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ARTICLE

TERMINATING HOPE: DEFENSIVE MEDICINE IN CASES OF POOR PRENATAL DIAGNOSES

*Andrew T. Bodoh**

INTRODUCTION

In early 2015, I was blessed with the birth of a daughter who has severe special needs.¹ I cherish the memories of her birthday. My wife had nearly eight months of motherhood already (my daughter was born five weeks early), but I experienced the joy of fatherhood as I sat with my first child in the NICU for several hours, as my wife rested.

We first learned of our daughter's condition some fifteen weeks before, when the twenty-week ultrasound revealed cerebrospinal fluid occupying a large part of my daughter's cranium, indicating a substantial, congenital brain malformation. My wife and I were referred to a children's hospital where, after a long day, we met the attending physician, a resident, and a social worker in a small room to receive the prognosis. The prognosis was far, far worse than the reality I witnessed in the NICU less than four months later. We were told, for instance, that our daughter would likely require continual, institutional medical support *if* she survived the first days after birth. Instead, with the care and encouragement of several excellent medical providers,² my daughter was discharged from the hospital within four days of her birth, without major interventions in the NICU. At four years old, she is nonverbal, nearly blind, and suffers from cerebral palsy, epilepsy, and a gross motor development delay, but she has not required prolonged institutionalization or in-home medical supervision. She loves music, going to school, and exploring the world with her hands and her tongue.

My wife and I declined the abortion offered to us in conjunction with the poor prenatal prognosis. As a litigation attorney, though, the experience made me wonder how the medicolegal system, including the risk of lawsuits

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1. Andrew T. Bodoh, *Hope Has Become a Liability Risk in Cases of Poor Prenatal Diagnoses*, SAVE THE 1 (Feb. 3, 2017), <https://www.savethe1.com/2017/02/03/hope-has-become-a-liability-risk-in-cases-of-poor-prenatal-diagnoses-by-andrew-t-bodoh-esq/>;

Zoe Romanowsky, *Little Girl Born with Rare Brain Disorder Defies Doctors Expectations*, ALETEIA (Feb. 27, 2017), <https://aleteia.org/2017/02/27/little-girl-born-with-rare-brain-disorder-defies-doctors-expectations>.

2. In particular, the author thanks doctors M.E., K.E., J.A., and nurse T.R.

alleging prenatal negligence, may influence a medical provider's behavior in such instances. In particular, what factors may encourage a medical provider, when addressing an adverse fetal condition, or the risk of an adverse fetal condition, to present a worst-case scenario to the family, or to speak with greater confidence about future hardships for the child and the family than the scientific evidence supports, or otherwise to encourage the termination of the pregnancy? While I do not know if, or to what extent, particular medical providers (such as my wife's) have been influenced by these factors, this Article identifies and studies those systematic incentives.

Put another way, this Article examines the reasons medical providers may practice defensive medicine by promoting elective abortions in response to adverse prenatal diagnoses.³ While many articles and cases have asserted a connection between the risk of lawsuits alleging prenatal negligence and the practice of defensive medicine in prenatal care, this Article examines the systemic connections in much greater detail within its narrow focus of adverse prenatal diagnoses.⁴ This Article considers, for instance, the

3. This Article focuses on adverse prenatal diagnoses, rather than other prenatal or preconception scenarios, such as adverse preconception genetics screenings or counseling, failures to provide or recommend preconception genetics screenings or counseling, failures to diagnose or treat fetal conditions properly in utero, or ineffective sterilizations or abortions. While such scenarios are often discussed in connection with one another, each has distinct practical, medicolegal dynamics, and so this Article focuses on prenatal diagnoses specifically.

4. See, e.g., *Plowman v. Fort Madison Cmty. Hosp.*, 896 N.W.2d 393, 407 (Iowa 2017) (accepting a wrongful birth claim and rejecting arguments about an increased risk of defensive medicine and more abortions); *Reed v. Campagnolo*, 630 A.2d 1145, 1152 (Md. 1993) (noting arguments of counsel that recognition of wrongful birth suits will cause overutilization of medical tests, affecting the standard of care); *Albala v. New York*, 429 N.E.2d 786, 788 (N.Y. 1981) (discussing the risk of physicians avoiding treatments that may cause birth defects in future pregnancies); *Becker v. Schwartz*, 386 N.E.2d 807, 818–19 (N.Y. 1978) (Wachtler, J., dissenting in part) (“A doctor exposed to liability of this magnitude will undoubtedly, in marginal cases, be inclined to practice ‘defensive medicine’ by advising abortion rather than run the risk of having to pay for the lifetime care of the child if it is born with a handicap. Thus the majority’s decision will involve human costs as well, in those cases where otherwise healthy children will be unnecessarily aborted as the only alternative to the threat of pecuniary liability.”); Paola Frati et al., *Preimplantation and Prenatal Diagnosis, Wrongful Birth and Wrongful Life: A Global View of Bioethical and Legal Controversies*, 23 HUM. REPROD. UPDATE 338, 347 (2017) (discussing English judicial opinions that oppose such causes of action based on concerns about defensive medicine, including abortion recommendations); Anthony Jackson, *Action for Wrongful Life, Wrongful Pregnancy, and Wrongful Birth in the United States and England*, 17 LOY. L.A. INT’L & COMP. L.J. 535, 554 (1995) (referencing “subconscious pressure to advise abortions in doubtful cases out of fear of actions for damages”); Michael A. Mogill, *Misconceptions of the Law: Providing Full Recovery for the Birth of the Unplanned Child*, 1996 UTAH L. REV. 827, 836 n.50 (referencing “unnecessary tests or operations”); Darpana M. Sheth, *Better Off Unborn? An Analysis of Wrongful Birth and Wrongful Life Claims*

connections between adverse patient outcomes and the risk of informal punishments, the influence of post-viability or late-term abortion bans in such cases, and the inherent challenges facing a provider in addressing an adverse prenatal diagnosis with a family.⁵

Adverse prenatal diagnoses are difficult for all involved, and this Article tries to be fair to providers and patients alike. My experiences⁶ and opinion, however, undoubtedly shape the language I choose and the arguments I advance. I support a broader legal recognition of fetal rights than the status quo, and I have sympathies with the social model of disability, which emphasizes the role social assumptions play in the limitations experienced by those with medical or mental health conditions.⁷ To illustrate, when a wheelchair-bound person encounters a stairway, the social model of disability recognizes that the medical condition does not alone limit the person's access to the next floor; rather, the stairway itself and the implicit assumption that people can climb stairs also cause the limitation the person experiences.⁸

Part I of this Article examines generally the medicolegal context that gives rise to the so-called practice of defensive medicine. It argues that providers

Under the Americans with Disabilities Act, 73 TENN. L. REV. 641, 665 (2006) (referencing the use of excessive medical testing); Paula Bernstein, Comment, *Fitting a Square Peg in a Round Hole: Why Traditional Tort Principles Do Not Apply to Wrongful Birth Actions*, 18 J. CONTEMP. HEALTH L. & POL'Y 297, 319 & n.139 (2001) (discussing the likelihood of excessive testing); Carolyn Lee Brown, Editorial Note, *Genetic Malpractice: Avoiding Liability*, 54 U. CIN. L. REV. 857, 880 (1986) (referencing overuse or avoidance of prenatal diagnostics); Matthew Diehr, Comment, *The State of Affairs Regarding Counseling for Expectant Parents of a Child with a Disability: Do ACOG's New Practice Guidelines Signify the Arrival of a Brave New World?*, 53 ST. LOUIS U. L.J. 1287, 1301–02 (2009) (referencing the ACOG's recommendations that all pregnant women undergo prenatal Down syndrome screening, and suggesting such practices “may place excessive pressure on women to have an abortion”); Bernadette Kennedy, Comment, *The Trend Toward Judicial Recognition of Wrongful Life: A Dissenting View*, 31 UCLA L. REV. 473, 500 (1983) (referencing the risk of “overdeterrence of potential birth defects” through physicians recommending abortion “where the mother is at even a slight risk” for birthing a child with special needs); W. Ryan Schuster, Note, *Rights Gone Wrong: A Case Against Wrongful Life*, 57 WM. & MARY L. REV. 2329, 2348 (2016) (referencing both the risk of excessive prenatal screening and of incentivizing the physicians to recommend abortion); see also, e.g., Thomas Keasler Foutz, Comment, “Wrongful Life”: *The Right Not To Be Born*, 54 TUL. L. REV. 480, 493 n.82 (1980) (arguing that to avoid suits, physicians must merely obtain informed consent).

5. See *infra* Parts I and II.

6. See *supra* note 1 and accompanying text.

7. Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 147–49 (2005). This social model is typically described as a competitor of the more traditional medical model of disability, in which the limitations are viewed as arising simply or predominantly from the medical condition. *Id.* at 146–47.

8. *Id.* at 148.

wish to avoid formal and informal punishments that stem from disciplinary, civil, and criminal processes, and this means avoiding adverse patient outcomes. Part II then examines the risks associated with poor prenatal diagnoses specifically, including the risk of lawsuits alleging prenatal negligence, and the practical difficulties medical providers face in addressing fetal anomalies. Part III examines an extraordinary case from Connecticut, *Meleney-Distassio v. Weinstein*, in which a couple sued two physicians for recommending an abortion based on an erroneous prenatal diagnosis. This case illustrates many of the concerns identified in this Article. Part IV argues that the current arrangement has social and moral costs. Part V then surveys the pros and cons of several options for improving the situation.

I. THE MEDICOLEGAL CONTEXT

To understand why a medical provider may try to terminate a parent's hope for a child in utero in response to prenatal evidence of an adverse fetal condition, one should explore the broader context, assessing the medicolegal system at a much more general level and approaching the problem incrementally. The first section of this Part provides a general framework for understanding defensive medicine, and the second section looks more specifically at medical malpractice lawsuits within this framework. Part II then looks at defensive medicine in the context of poor prenatal diagnoses.

