and her responsible physician,"²⁹ was he being simplistic? Dr. Nathanson would seem so to conclude.

And what of the "familial" considerations involved in the abortion decision? What are "familial" considerations? Justice Blackmun mentioned the problems of the unwanted child, the child who is not likely to receive sufficient parental care because of psychological or other incapacities, and the stigma of unwed motherhood.³⁰ These are all, in a sense, familial considerations. But what of other familial considerations? Does the physician have a consultative responsibility to consider paternal rights, whatever they may be? Justice Blackmun, of course, expressly declined to consider "the father's rights, if any exist in the constitutional context, in the abortion decision."³¹ But one recent state court decision, *Murray v. Vandevander*,³² provides some measure of guidance. The *Murray* decision did not involve the question of abortion, but its reasoning seems fairly analogous to the problem of the physician's responsibil-

²⁶*Id.*, at 1190.

²⁷*Id.*, at 1189, 1190.

²⁸*Supra*, n. 4.

²⁹*Supra*, no. 5.

³⁰*Id.*

³¹*Roe v. Wade*, 410 U.S. 113, 165 (1973), *fn*te. 67.

³²*Murray v. Vandevander*, 522 P.2d 302 (Okl. App. 1974).

ity to consider paternal rights in the abortion decision. In *Murray*, Dr. D. C. Vandevander had performed a hysterectomy on Artie V. Murray, the wife of the plaintiff. Mr. Murray alleged that Dr. Vandevander "induced, and by the means of overreaching and unprofessional medical advice, prevailed upon . . . [his] wife . . . to submit to such surgery, . . ." and that he [Murray] ". . . had warned and specifically notified said defendant that he did not approve, but in fact, strenuously objected to the performance of such surgery."³³ Murray's theory of recovery was loss "of consortium and 'the right to reproduce another child.'"³⁴ The Court of Appeals of Oklahoma found "that the right of a person who is capable of competent consent to control his [*sic*] own body is paramount" and ruled that consequently "[t]here was no necessity for the physician in the instant case to obtain the consent of the plaintiff [husband]."³⁵ If this line of reasoning holds true for the abortion decision,³⁶ there would seem to be little for the physician to fear from the possibility of a later assertion of paternal rights.

III. A SYNTHESIS

What, then, is the physician's role in the abortion decision? Are there only two alternatives: Blackmun's semi-deification of the physician's counseling competence or Nathanson's cumbersome committee of assorted specialists? There is a middle ground between Blackmun and Nathanson, a ground which will enable the physician to discharge the counseling responsibility to the full extent of Blackmun's confidence as well as Nathanson's concern for practical competence, and a ground which will provide a measure of concern for potential paternal and other familial rights. Both Nathanson and Blackmun (though Blackmun less obviously) viewed the physician's counseling role as directive. But there is another widely accepted and used counseling approach that is particularly amen-

³³*Id.*, at 303.

³⁴*Id.*

³⁵*Id.*, at 304.

³⁶It is admitted, of course, that the cases are easily distinguishable. In *Murray*, the court saw the issue as the husband's "right to a child-bearing wife as an incident of their marriage." *Id.* The abortion context, of course, involves the assertion of a paternal right to protect "potential human life." Justice Blackmun was clear in stating that the State has an interest in protecting such life (though its interest does not become "compelling" until viability). 410 U.S. 113, 163. But the question still remains: Does the prospective father have an interest which is "compelling," and if so, to what extent must a physician respect it?

able to abortion counseling: placing the counselee in touch with her own feelings.

There are, of course, different theories of counseling. The direct method, usually seen as appealing to lawyers for its brisk, brass-tacks approach, tends to emphasize dynamic intervention. The counselor brings a new force into the situation and to some extent adopts the counselee's problem as his or her own. Intervention, understandably, involves a shifting of a large measure of responsibility for the contemplated decision over to the counselor. On the other end of the spectrum, school, marriage, psychological, and pastoral counselors have usually favored the nondirective, sometimes called Rogerian, method. The nondirective method focuses on allowing the counselee to ventilate her own feelings. The counselor, in a nonjudgmental but controlled manner, listens, comments when appropriate, and in general tries to place the counselee in touch with her own feelings enough so that the *counselee* can make the appropriate decisions. Both methods (really extremes—there are other methods in between) require some attention to, and control of, the ego defense mechanisms which interfere with one's ability to accept advice (directive) on the one hand, and one's ability to assess one's own true feelings with relative objectivity.³⁷

The question arises: Which method of counseling is more appropriate for the patient who is faced with the abortion decision? It is Dr. Nathanson's view that the type of counseling pregnant women contemplating abortions are presently receiving is decidedly directive: "the narrow partisanship of committed young women who have had abortions and who typically staff the counselor ranks of hospitals and clinics now."³⁸ Nathanson, of course, recognizes that another type of counseling is more appropriate—the type that provides the woman with enough informational input to enable her to make her own decision unassisted.³⁹ Moreover, Justice Blackmun's recognition of the abortion decision as one fraught with emotion and piercing to the essence of the decider's own personal value system⁴⁰ would seem to involve a call for the nondirective type.