A. *From Patient Autonomy to Defensive Medicine*

Today, our society expects every competent patient to cooperate, and to be allowed to cooperate, in decisions pertaining to his or her medical care.⁹ Indeed, the patient is typically considered the final decision-maker in most matters concerning medical treatment.¹⁰ As the American Medical

9. See CODE OF MEDICAL ETHICS §§ 1.1.3–1.1.4 (AM. MED. ASS'N 2016), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf>; Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 982 (2009) (describing informed consent as "one of the fundamental building blocks of the modern physician-patient relationship"); *id.* at 984 (describing the "building blocks of bioethics" as including an "emphasis on individual rights [and] the primacy of autonomy").

10. CODE OF MEDICAL ETHICS §§ 1.1.3–1.1.4 (AM. MED. ASS'N 2016), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf>; Johnson, *supra* note 9, at 982, 984; Kristen Ann Curran, Comment, *Informed Consent: A Right Without a Remedy Examined Through the Lens of Maternity Care*, 21 AM. U. J. GENDER SOC. POL'Y & L. 133, 138 n.25 (2012); Darrin P. Dixon, *Informed Consent or Institutionalized Eugenics? How the Medical Profession Encourages Abortion of Fetuses with Down Syndrome*, 24 ISSUES L. & MED. 3, 46 (2008) ("Twenty-years ago doctors were the sole medical decision-

Association's Code of Ethics states, "Autonomous, competent patients control the decisions that direct their health care."¹¹ This ideal, however, is undermined by the complexities of modern medicine. The practice of medicine requires expertise. Even apart from the skills required, for instance, to perform surgery or to use specialized medical equipment, patients often do not have the capacity or the know-how to collect and to digest the information necessary to make timely, informed healthcare decisions without the counsel of medical professionals.¹²

The divide between the ideal of patient autonomy and the need for expert care challenges the medicolegal system, and our society has adopted the approach of cautious trust in medical professionals.¹³ With respect to trust, we as individuals, and collectively as a society, allow medical professionals to guide us in life and death decisions, often with the mantra that the doctor knows best.¹⁴ We expect medical professionals to have answers to our questions about what we are experiencing, what is causing it, and what will cure it. We also allow medical providers fairly broad discretion in their professional sphere.¹⁵ At the same time, we act with caution. We impose training and testing on those attempting to enter the profession to determine if they are worthy of our trust.¹⁶ We also regulate, for instance, what drugs

makers and now much emphasis has been placed on patient autonomy and self-determination within the medical context.”).

11. CODE OF MEDICAL ETHICS § 1.1.4 (AM. MED. ASS'N 2016), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf>.

12. See generally Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice*, 125 ANNALS INTERNAL MED. 763 (1996).

13. Cf. Johnson, *supra* note 9, at 978 n.27 (“Trust has assumed a central position in discussions of efforts to regulate physician behavior. Most of the literature addressing the difficult issue of the extent to which society, and patients in particular, generally trusts physicians, explains patterns in the regulation of medical practice or can be used as a guide for choices in regulatory form”); Quill & Brody, *supra* note 12 (discussing the need to balance the patients’ autonomy and the physicians’ expertise).

14. Cf. Katherine Say, Note, *Wrongful Birth – Preserving Justice for Women and Their Families*, 28 OKLA. CITY U. L. REV. 251, 284 (2003) (“Real danger lies . . . in physicians’ misperception that their patients rely on the practitioner to make decisions for them. Society has long conferred on physicians the extraordinary power they presume. This power manifests itself in the control of information flow, to the detriment of informed prenatal decision-making. In addition, a physician’s advice may be colored by personal political or moral beliefs, destroying the ideal of judgment-neutral information exchange.”).

15. *Id.*

16. See DAVID A. JOHNSON & HUMAYUN J. CHAUDHRY, MEDICAL LICENSING AND DISCIPLINE IN AMERICA: A HISTORY OF THE FEDERATION STATE MEDICAL BOARDS 1–2 (2012) (summarizing the training and licensure requirements but noting “the system is not foolproof, judging by

reach the market, what medical claims the drug manufacturers may make in the marketplace, and who has the power to prescribe and dispense such drugs.¹⁷

We also allow medical professionals to be held accountable for breaches of trust through formal professional discipline, civil liability, and even criminal sanctions.¹⁸ In theory, the medicolegal system administers formal disciplinary, civil, and criminal sanctions for breaches of established medical, legal, and ethical standards, with the protections of due process, in order to discourage, remedy, and punish such breaches.¹⁹ In practice, however, medical providers experience informal punishments or adverse consequences before, during, and after such proceedings.²⁰ Informal punishments include, for instance, inconvenience, distress, personal or professional humiliation, financial costs, legal fees, temporary suspension or loss of medical privileges, administrative leave, and loss of employment.²¹ While in theory medical providers have nothing to fear if they comply with medical, legal, and ethical standards, as the process will protect the innocent

the caseloads of today's state medical board investigators and the more than 6,000 substantive disciplinary actions . . . taken annually against physicians").

17. See Suzanne White Junod, *FDA and Clinical Drug Trials: A Short History*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/media/110437/download> (last visited Oct. 28, 2019).

18. See generally Kara M. McCarthy, Note, *Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism To Assure Quality Health Care*, 28 SETON HALL L. REV. 569 (1997) (discussing the various methods of disciplining physicians for errors in medical practice).

19. See *id.*

20. See Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 48 (2011) (indicating that physicians "are no longer able to pass increased malpractice premiums on to their patients or insurers"); Johnson, *supra* note 9, at 978 ("There is a rather substantial body of research . . . that identifies apparently unique experiences, motivations, and reactions on the part of physicians. Research examining the training of physicians, for example, reveals heightened sensitivity to shame associated with errors In addition, significant distrust on the part of physicians toward the legal system may influence them to react differently to legal risks and incentives as compared to other risks and incentives."); *id.* at 1029 ("The costs [to physicians] of the inquiry or investigation include financial costs, disruption of the practice, damage to reputation, resultant ostracism or termination of necessary business relationships, stress, shame, and other losses that are quite significant."); McCarthy, *supra* note 18.

21. Furrow, *supra* note 20, at 48; Johnson, *supra* note 9, at 978, 1029; Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RESOL. 109, 115–116 (2012).

from formal sanctions,²² informal punishments arising from the process fall on the innocent as well as the guilty, and there is also the risk of erroneous judgments.²³ Medical providers, therefore, may reasonably try to reduce the risk of formal and informal punishments, rather than simply avoiding the behaviors that are legitimately the target of formal punishments. This means, in practice, physicians should try to avoid unexpectedly severe adverse patient outcomes.

A bad patient outcome—that is, any outcome perceived to be both unexpected and adverse by the patient, the patient’s family, or others—increases the risk of formal or informal punishments in several ways. First, an adverse patient outcome may cause someone to initiate formal proceedings.²⁴ The poor outcome may motivate the patient or the patient’s family to file a civil, criminal, or disciplinary complaint against the medical provider. Similarly, an adverse outcome may influence those who witnessed actual or suspected provider misconduct to report it. A severe adverse patient outcome might also trigger an automatic investigation under established institutional policies. Second, a patient’s outcome may be a factor in determining the time and resources dedicated to the formal investigation, as part of a civil, criminal, or disciplinary process. This is often a matter of resource allocation—using limited resources on matters deemed the most important—but other factors, such as legal strategy, may contribute to this. For instance, a medical practice may limit its internal investigation of a simple medical error because the information it uncovers may be used against the organization in a civil suit.²⁵ A severely adverse patient outcome, however, may compel the practice to investigate in depth. Third, an adverse outcome may tip the balance to a finding of wrongdoing. For instance, the

22. See, e.g., Foutz, *supra* note 4, at 492 n.82 (critiquing concerns about a link between lawsuits and defensive medicine by arguing that to avoid suits, physicians must merely obtain informed consent).

23. Michael D. Benson et al., *Hospital Quality Improvement: Are Peer Review Immunity, Privilege, and Confidentiality in the Public Interest?*, 11 NW. J.L. & SOC. POL’Y 1, 2, 8–11 (2016); David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2027–28 (2006); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 926–27 (1993).

24. See Gerald B. Hickson et al., *Factors that Prompted Families To File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS’N 1359, 1359 (1992); Wendy Levinson, *Doctor-Patient Communications and Medical Malpractice: Implications for Pediatricians*, 26 PEDIATRIC ANNALS 186 (1997).

25. Cf. Margo Schlanger, *Second Best Damage Action Deterrence*, 55 DEPAUL L. REV. 517, 517–18, 532 (2006) (discussing the “suppression of information-production for fear of resulting litigation”).

outcome may color the evaluation of the evidence.²⁶ Similarly, scapegoating is a possibility—blaming the provider for the bad outcome for the sake of public perception or to shift attention away from other blameworthy people, institutions, or practices.²⁷ Fourth, the bad patient outcome may be a factor in evaluating the formal sanctions administered, whether legitimately or illegitimately.

Medical providers may overestimate the personal and professional risks of bad patient outcomes.²⁸ Day-to-day experiences—such as periodic malpractice insurance payments or the stories from colleagues and instructors—may affect a provider’s evaluation of the risks, making the provider unduly wary of adverse proceedings.²⁹ The American Medical Association (“AMA”), advocating for tort reform, highlights the concerns this way:

Because being sued is such a common event over the course of a physician’s career, and because medical liability insurance is so costly, the fear of liability hangs like a cloud over physicians—and it never goes away. The liability environment influences how physicians practice and affects patients’ access to care and treatment.³⁰

The risks associated with adverse patient outcomes may motivate providers to avoid these outcomes through objectionable practices. A provider may, for instance, recommend or undertake tests or procedures that involve risks, costs, or patient suffering disproportionate to the anticipated medical benefit, to avoid a small or remote risk of an adverse patient

26. See DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 203–04 (2011) (discussing outcome bias—the tendency in hindsight to blame decision-makers for not avoiding a bad outcome).

27. See Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 ST. LOUIS U. L.J. 79, 94–95 (1994) (noting that medical malpractice cases focus on physician mistakes rather than other causes of poor healthcare).

28. See Katharine Van Tassel, *Harmonizing the Affordable Care Act with the Three Main National Systems for Healthcare Quality Improvement: The Tort, Licensure, and Hospital Peer Review Hearing Systems*, 78 BROOK. L. REV. 883, 912 n.138 (2013).

29. Cf. Jodi Halpern & Robert M. Arnold, *Affective Forecasting: An Unrecognized Challenge in Making Serious Health Decisions*, 23 J. GEN. INTERNAL MED. 1708, 1710 (2008) (“[S]tudies show that physicians’ specific professional biases may lessen their ability to see patients’ situations clearly, for example, when they are overly influenced by the memory of a rare bad outcome.”).

30. AM. MED. ASS’N, *MEDICAL LIABILITY REFORM NOW!* 2 (2018 ed.), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/mlr-now.pdf>.

outcome.³¹ The provider may inflate the adverse prognosis or diagnosis, or overstate the risks of the condition to the patient, or pretend a test or practice is routine, in order to justify a course of care the patient might otherwise reasonably reject, or to otherwise influence the patient's expectations and mitigate the patient's surprise if an adverse outcome occurs.³² The provider may also refer, transfer, or decline to care for patients with a heightened risk of an adverse outcome.³³ A provider might try to hide a bad outcome, obscure its cause, or make the case more difficult to prove for the potential claimant and easier to defend for the provider.³⁴ The provider may substitute a more active course of care for a more passive one to impress the patient that what can be done is being done.³⁵ A provider may make treatment decisions intended to minimize the risk or type of formal or informal punishments if an adverse outcome is probable or unavoidable.³⁶ Using these practices, whereby the best medical care and judgment is subordinated to efforts to mitigate the provider's professional or legal risks, is typically called the practice of defensive medicine.³⁷

In short, defensive medicine is not simply the fault of medical providers or the medical establishment. It is, in part, a byproduct of a system that subjects medical providers to formal or informal punishments that correlate too strongly with adverse patient outcomes rather than actual provider misconduct. With this overview in mind, the next section specifically explores the role of civil malpractice lawsuits in the medicolegal system and how these suits motivate the practice of defensive medicine.

31. See Isaac D. Buck, *Overtreatment and Informed Consent: A Fraud-Based Solution to Unwanted and Unnecessary Care*, 43 FLA. ST. U. L. REV. 901, 910–13 (2016) (discussing the provision of unnecessary treatment); Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L. & CONTEMP. PROBS. 7, 65 (2006); Schlanger, *supra* note 25, at 517–18, 524–25; David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609, 2612–13 (2005); Mark Strasser, *Yes, Virginia, There Can Be Wrongful Life: On Consistency, Public Policy, and the Birth-Related Torts*, 4 GEO. J. GENDER & L. 821, 833 (2003); AM. MED. ASS'N, *supra* note 30, at 5.

32. Cf. Schlanger, *supra* note 25, at 517 (“[P]otential litigation can induce potential defendants to favor more cognizable or demonstrable care, and less cognizable or demonstrable harm.”).

33. *Id.* at 534.

34. *Id.* at 517–18, 525, 532–33.

35. See Levinson, *supra* note 24 (discussing how perceptions of poor communication and inadequate attention promote dissatisfaction and motivate litigation).

36. See generally Schlanger, *supra* note 25.

37. E.g., Studdert et al., *supra* note 31, at 2609.

B. *Civil Lawsuits and Defensive Medicine*

In regulating the practice of medicine, our medicolegal system allows patients injured by a medical professional to sue for damages, awarded as a monetary sum. In theory, civil lawsuits against medical providers serve several functions. They shift the cost of the harm from the patient and social welfare programs to those responsible for causing the harm and to insurers of the wrongdoers.³⁸ Such suits are presumed to deter the bad behavior of medical professionals.³⁹ Such suits may also award exemplary and punitive damages.⁴⁰ Litigation also typically permits a judgment on a more complete and accurate record than other dispute resolution methods.⁴¹ In general, these suits are intended to support the system of cautious trust in medical professionals.⁴²

The type of civil claim most relevant to this article is negligence.⁴³ Negligence claims allege that some action or inaction of the medical provider breached the applicable standard of reasonably prudent medical care. More specifically, the plaintiff must show (1) a duty recognized in the common law, such as the duty to act as a reasonably prudent medical provider would have acted under the circumstances, a norm called the “standard of care,” (2) a breach of that duty, (3) an injury, and (4) the causal relationship between the breach and the injury.⁴⁴

Notably, there must be both a demonstrable breach of the duty and demonstrable damages caused by that breach, so a doctor will escape civil liability if there are no provable damages, even if the doctor was negligent. Conversely, causing an injury alone does not create liability when the provider’s conduct was within the standard of care.⁴⁵ Notably, too, as

38. See Hensel, *supra* note 7, at 171; Diehr, *supra* note 4, at 1301.

39. Christopher J. Robinette, *Why Civil Recourse Theory Is Incomplete*, 78 TENN. L. REV. 431 (2011); Diehr, *supra* note 4, at 1301; Kennedy, *supra* note 4, at 491–92.

40. See, e.g., *Curlender v. Bio-Science Labs.*, 165 Cal. Rptr. 477, 489–90 (Cal. Ct. App. 1980).

41. Florence Yee, Note, *Mandatory Mediation: The Extra Dose Needed To Cure the Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 406–07 (2006).

42. See Havighurst & Richman, *supra* note 31, at 65.

43. See generally Jackson, *supra* note 4 (discussing the various classes of negligence actions that may arise due to prenatal negligence).

44. See generally Alan J. Belsky, *Injury as a Matter of Law: Is This the Answer to the Wrongful Life Dilemma?*, 22 U. BALT. L. REV. 185, 205–248 (1993); Bernstein, *supra* note 4, at 302–03; Brown, *supra* note 4, at 861–64; Say, *supra* note 14, at 264–65; Foutz, *supra* note 4, at 488; Jackson, *supra* note 4; Sheth, *supra* note 4, at 645–648; Kennedy, *supra* note 4, at 482–90.

45. See Havighurst & Richman, *supra* note 31, at 66. The asymmetry created by this rule—namely that different medical providers committing substantially the same negligent act may

impressive as “the standard of care” sounds, it is often little more than whatever a paid expert witness persuades the judge or jury to believe it is.⁴⁶ After all, this legal standard is intended to be flexible.⁴⁷ It is not intended to restrict the evolution of medical practice or to dictate checklist-style care when a case-by-case approach is more appropriate. It is therefore for the judge or jury to determine what the standard requires and whether the standard was breached after the presentation of expert opinions and evidence.⁴⁸

The risk of civil lawsuits for negligence tends to influence medical professionals because of the formal and informal punishments associated with such suits.⁴⁹ First, a civil suit is typically a permanent, public allegation of misconduct.⁵⁰ A civil suit is normally public from the moment the case is filed with the court. Medical providers have obvious personal and professional reasons to avoid public allegations of misconduct. By contrast, many forms of employment or professional discipline are substantially private, at least until there is a finding of misconduct.⁵¹ Second, lawsuits take an emotional toll on the defendant.⁵² The process is adversarial, with parties seeking to gain an advantage through tactics that obscure the merits of the case. An almost random jury of laypeople may decide the merits of the medical care provided. The provider will face inquiries from his or her employer, attorney, and insurer, to say nothing of the opposing counsel or party. Facing the adverse consequences of a past decision, whether the decision was right or wrong, will also be emotionally troubling, especially in

experience dramatically different consequences based on the outcome of the act—is often discussed in academic literature under the term “moral luck.” E.g. Justin W. Martin and Fiery Cushman, *The Adaptive Logic of Moral Luck*, in JUSTIN SYTSMA & WESLEY BUCKWALTER, EDS., *A COMPANION TO EXPERIMENTAL PHILOSOPHY* 190 (2016); John C.P. Goldberg & Benjamin C. Zipuraky, *Tort Law and Moral Luck*, 92 CORNELL L. REV. 1123 (2007); Morris B. Hoffman, *Ten Legal Dissonances*, 62 MERCER L. REV. 989, 1007–09 (2011).

46. See Belsky, *supra* note 44, at 245; Adam Candeub, *Contract, Warranty, and the Patient Protection and Affordable Care Act*, 46 WAKE FOREST L. REV. 45, 71–72 (2011); Christopher Tarver Robertson, *Blind Expertise*, 85 N.Y.U. L. REV. 174, 177–78, 184–88 (2010); Yee, *supra* note 41, at 408–09.

47. E.g., *Smethers v. Campion*, 108 P.3d 946, 949 (Ariz. Ct. App. 2005).

48. E.g. *id.* at 949–50.

49. Dixon, *supra* note 10, at 50–53; Havighurst & Richman, *supra* note 31, at 65 (“[M]alpractice claims also impose substantial reputational and emotional costs on physicians.”); Studdert et al., *supra* note 31, at 2612.

50. See Weiler, *supra* note 23, at 943.

51. See, e.g., Benson et al., *supra* note 23 (discussing the privacy protections afforded to hospital peer review processes).

52. Johnson, *supra* note 9, at 978, 1000–02, 1029.

connection with a lawsuit. Third, there is often a risk of direct or indirect financial loss, such as the obligation to pay an insurance deductible, all or a portion of the judgment or settlement, attorney fees, or increased insurance premiums.⁵³ Finally, the provider will need to disclose and to explain the circumstances of the lawsuit in the future.⁵⁴

Most of the risks associated with lawsuits, unfortunately, are more closely connected to the fact of the litigation or the process itself, rather than a finding of misconduct by a judge or jury. Most of these harms fall on the provider that is wrongly sued as well as the one that is justly sued. The risk of being sued, in turn, is more strongly associated with bad patient outcomes than with bad behavior of the medical professional.⁵⁵ Several factors deter claims—even meritorious claims—from being brought when there is no severe, adverse patient outcome, and increase the likelihood of a lawsuit when after a severe, adverse patient outcome, even if there was no negligence.