In 1971, more than a year before *Roe* and *Doe*, Dr. Julius C. Butler of the University of Washington School of Medicine and

³⁷See H. Freeman and H. Weihofen, *Clinical Law Training—Interviewing and Counseling* (1972).

³⁸291 *New England Journal of Medicine* 1189, 1190 (1974).

³⁹*Id.*

⁴⁰*Supra*, n. 8.

Byron N. Fujita, counselor and research assistant, had occasion to address this very problem. Their conclusions:

The core consideration in counseling is to determine whether the pregnancy should be terminated or continued to term. Of primary importance, of course, is the patient's attitude toward abortion. . . .

As much as possible, other involved persons should be included in the discussion, although time should be allotted for private discussion. These include the involved male and the parents when appropriate and possible. The involved male should be included in the discussion with the patient because he should assume a part of the responsibility. He may be important in resolving the immediate crisis in the patient's subsequent sexual adjustment.⁴¹

Butler and Fujita seemed to contemplate both directive and nondirective counseling, especially in the context of the prospective father's participation in the discussions. If one were to focus purely on the nondirective method as the more appropriate approach to abortion counseling, what role do the interests of the prospective father play? What do the interests of the involved male have to do with the true feelings of the pregnant woman? In some cases, obviously very little or nothing. But in others, perhaps everything. Just as the pregnant woman must be aided through all the usual ego defense mechanisms to her own true view of the nature of abortion and its place in her own true value system or religious orientation, so too must she be aided to *her own* view of her spouse's or the involved male's posture with respect to the decision. For some, abortion will mean little more than the removal of an unwanted appendage. For others, it will mean an act of the most severe moral consequences—so severe that future coping may be difficult or impossible. Similarly, the reaction of the involved male, his viewpoint, his projected reaction, may be of no true significance to the woman. But to some it may be overwhelming, indeed so formidable that the counselor can accurately project that any post abortion adjustment will be too difficult.

The interests of parents is a similar, though not identical, consideration. A year ago, Dr. A. Frans Koome of Washington State was convicted of performing an abortion on an unmarried minor without first obtaining the consent of her parents. Such consent was required by Section 9.02.070 (a) of the Revised Code of the State of Washington. Koome's conviction was reversed by the Washington

⁴¹J. Butler, M.D., and B. Fujita, B.A., *Abortion Screening and Counseling: A Brief Guide for Physicians*, 50 *Postgraduate Medicine* 208, 211, 212 (1971).

Supreme Court which held that the consent requirement interfered with the minor's constitutionally guaranteed right of privacy.⁴² The case, of course, is a geographically limited precedent, and physicians in other states will, no doubt, be wary of similar state consent laws, but the case suggests another consideration. Are there counseling reasons, apart from statutory compulsions, which mandate, or at least suggest the advisability of, including parental considerations in the decisional equation? And, of course, there are. Butler and Fujita viewed the consideration apart from the point of view of the minor:

When appropriate, discussion with parents should be encouraged, particularly if the patient is under age 16. Almost without exception, younger women do not like to tell their parents. They fear parental reactions of shame or disappointment or a threatening posture. Oftentimes, the fact of intercourse, which the pregnancy exposes, causes the gravest concern for parents and should be fully discussed. Clinical experience has shown that openness with the parents about the predicament, especially if initiated by the patient, has a better chance of eliciting emotional support, something the patient may desperately need.⁴³

Again, Butler and Fujita seemed to contemplate both the directive and nondirective types of counseling. It may be, from the counseling point of view, that the patient needs no parental emotional support whatsoever despite her tender age, or it may appear from precounseling interviews that parental interests would be counterproductive and make it more difficult for the young patient to get in touch with her true feelings. The other side of the coin is that the interests of the parents may, and if Butler and Fujita's view is accepted, usually will be beneficial and productive. In that case, thorough and competent nondirective counseling would include those interests.

But whatever theory of counseling one prefers, it is clear that the physician, for good or ill, has been entrusted by the United States Supreme Court with an unprecedentedly large measure of official counseling responsibility, and much needs to be done to aid the physician who wishes to discharge this responsibility in a sensitive and humane manner.

⁴²See *State of Washington v. Koome*, 530 P.2d 260, 263 (Wash. 1975).

⁴³J. Butler, M.D., and B. Fujita, B.A., *Abortion Screening and Counseling: A Brief Guide for Physicians*, 50 *Postgraduate Medicine* 208, 212 (1971).