To understand these factors, we must look at the situation in detail from the perspective of the claimant and the claimant's attorney. No medical malpractice suit exists without a claimant—typically someone who has suffered a bad outcome and believes the medical provider is to blame, or the patient's legal representative. In cases involving prenatal fetal anomalies, the claimant will be the child with special needs or the family of that child. Because malpractice litigation is complicated, the claimant normally needs an attorney. To get an attorney, the claimant must persuade an attorney to accept the case, and the claimant and the attorney must broker an acceptable fee arrangement.

In deciding whether to represent a claimant in a medical malpractice suit, and on what terms, the attorney will usually perform a rough, and often intuitive, evaluation of the case.⁵⁶ The attorney's initial calculus can be summarized most simply as follows:

53. See *id.* at 1029; *Medical Malpractice Insurance Complete Guide*, CUNNINGHAM GROUP, <https://www.cunninghamgroupins.com/medical-malpractice-insurance-complete-guide/> (last visited Oct. 11, 2019); Matt Thompson, 5 *Primary Factors that Affect a Physicians Malpractice Insurance Premium*, DIEDERICH HEALTHCARE (Feb. 23, 2016), <https://www.diederichhealthcare.com/the-standard/5-primary-factors-that-affect-a-physicians-malpractice-insurance-premium/>.

54. CUNNINGHAM GROUP, *supra* note 53; Thompson, *supra* note 53. See also 45 C.F.R. §§ 60.1–.22 (2004) (regulating mandatory reports to the National Practitioners Database, and access to this information).

55. See Johnson, *supra* note 9, at 992, 999–1000; Studdert et al., *supra* note 23, at 2029–31.

56. See Jonathan T. Molot, *A Market in Litigation Risk*, 76 U. CHI. L. REV. 367, 384 (2009).

$$\begin{array}{r}
 \text{(A) Probability of obtaining a recovery} \\
 \times \text{(B) Probable recovery if successful} \\
 \hline
 \text{(C) Gross value of the case} \\
 - \text{(D) Probable cost and fees} \\
 \hline
 \text{(E) Probable net value to client}^{57}
 \end{array}$$

In a complex and labor-intensive case like a medical malpractice suit, the attorney will typically want a substantial fee (see line D). A claimant usually cannot afford to pay an hourly fee, as medical malpractice cases are time intensive. The attorney, on the other hand, generally will not accept the case on a contingency fee basis unless the gross value of the case (line C) is high, because the fee will be a percentage of the recovery, if any.⁵⁸ Considering also the high costs of medical experts for malpractice litigation (a factor in line D), the case must have a high gross value (line C) to offset the probable costs and fees (line D) and produce a net value to the client (line E).

The attorney's representation, therefore, typically depends on the estimated gross value of the case (line C). The gross value of the case, in turn, equals the probability of obtaining a recovery (line A) multiplied by the probable recovery (line B). In medical malpractice claims, the probable recovery (line B) dominates this calculation. The claimant typically can supply enough information for the attorney to have a rough but reliable idea of whether the recovery could be substantial (line B). In fact, the material issue is simply whether the patient's outcome was adverse and severe. A severe outcome generally equates to a large recovery, if successful, and a less severe outcome generally equates to a smaller potential recovery (line B). By contrast, the likelihood of winning the case (line A) is often impossible to evaluate reliably at the outset of the representation. First, the attorney often will not know with a high degree of confidence the appropriate medical care in the specific circumstance, or whether the adverse outcome might be attributed to some independent cause. These facts are essential to evaluating the likelihood of prevailing on the claim (line A).⁵⁹ Second, at the outset of the case, the attorney often does not have enough information to know what actually happened to produce the outcome, much less what the testimony will be at trial. Medical records, for instance, usually tell more about the severity

57. For more complicated methods of calculating this, see Thomas H. Belknap, *Calculating Settlement Value of a Case*, MAR. REPORTER & ENG'G NEWS (Apr. 2014), <https://www.blankrome.com/sites/default/files/86063803942C25C141FAC6C2A1F39546.pdf>; Peter Toll Hoffman, *Valuation of Cases for Settlement: Theory and Practice*, 1991 J. DISP. RESOL. 1 (1991).

58. Nora Freeman Engstrom, *Lawyer Lending: Costs and Consequences*, 63 DEPAUL L. REV. 377 (2014); Molot, *supra* note 56, at 384.

59. Studdert et al., *supra* note 23, at 2029–31.

of the outcome than about who, if anyone, or what, if anything, is responsible for the bad outcome. The claimant's narrative of events will also be unreliable to some greater or lesser degree. A patient, for instance, will not have personal knowledge of many aspects of the course of care, such as what happened while under general anesthesia. Moreover, the emotional trauma of the experience often colors the claimant's memories of the events, making the medical professionals appear more blameworthy in the claimant's recounting than the facts may justify.⁶⁰ Attorneys know the same is true in reverse for the medical professionals, creating disputes of fact. Disputes about the facts, then, are reasonably expected and do not necessarily represent malicious lies or bad faith. Rather, they are often the natural and predictable result of imperfect human memory in emotionally stressful circumstances. This creates, however, great uncertainty in the probability of winning the case (line A).

As a business matter, a medical malpractice attorney must be cautious of overestimating the value of the case at the outset (line C), especially if the attorney is offering a contingency fee. As such, given the typical high degree of uncertainty in the prospects of winning a medical malpractice case (line A), the attorney usually will be extremely cautious to take a case unless the probable recovery if successful (line B) is sufficiently high to offset the risk and uncertainty. Put another way, the attorney will not take the case unless the patient suffered a severe, adverse outcome. If the outcome is bad enough, even a small chance at a substantial fee may be worth the risk to the attorney. Therefore, the severity of the patient's outcome roughly correlates to the likelihood that an attorney will accept the representation on workable terms and initiate a lawsuit against the provider. The attorney often will not know if the provider was, in fact, negligent at the outset of the case.

Note, too, a claimant may be more willing to accept high fees and costs for a lawsuit (line D), as well as a prospect of little or no recovery (line E), if the experience was so severe that the claimant has a goal other than a financial recovery, such as justice, the desire to punish the provider, the desire to prevent this outcome for others in the future, or the opportunity to speak out against the provider or the medical system. This is one way a severe patient outcome may increase the resources spent to investigate and to prosecute a

60. Cf. Dixon, *supra* note 10, at 45–47; Deborah Davis & William C. Follette, *Foibles of Witness Memory for Traumatic/High Profile Events*, 66 J. AIR L. & COM. 1421, 1454–67 (discussing how trauma and stress impair memory in several ways); Deborah Davis, Markus Kemmelmeier, & William C. Follette, *Memory for Conversation on Trial*, in HANDBOOK OF HUMAN FACTORS IN LITIGATION 12–4, 12–5 (Y. Ian Noy & Waldemar Karwowski eds., 2004); KAHNEMAN, *supra* note 26, at 203–04 (discussing outcome bias—the tendency in hindsight to blame decision-makers for not avoiding a bad outcome).

complaint against the provider, increasing the risks associated with an adverse patient outcome.

Given these factors, one could reasonably predict three results. First, many meritorious malpractice claims are never brought, because the estimated gross value of the claims (line C) are estimated to be too small relative to the expected costs and fees (line D). Second, the claims that are brought tend to have high recoveries when they are successful (see lines B and C). Third, a large fraction of the claims that are brought are unsuccessful, because the probability of winning the case (line A) is so uncertain at the outset. The available data conform to these predictions. The majority of patients who suffer a medical injury due to a provider's negligence do not sue.⁶¹ One study found that for every malpractice claim brought, there were 7.6 incidents of medical negligence causing adverse outcomes.⁶² Likewise, claimants often fail to obtain a recovery, but a successful claim typically brings a substantial recovery. One broad study of the malpractice claims from 1991 to 2005 showed that 78% of the claims that were initiated did not result in a payment to the claimant, but the mean indemnity payment in successful claims was \$274,887.⁶³ Another later study, using data through 2015, showed again that only about a quarter of the claims resulted in an indemnity payment, but the average payment in successful claims was \$365,503.⁶⁴ While one-third of the indemnity payments between 2006 and 2015 were less than \$100,000, payments exceeding one million dollars accounted for 41.9% of the total of the indemnity payments.⁶⁵ The average trial award for successful claims closed in 2015 was \$1,121,815, though trial awards accounted for only 3.5% of the total amount of indemnity payments.⁶⁶ Additionally, claims that do not involve a medical error are more likely to go to trial due to lack of settlement than claims that do involve a medical error, though meritless claims rarely result in a verdict for the claimant.⁶⁷

61. Studdert et al., *supra* note 23, at 2025.

62. A. Russel Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991).

63. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629, 629 (2011).

64. Jose R. Guardado, *Medical Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition, 2006–2015*, AM. MED. ASS'N POL'Y RES. PERSP., at 2–3 (2018), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-liability-insurance-claim.pdf>.

65. *Id.*

66. *Id.*

67. Studdert et al., *supra* note 23, at 2028.

Returning to the theme of defensive medicine, providers respond to this risk of lawsuits and to high malpractice insurance premiums by practicing defensive medicine. For instance, a 2017 survey of 601 primary care providers and specialists found that 86% of them believed that the fear of malpractice was a reason for ordering unnecessary tests or procedures.⁶⁸ Concerns about liability may also influence the education of medical students and young providers, perpetuating and institutionalizing inappropriate medical practices.⁶⁹

In short, while malpractice litigation is intended to compensate victims of medical negligence, providers reasonably wish to avoid such suits, whether the claims are ultimately successful or not. A substantial adverse patient outcome creates the risk of a malpractice claim, regardless of the provider's responsibility. Providers therefore try to avoid adverse outcomes through the practice of defensive medicine.

II. DEFENSIVE MEDICINE IN CASES OF POOR PRENATAL DIAGNOSES

Part I of this Article examines defensive medicine generally in its social context. This Part of the Article looks more closely at defensive medicine in the context of poor prenatal diagnoses. It argues that specific social, scientific, legal, and ethical difficulties attending poor prenatal diagnoses give providers reasons to go beyond discussing terminating the pregnancy, and to actively encourage the woman to do so.⁷⁰

A. *Defensive Medicine in Obstetric Care*

Obstetricians and gynecologists are generally recognized as having the highest rate of malpractice claims among medical specialists.⁷¹ While only a small fraction of this is likely tied to poor prenatal diagnoses, the general concern about liability can contribute to a culture of defensive medicine in

68. Choosing Wisely, *DataBrief: Findings from a National Survey of Physicians*, AM. BOARD INTERNAL MED. FOUND. 1, 5–6 (2017), <http://www.choosingwisely.org/wp-content/uploads/2017/10/Summary-Research-Report-Survey-2017.pdf>.

69. Alexius Cruz O'Malley, *Preventing a Return to Twilight and Straightjackets: Using the Patient Protection and Affordable Care Act as a Starting Point for Evidence-Based Obstetric Reform in the United States*, 8 NW. J.L. & SOC. POL'Y 295, 315–16 (2013).

70. See Buck, *supra* note 31, at 923 (noting that providers may not discuss alternatives when they consider the risks or benefits not worth discussing or when they strongly support a particular treatment option).

71. Jose R. Guardado, *Medical Liability Claim Frequency Among U.S. Physicians*, AM. MED. ASS'N POL'Y RES. PERSP. 1, 8 (2017), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf>.

prenatal care. In a 2015 survey, nearly three-quarters (73.6%) of the responding OB-GYNs reported that they had been sued.⁷² Each OB-GYN who responded had experienced, on average, 2.59 claims.⁷³ Approximately forty percent of the claims with a result reported in the survey responses involved payments on behalf of the medical provider, averaging nearly one-half million dollars, with the average payment for a neurologically impaired infant exceeding \$1,000,000.⁷⁴ Nearly half (49.7%) of the OB-GYNs acknowledged they had altered their practices between 2012 and 2014 out of fear of liability, including 23.8% who decreased the number of high-risk obstetrics patients they accepted.⁷⁵ Nearly forty percent (39.8%) claimed they made adjustments to their practices between 2012 and 2014 based on the affordability or the availability of liability insurance, including 13.6% that decreased the number of high-risk obstetrics patients they accepted.⁷⁶ Meanwhile, the cost of malpractice premiums for OB-GYNs vary widely.⁷⁷ In 2014, these costs tended to exceed \$100,000 annually in twelve states, with a peak of \$214,999 a year in New York.⁷⁸ Survey data from 2015 indicate OB-GYNs spent an incredible average of 10.6% of their gross income on liability insurance premiums.⁷⁹ In another study, reviewing data from 1991 to 2005, obstetrics and gynecology accounted for eleven of the sixty-six awards in excess of one million dollars that the study identified, more than any other specialty.⁸⁰ Another study found that malpractice claims against OB-GYNs

72. Andrea M. Carpentieri et al., *Overview of the 2015 American Congress of Obstetricians and Gynecologists' Survey on Professional Liability* 3, AM. CONG. OF OBSTETRICIANS AND GYNECOLOGISTS (Nov. 3, 2015), <https://www.acog.org/-/media/Departments/Professional-Liability/2015PLSurveyNationalSummary11315.pdf>; see also Guardado, *supra* note 71, at 8 (reporting that 63.6% of responding OB-GYNs reported having been sued).

73. Carpentieri et al., *supra* note 72, at 3.

74. *Id.* at 4.

75. *Id.* at 3; see also Studdert et al., *supra* note 31, at 2612 (reporting that 59% of OB-GYNs indicated they often referred patients to other specialists in unnecessary circumstances).

76. Carpentieri et al., *supra* note 72, at 1–2.

77. *How Much Does Medical Malpractice Insurance Cost?*, GALLAGHER HEALTHCARE: INDUS. INSIGHTS BLOG (Dec. 12, 2017), <https://www.gallaghermalpractice.com/blog/post/how-much-does-medical-malpractice-insurance-cost>.

78. *Id.*; see also Jose R. Guardado, *Medical Professional Liability Insurance Premiums: An Overview of the Market from 2006 to 2017*, AM. MED. ASS'N POL'Y RES. PERSP. 1 (2018), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-liability-insurance-premiums.pdf>.

79. Carpentieri et al., *supra* note 72, at 2.

80. Jena et al., *supra* note 63, at 633.

were the most likely to be litigated.⁸¹ Thus, fear of litigation, high malpractice premiums, and the practice of defensive medicine are common and acute in obstetric care.

B. *Practical Difficulties of Poor Prenatal Diagnoses*

Negotiating the risks of civil lawsuits can be particularly difficult in obstetrics and other medical disciplines involving pregnancy because of the medicolegal conflicts that can arise.⁸² In obstetrics, the doctor has two patients, one wholly dependent on the other, with interrelated medical conditions that may come into conflict with one another.⁸³ Additionally, in the United States, the mother has a broad right to terminate the prenatal life at will.⁸⁴ Pregnancies that pose a substantial risk to the health or life of the mother represent particularly troubling cases, but the broad right to abort

81. Anupam B. Jena et al., *Outcomes of Medical Malpractice Litigation Against US Physicians*, 172 ARCHIVES INTERNAL MED. 892, 893 (2012).

82. See Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451 (2000).

83. Frati et al., *supra* note 4, at 339–40.

84. The prevailing legal standards were articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). States may regulate and even prohibit abortion at or after fetal viability except where abortion is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. *Id.* at 879. Pre-viability regulations are legitimate only if they do not impose an undue burden on the right to abortion. *Id.* at 878. An undue burden exists if the purpose or effect of the regulation is to place a substantial obstacle in the path of a woman seeking an abortion. *Id.* Regulations to further the health or safety of the woman, to promote the state's interest in prenatal life, to ensure the decision to abort is an informed decision, or to persuade a woman not to have the abortion, are also judged by the undue burden standard. *Id.*

The guarantee of the right to a post-viability abortion to preserve the life or health of the mother may be fairly broad. The life and health of the mother exception was articulated in *Roe v. Wade*, 410 U.S. 113, 163–64 (1973), and explained in the companion case of *Doe v. Bolton*, 410 U.S. 179, 191–92 (1973). *Bolton* held that “the medical judgment [concerning the need for the abortion for the life and health of the mother] 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.” *Id.* at 192.

Most states, in fact, place substantial limitations on late-term abortions, either at fetal viability, or in the third trimester, or after a specified number of weeks. *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST., <https://www.guttmacher.org/print/state-policy/explore/state-policies-later-abortions> (last visited Dec. 11, 2019). As of December 1, 2019, twenty-six states have post-viability abortion bans in effect that limit the woman's health exception to physical health, and two states have laws in effect that do not include a health of the mother exception. *Id.*

such pregnancies and the general social acceptance of such abortions mitigate some of the difficulties in practice.⁸⁵

Cases involving a poor prenatal diagnosis without a risk to the mother are often extremely complicated to address at a practical level. First, many severe conditions can be detected in utero but cannot be cured, whether before or after birth, and some may cause fetal demise.⁸⁶ Options for prenatal and postnatal interventions are expanding, but abortion may be the only option to avoid the burdens of bearing a child expected to die in utero or shortly after birth, or bearing and raising a child with special needs.⁸⁷ In cases where prenatal or postnatal treatment may be an option, practical considerations—such as the cost of the treatment, the inconvenience, the risk to the mother's health, the risk of a premature birth, and other potential side effects—may preclude treatment.⁸⁸

Second, prior to the adverse diagnosis, the family typically expects the child to be born healthy. A common mantra of expectant mothers is, "As long as my child has ten fingers and ten toes, I am happy." Even when family medical history or prior genetic screenings suggest an adverse condition is possible, the family may hope for the best and suppress fears and doubts.⁸⁹ The family is often unprepared for an adverse prenatal diagnosis, and a bad diagnosis and prognosis is likely to cause an emotional shock.⁹⁰ The family

85. See *Casey*, 505 U.S. at 879 (guaranteeing the right to abortion to save the life of the mother); GUTTMACHER INST., *supra* note 84 (indicating that every state that bans late-term abortion has a life of the mother exception); *Legality of Abortion, 2018–2019 Demographic Tables*, GALLUP, <https://news.gallup.com/poll/244097/legality-abortion-2018-demographic-tables.aspx> (last visited Nov. 19, 2019) (indicating only 18% of the respondents wanted abortion to be illegal under all circumstances, and 35% wanted abortion to be legal in only a few circumstances). The issue of early-term abortions on the basis of adverse prenatal diagnoses recently garnered attention after Indiana sought to prohibit them. The law was invalidated by a panel of the Seventh Circuit, and the Supreme Court denied certiorari on that issue. *Box v. Planned Parenthood of Indiana & Kentucky, Inc.*, 139 S. Ct. 1780 (2019).

86. Frati et al., *supra* note 4, at 339.

87. *Id.* at 342.

88. *Id.*

89. See Penelope Pitt, Belinda J. McClaren, & Jan Hodgson, *Embodied Experiences of Prenatal Diagnosis of Fetal Abnormality and Pregnancy Termination*, 24 REPROD. HEALTH MATTERS 168, 171 (2016) ("Melinda, who had previously terminated a pregnancy for a fetal abnormality, described receiving the news at her 12 week scan that her current pregnancy had abnormalities as 'looking down the barrel of another termination.'").

90. Himar H. Bijma et al., *Decision-Making After Ultrasound Diagnosis of Fetal Abnormality*, 16 REPROD. HEALTH MATTERS 82, 84–86 (2008); Tommy Carlsson & Elisabet Mattsson, *Emotional and Cognitive Experiences During the Time of Diagnosis and Decision-Making Following a Prenatal Diagnosis: A Qualitative Study of Males Presented with Congenital Heart Defect in the Fetus Carried by Their Pregnant Partner*, 18 BMC PREGNANCY

must adjust to a new and adverse reality.⁹¹ The family may need to grieve.⁹² At the same time, critical decisions often must be made related to the pregnancy, including whether to terminate the pregnancy.⁹³ This is hardly an ideal mindset for decision-making. The family may look to the medical professional delivering the bad news for a specific recommendation, elevating the provider's role to that of a surrogate decision-maker.

Third, regardless of the doctor's moral values, the doctor is obliged (at least as a practical matter) to advise the woman that she has the option to terminate the pregnancy through abortion, unless the law prohibits the abortion in the circumstance.⁹⁴ Some states prohibit some second- or third-trimester abortions unless the woman's health or life is in jeopardy.⁹⁵ If the woman has a legal right to the abortion under the circumstance, however, the doctor must treat abortion as a valid medical option, even if the doctor will decline to perform the abortion.⁹⁶ A provider risks a malpractice lawsuit if he or she fails to advise the woman that abortion is an option when there is evidence of a fetal anomaly and the woman can lawfully obtain an abortion in the state.⁹⁷ The potential damages in the case could be substantial, increasing the risk a suit would be brought.⁹⁸

Fourth, in states that regulate such abortions later in the pregnancy, providers face the additional challenge of a time constraint. As of December

& CHILDBIRTH 26 (2018); Joan G. Lalor et al., *Unexpected Diagnosis of Fetal Abnormality: Women's Encounters with Caregivers*, 34 BIRTH 80, 83–86 (2007); Pitt, McClaren, & Hodgson, *supra* note 89, at 171; Stina Lou et al., *Parental Response to Severe or Lethal Prenatal Diagnosis: A Systematic Review of Qualitative Studies*, 37 PRENATAL DIAGNOSIS 731 (2017); see Tommy Carlsson et al., *Involvement of Persons with Lived Experience of a Prenatal Diagnosis of Congenital Heart Defect: An Explorative Study To Gain Insights into Perspectives on Future Research*, 2 RES. INVOLVEMENT & ENGAGEMENT 1, 8 (2016).

91. Bijma et al., *supra* note 90, at 85; Dixon, *supra* note 10, at 47. Cf. KAHNEMAN, *supra* note 26, at 302–304 (discussing the aversion to the loss, where the loss is an unrealized goal).

92. Bijma et al., *supra* note 90, at 85; Carlsson & Mattsson, *supra* note 90; Lalor et al., *supra* note 90, at 80–81.

93. Cf. Frati et al., *supra* note 4, at 342 (“In such circumstances, the pregnant woman is asked to make decisions about her own medical care that unavoidably involves the health, prognosis and even the possibility of survival of her unborn child. Women themselves might find it difficult to decide for or against treatment.”).

94. See Bernstein, *supra* note 4, at 318–19. See generally Jackson, *supra* note 4 (discussing the various classes of negligence actions that may arise in this context).

95. See *supra* note 84.

96. See Bernstein, *supra* note 4, at 318–19.

97. E.g., *Simms v. United States*, No. 3:11-0932, 2014 U.S. Dist. LEXIS 174132, at *1–3 (S.D. W. Va. Dec. 17, 2014) (involving disputes about whether a woman was advised of her right to terminate a pregnancy in conjunction with the adverse prenatal diagnosis).

98. See *infra* note 129.

2019, forty-three states prohibit nontherapeutic abortions at some point in the pregnancy, ranging from the twentieth week to about the twenty-sixth week of the pregnancy.⁹⁹ To give a concrete example, if the state prohibits such abortions after twenty-four weeks, and the fetal anomaly is discovered at twenty-two weeks, the provider has just two weeks to allow the woman to recover from the shock, make the informed decision, and have the abortion, if that is what she chooses.¹⁰⁰

Fifth, diagnoses are often based on imperfect, ambiguous, or probabilistic information that easily can be misunderstood.¹⁰¹ A classic case is Down syndrome.¹⁰² The available tests for Down syndrome are not perfectly accurate, and understanding the significance of the error rate is difficult. To illustrate, if a test for Down syndrome has a sensitivity rate of 99.5%, then approximately 5 of every 1000 mothers carrying a child with Down syndrome will receive an erroneous negative reading if tested; the test misses the actual existence of the condition 0.5% of the time.¹⁰³ If the Down syndrome test has a specificity rate of 99.9%, then approximately 1 in every 1,000 mothers who receive a positive Down syndrome test result are, in fact, not carrying a child with that condition; the test erroneously reports that the condition exists 0.1% of the time.¹⁰⁴ The remaining 99.4% of the tests (994 of 1,000 tests) produce accurate readings. While this seems highly reliable, the statistics are misleading. In fact, a false positive is indistinguishable from a true positive, and the true positives are some part of the approximately 994 accurate readings. Suppose, for instance, that 100,000 pregnant women each has a 1 in 250 chance that her child in utero has Down syndrome.¹⁰⁵ Approximately 400 of these pregnancies will therefore be affected with Down syndrome, and approximately 99,600 pregnancies will not be affected. (The risk of Down syndrome affecting the pregnancy increases exponentially with maternal age, from approximately 1 in 1,600 pregnancies at the age of 20, to 1 in 30 pregnancies at the age of 45.¹⁰⁶ Down syndrome is estimated as affecting

99. GUTTMACHER INST., *supra* note 84.

100. Frati et al., *supra* note 4, at 344.

101. Cf. Jackson, *supra* note 4, at 535–36 (referencing the inaccuracies of tests for Tay Sachs).

102. See generally Dixon, *supra* note 10; Diehr, *supra* note 4, at 1305–10.

103. See Dixon, *supra* note 10, at 37.

104. See *id.*

105. Mark W. Leach, *How Accurate Is the New Blood Test for Down Syndrome?*, DOWN SYNDROME PRENATAL TESTING (July 30, 2013), <http://www.downsyndromeprenataltesting.com/how-accurate-is-the-new-blood-test-for-down-syndrome/>.

106. David S. Newberger, *Down Syndrome: What You Need To Know When You're Pregnant*, 62 AM. FAM. PHYSICIAN 837 (Aug. 15, 2000). Cf. Diehr, *supra* note 4, at 1305 (noting

about 1 in every 500 pregnancies.¹⁰⁷ Using the 99.9% sensitivity and 99.5% selectivity rates, if all these women were tested, there would be approximately 360 accurate positive readings (Down syndrome correctly detected), only 40 erroneous negative readings (Down syndrome missed by the test), 100 false positive readings (Down syndrome erroneously reported as detected), and 95,500 accurate negative readings (Down syndrome correctly determined not to be present). The doctors that review the results and the mothers receiving the results will see a negative reading in approximately 95,540 instances and a positive reading in approximately 460 instances, without knowing if their test produced a true or false result. In fact, *approximately one of five women who receive positive test results* (21.74%—approximately 100 out of 460 positive readings) *would not actually be carrying a child with Down syndrome*; these women received the false-positive test results.¹⁰⁸ If a woman has a 1 in 500 chance that her child in utero has Down syndrome, a positive test result will be an erroneous 35.71% of the time, based on a 99.9% specificity and a 99.5% sensitivity rate. Depending on the reasons for the false reading, additional testing may produce repeated errors.¹⁰⁹ The additional risk of human error increases the possibility of an erroneous result being reported.¹¹⁰ Unfortunately, the abortion rate in cases of a Down syndrome diagnosis is estimated to be as high as eighty to ninety percent, and all women, no matter

that the chance of having a baby with Down syndrome is above 1 in 250 at age thirty-five) (quoting Len Leshin, *Prenatal Screening for Down Syndrome*, DOWN SYNDROME: HEALTH ISSUES (1995), <http://www.ds-health.com/prenatal.htm>); Dixon, *supra* note 10, at 10 (asserting the risk of Down syndrome afflicting the pregnancy of a woman who is thirty-five is 1 in 385, and the risk of her having a fetus with other anomalies is 1 in 434, making her total risk of chromosomal anomaly 1 in 204).

107. Jean Gekas et al., *Non-Invasive Prenatal Testing for Fetal Chromosome Abnormalities: Review of Clinical and Ethical Issues*, 9 APPLICATION CLINICAL GENETICS 15, 15 (2016).

108. See Leach, *supra* note 105; cf. Hoffman, *supra* note 45, at 994–97 (discussing this failure to pay attention to base rates). In his book *THE DRUNKARD'S WALK: HOW RANDOMNESS RULES OUR LIVES* 114–16 (2008), theoretical physicist Leonard Mlodinow illustrates this surprising truth of statistics with a personal story. He describes that in 1989, he tested positive for HIV. His doctor advised him the test returned false positives in only 1 of 1,000 instances, and his doctor concluded that Mlodinow had only a 1 in 1,000 chance of being healthy given the positive test. According to Mlodinow's calculations, however, since a person with his characteristics has only a 1 in 10,000 chance of being HIV positive, he actually had a 10 out of 11 chance that he was not HIV positive despite the positive test.

109. See Dixon, *supra* note 10, at 36.

110. See *id.* at 40–41; Brandy Zadrozny, *Parents Sue Doctors over "Wrongful Abortion,"* DAILY BEAST (Jan. 29, 2015), <https://www.thedailybeast.com/parents-sue-doctors-over-wrongful-abortion/> (allegation that human error caused an erroneous diagnosis of an intersex fetus).

their age, are encouraged to undergo Down syndrome screening.¹¹¹ Thus, the harms arising from even small error rates may be greatly exaggerated by poor comprehension of what those error rates mean.

Even where the diagnosis is relatively certain, though, there may be insufficient information for a reasonably accurate prognosis.¹¹² Medicine's ability to detect conditions that typify serious special needs far exceeds medicine's ability to specify what those special needs will be, much less what the condition will mean for the day-to-day life of the family or the affected individual.¹¹³ As one author notes:

[T]he range of functioning among individuals with the same disabilities can vary dramatically. An individual with Down syndrome, for example, may be profoundly mentally retarded and severely restricted in motor functioning or may be capable of meaningful employment, relationships, and community engagement. A child with cystic fibrosis likewise might die from it, survive with physical disability, or suffer no noticeable impairment.¹¹⁴

Any parent facing a poor prenatal diagnosis for a child, though, will want the doctor to describe what the diagnosis will mean in practice in the future.¹¹⁵ This dynamic encourages medical professionals to speak to matters beyond the scope of their expertise, presenting what may be incomplete or incarnate information, or speaking with greater confidence than a fair view of the situation merits.¹¹⁶

Sixth, in these situations, the pregnant woman facing a poor prenatal diagnosis may feel a strong sense of isolation.¹¹⁷ The choice to have an abortion or not is legally hers and hers alone, regardless of the desires of

111. Diehr, *supra* note 4, at 1289, 1301, 1306. *But see* Dixon, *supra* note 10, at 5–7 (arguing that the estimate of 90% may be too high); *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1782, 1790–91 (2019) (Thomas, J., concurring) (citing a *Washington Post* article that placed the abortion rate at 67% for Down syndrome diagnoses in the United States).

112. Diehr, *supra* note 4, at 1311.

113. *E.g.*, Dixon, *supra* note 10, at 37–38.

114. Hensel, *supra* note 7, at 183 (footnotes omitted).

115. *See* Lalor et al., *supra* note 90, at 83–86.

116. Dixon, *supra* note 10, at 4, 21–24, 27.

117. Denise Côté-Arsenault & Erin Denney-Koelsch, “My Baby Is a Person”: Parents’ Experiences with Life-Threatening Fetal Diagnosis, 14 J. PALLIATIVE MED. 1302, 1304, 1306–07 (2011).

others, including the father of the child.¹¹⁸ A medical provider must, therefore, tailor the communications to the mother. The provider may marginalize others in the woman's decision-making process, whether intentionally or not.¹¹⁹ The diagnosis, prognosis, and option to terminate the pregnancy may also be presented to the woman in a setting in which she is physically isolated from those she may look to for advice, including family members that are not present, other medical providers, or spiritual counselors. This may induce her to rely on the medical provider as her sole or chief advisor in the matter.

Seventh and finally, as intimated above, the provider's risk of a lawsuit for failing to advise a woman of the right to an abortion is not wholly eliminated by actually advising the woman of the right to the abortion. Given the emotional shock of a poor prenatal diagnosis, the parents may not have a clear recollection of the conversation that follows.¹²⁰ This memory lapse may lead to a lawsuit if the family continues the pregnancy to term but claims the provider withheld information that would have induced the woman to terminate the pregnancy.¹²¹ As discussed above, even if it will be difficult to prove a breach in the standard of care because of the factual dispute, a lawyer may well take the case because of the potential for a large verdict. Also, as described above, the lawsuit itself causes many hardships for the provider, whether the provider wins or loses.

The civil tort claims associated with poor prenatal diagnoses and the birth of children with special needs are a familiar subject in legal journals.¹²² The nomenclature of these claims—"wrongful birth," "wrongful life," and

118. Cf. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 887–96 (1992) (invalidating a spousal notification law as unduly burdening the woman's right to an abortion); Lalor et al., *supra* note 90, at 86.

119. Lalor et al., *supra* note 90, at 85.

120. See Carlsson et al., *supra* note 90, at 6–8; Tommy Carlsson et al., *Experiences of Informational Needs and Received Information Following a Prenatal Diagnosis of Congenital Heart Defect*, 36 *PRENATAL DIAGNOSIS* 515, 517–20 (2016).

121. Cf., e.g., *Simms v. United States*, No. 3:11-0932, 2014 U.S. Dist. LEXIS 174132, at *1–3 (S.D. W. Va. Dec. 17, 2014) (involving disputes about whether a woman was advised of her right to terminate a pregnancy in conjunction with the adverse prenatal diagnosis).

122. See generally, e.g., Jackson, *supra* note 4 (discussing the various classes of negligence actions that may arise in this context). See Constance Frisby Fain, *Wrongful Life: Legal and Medical Aspects*, 75 *KY. L.J.* 585, 587–88 (1986); Frati et al., *supra* note 4, at 343; Hensel, *supra* note 7; Mogill, *supra* note 4, at 827–28; Schuster, *supra* note 4; Sheth, *supra* note 4, at 645; Strasser, *supra* note 31, at 821–22; Brown, *supra* note 4; Bernstein, *supra* note 4; Diehr, *supra* note 4, at 1295–1304; Foutz, *supra* note 4; Kennedy, *supra* note 4; Say, *supra* note 14; Kate Wevers, Note, *Prenatal Torts and Pre-Implantation Genetic Diagnosis*, 24 *HARV. J.L. & TECH.* 257 (2010).

“wrongful pregnancy,” for instance—is more ambiguous than helpful for our purposes, and some of these terms may be used for cases that do not involve disabilities, let alone prenatally diagnosed disabilities.¹²³ Simply put, if the jurisdiction permits it, a medical provider who allegedly failed to disclose an unfavorable fetal condition, or who allegedly failed to recommend abortion adequately in the case, could be sued based on allegations that the failure breached the standard of care and caused damages, namely the lost opportunity to abort the pregnancy because of the disability.¹²⁴ The plaintiff in such a suit will typically be either or both parents or the child, depending on the circumstances and what the state allows.¹²⁵ When the woman has a legal right to an elective abortion, which typically includes a eugenic abortion,¹²⁶ the claimant may allege that the provider’s failure to discuss the

123. See *Viccaro v. Milunsky*, 551 N.E.2d 8, 9 n.3 (Mass. 1990) (“These labels are not instructive. Any ‘wrongfulness’ lies not in the life, the birth, the conception, or the pregnancy, but in the negligence of the physician. The harm, if any, is not the birth itself but the effect of the defendant’s negligence on the parents’ physical, emotional, and financial well-being resulting from the denial to the parents of their right, as the case may be, to decide whether to bear a child or whether to bear a child with a genetic or other defect.”); Fain, *supra* note 122, at 587–88 (noting that “a great deal of confusion has existed regarding the use of the term ‘wrongful life,’ with that label being given to a variety of factual situations” and describing wrongful life suits not related to disabilities); Hensel, *supra* note 7, at 150–62, 164–66; Jackson, *supra* note 4, at 566 (suggesting the “wrongful life” label is prejudicial to the merits of the cause of action); Mogill, *supra* note 4, at 827–28 (discussing the additional terms of “wrongful conception” and “wrongful pregnancy”); Sheth, *supra* note 4, at 645 (noting “jurists and scholars do not always use the terms consistently”); Strasser, *supra* note 31 (discussing the subtle distinctions among the states’ treatment of wrongful conception and wrongful pregnancy, wrongful birth, and wrongful life, and practical difficulties in distinguishing one claim from another); Foutz, *supra* note 4, at 483–84, 488–98; Kennedy, *supra* note 4, at 482–90; Say, *supra* note 14, at 261, 264.

124. Wevers, *supra* note 122, at 263–66. See generally Fain, *supra* note 122, at 587–614 (discussing wrongful life suits); Hensel, *supra* note 7, at 142–44, 164–70; Jackson, *supra* note 4 (discussing the various classes of negligence actions that may arise in this context); Bernstein, *supra* note 4, at 299; Diehr, *supra* note 4, at 1287–88; Foutz, *supra* note 4; Say, *supra* note 14, at 266.

125. Fain, *supra* note 122, at 585–86; Hensel, *supra* note 7, at 142–44; Bernstein, *supra* note 4, at 300–02; Diehr, *supra* note 4, at 1287–88, 1295–98; Foutz, *supra* note 4, at 483–84; Schuster, *supra* note 4, at 2337–38.

126. *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r of the Ind. State Dep’t of Health*, 888 F.3d 300, 303, 305–06 (7th Cir. 2018) (invalidating a state law prohibiting abortions based on race, color, national origin, ancestry, sex, or diagnosis or potential diagnosis), *vacated in part*, 727 Fed. App’x 208 (7th Cir.), *vacated*, 917 F.3d 532 (7th Cir.), *rev’d in part*, *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780 (2019). In this case, on a petition for certiorari to the U.S. Supreme Court, Justice Thomas argued in a concurrence, “The Court’s decision to allow further percolation [on the issue of state bans on abortions based on race, sex, or disability] should not be interpreted as agreement with the decisions below. Enshrining

adverse condition or the abortion option adequately was a proximate cause of the child being born alive.¹²⁷ Damages in these suits may include, but are not necessarily limited to, the extraordinary expenses of caring for the child.¹²⁸ The damage award can easily run into the millions, depending on the child's condition, even when the family has private insurance that will absorb a portion of these expenses or require medical providers to reduce their charges.¹²⁹

The imprecise language used in case law and statutes, the evolving nature of the law, and distinctions among the legal standards employed across the nation make it difficult to detail precisely in which jurisdictions, and under what circumstances, a medical provider might be sued for the birth of a child

a constitutional right to an abortion based solely on the race, sex, or disability of an unborn child, as Planned Parenthood advocates, would constitutionalize the views of the 20th-century eugenics movement.” *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1792 (2019) (Thomas, J., concurring).

127. *E.g.*, *Simms v. United States*, No. 3:11-0932, 2014 U.S. Dist. LEXIS 174132, at *1, *9-10 (S.D. W. Va. Dec. 17, 2014) (involving disputes about whether a woman was advised of her right to terminate a pregnancy in conjunction with the adverse prenatal diagnosis).

128. *See generally* Belsky, *supra* note 44, at 196-205 (discussing the damages allowed by law under the various claims); Bernstein, *supra* note 4, at 306; Brown, *supra* note 4, at 864; Diehr, *supra* note 4, at 1293-94; Fain, *supra* note 122, at 590; Frati et al., *supra* note 4, at 343-44; Hensel, *supra* note 7, at 150-62; Jackson, *supra* note 4; Kennedy, *supra* note 4, at 489; Mogill, *supra* note 4, at 828-31, 842-72; Schuster, *supra* note 4, at 2336; Wevers, *supra* note 122, at 264-66.

129. *E.g.*, *Simms v. United States*, 839 F.3d 364, 370 (4th Cir. 2016) (reviewing a \$12,222,743 wrongful birth award, and finding the trial court correctly used the amount the hospital charged for the services, rather than the amount Medicaid paid, but remanding for a statutory post-verdict collateral source hearing); *Wilkie v. Aslam*, No. BPG-08-1425, 2009 U.S. Dist. LEXIS 97503, at *13-14 (D. Md. Oct. 21, 2009) (rejecting the argument that a wrongful birth damage award is to be reduced by the amount paid for the child through public assistance programs); *Wuth v. Lab. Corp. of Am.*, 359 P.3d 841 (Wash. Ct. App. 2015) (upholding a verdict totaling \$50,000,000 on wrongful birth and wrongful life claims); *Chamberland v. Physicians for Women's Health, LLC*, No. CV010164040S, 2006 Conn. Super. LEXIS 451 (Conn. Super. Ct. 2006) (upholding a \$12,000,000 wrongful birth award, plus interest, subject to a \$428,937.70 collateral source deduction); Demetrios C. Batsides & Melissa S. Geller, *The Cross-Border Dilemma: Wrongful-Birth and -Life Litigation in NJ*, N.J. L.J. (May 11, 2016, 3:42 PM), <https://www.law.com/njlawjournal/almID/1202757420585/> (indicating that reported New Jersey settlements and verdicts in such cases have “almost always exceeded \$1 million and have often ranged between \$2.5 million and \$10 million”); Andrew G. Slutkin, *Wrongful Birth...*, MD. MED. MALPRACTICE LAW. BLOG (July 1, 2010), https://www.marylandmedicalmalpracticelawyerblog.com/wrongful_birth_in_maryland_ver/ (referencing a \$7.1 million wrongful birth verdict); *Verdicts & Settlements*, O'CONNOR, PARSONS, LANE & NOBLE, <http://lawnj.net/verdicts/28million-wrongful-birth/> (describing a \$28 million verdict for a wrongful birth claim) (last visited Aug. 31, 2019).

with special needs.¹³⁰ Many states have declined to recognize such claims, at least at this point, and many state legislatures have enacted laws prohibiting such suits in one manner or another.¹³¹ Currently, though, four states allow lawsuits against a medical provider by a person that claims he or she should have been aborted.¹³² About half of the states recognize suits brought by the mother, and possibly the father and other family members, against the medical provider after the birth of a child that the mother claims she would have aborted had she known of the child's adverse condition.¹³³

C. *The Practical Effects of These Difficulties*

In each communication with a family about a poor prenatal diagnosis or prognosis, and particularly in reporting the initial bad news, the provider has to determine how to share the information. The factors outlined above will affect this decision. With respect to terminating the pregnancy, the doctor is typically obliged to discuss the option, so the question is not “*Do I discuss it?*” but rather, “*Do I recommend it?*” (the third factor).¹³⁴ This decision may shape the entire discussion. There may be no realistic option to treat the condition (the first factor). Terminating the pregnancy in such cases will often appear an appealing and even a merciful option, at least compared to either the unexpected prospect of caring for a disabled child and the uncertainty about how difficult the child's and the family's future will be, or alternatively the prospect of continuing the burdens of a pregnancy in which the child is likely to die in utero (the second factor). Moreover, if the provider expects the family to choose abortion, emphasizing the adverse prognosis may be psychologically beneficial and even therapeutic, by reducing doubts about the decision.¹³⁵ In states that restrict late-term nontherapeutic abortions, the

130. See Bernstein, *supra* note 4, at 307–10 (discussing Nevada's and Indiana's refusal to adopt the “wrongful life” label for such claims); Strasser, *supra* note 31, at 833 (discussing the subtle distinctions among the states' treatment of wrongful conception and wrongful pregnancy, wrongful birth, and wrongful life, and practical difficulties in distinguishing one claim from another).

131. Bernstein, *supra* note 4, at 311–15; Frati et al., *supra* note 4, at 344; Say, *supra* note 14, at 261–64.

132. Diehr, *supra* note 4, at 1297 & n.80 (identifying California, New Jersey, Washington, and Maine); Schuster, *supra* note 4, at 2336.

133. Diehr, *supra* note 4, at 1297 (asserting twenty-three state recognize wrongful birth actions); Frati et al., *supra* note 4, at 344 (listing twenty-four states); Say, *supra* note 14, at 261 n.70 (citing cases from twenty-four jurisdictions).

134. See Kennedy, *supra* note 4, at 499–500.

135. See Majike Korenromp, *Parental Adaptation to Termination of Pregnancy for Fetal Anomalies* 20, 22, 26, 34–35, 40, 43, 46, 50, 54, 60, 66, 69, 76, 82, 85–86, 94–95, 110, 126–27, 132–37, 140 (2006), <https://dspace.library.uu.nl/handle/1874/9774>.

doctor may be obliged to press for a prompt or immediate decision (the fourth factor). Psychological or physical isolation of the woman in the decision-making process can make her vulnerable to the influence of the medical provider, whether that is the medical provider's intention or not (the sixth factor).¹³⁶ Imperfect information as to either the diagnosis or the prognosis, or both, also allows the medical provider to interpret and present the data as the provider may choose in answering the critical question of "What's going to happen?" (the fifth factor).

In this context, the risks associated with a lawsuit or other disciplinary action (the seventh factor) can further incentivize the provider to recommend an abortion.¹³⁷ Abortion eliminates the risk of wrongful birth or wrongful life suits by excluding the precondition of the suit, namely the child being born alive.¹³⁸ Abortion practically eliminates the risk of negligence claims or disciplinary complaints based on an erroneous diagnosis or prognosis—such as a false positive on the Down syndrome test, or an erroneous prediction that the disability will be severe—because the error would not likely be discovered once the abortion occurs.¹³⁹ If the error is discovered and disclosed before the abortion, the woman typically has not suffered legally compensable harm. The risk of injury to the woman through the abortion can be addressed through signed consent forms disclosing the risk.¹⁴⁰ This risk also falls on the abortion provider, who might not be the person that recommends the abortion. Moreover, even if the medical provider is successfully sued for recommending an abortion, the damages

136. Dixon, *supra* note 10, at 39–40; see Lalor et al., *supra* note 90, at 85–86.

137. See Bernstein, *supra* note 4, at 318–19; Diehr, *supra* note 4, at 1289; Dixon, *supra* note 10, at 39–40, 51–53; Fain, *supra* note 122, at 626–29 (noting that doctors are concerned about wrongful life suits); Jeffrey Klagholz & Albert L. Strunk, *Overview of the 2009 ACOG Survey on Professional Liability*, ACADEMIA, https://www.academia.edu/707493/Overview_of_the_2009_ACOG_survey_on_professional_liability (last visited Nov. 20, 2019); see also Ronen Perry & Yehuda Adar, *Wrongful Abortion: A Wrong in Search of a Remedy*, 5 YALE J. HEALTH POL. L. & ETHICS 507, 523–24, 544–47 (2005) (arguing that the law currently does not provide an adequate incentive to providers to abstain from giving inaccurate information that may lead to an unnecessary abortion). Recommending abortion in such instances to mitigate the risks associated with the birth of a special needs child is an example of substituting one method of care for another, as discussed by Schlanger, *supra* note 25. In fact, this is roughly equivalent to a substitution that Schlanger describes as “not entirely plausible,” namely selecting death over a severe injury to a potential plaintiff. *Id.* at 530.

138. Hensel, *supra* note 7, at 165–67; Kennedy, *supra* note 4, at 484.

139. Perry & Adar, *supra* note 137, at 546–47. *But see infra*, Part III.

140. *Cf.* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 66–67 (1976) (upholding a law requiring a woman to sign a written consent form detailing the risks associated with an abortion).

awarded may be substantially less than a suit if the child were born alive and with disabilities.¹⁴¹

Beyond merely discussing or recommending abortion, the medical provider is incentivized to *persuade* the woman to accept the abortion.¹⁴² After all, if the provider merely recommends an abortion, and the woman declines, the provider may face substantially the same legal and disciplinary actions if the woman does not recall the conversation or claims the provider did not do enough to explain the dire situation.¹⁴³ Moreover, persuasion can be accomplished subtly.¹⁴⁴ The diagnosis and prognosis might be framed to emphasize the probability of fetal demise or the low expected quality of life for the child.¹⁴⁵ Uncertainty about the future and the attendant feeling of a loss of control may easily motivate the woman to agree to an induced abortion.¹⁴⁶ The cost and difficulty to the family of providing medical care might be discussed. Moral or religious objections, or emotional aversion to abortion, might be minimized by framing this as an extraordinary case. The woman might be gently pressed for a prompt decision, minimizing the time she has to overcome the initial shock or to connect with personal, medical, or spiritual advisors.¹⁴⁷ The provider may justify these communications, professionally and personally, reasoning that the woman has to be prepared for the worst, that more details would be overwhelming, that the family will suffer less mental distress with an abortion if they have fewer doubts as to the need to terminate the pregnancy, and that termination is the right decision.¹⁴⁸

141. See Perry & Adar, *supra* note 137, at 518–22, 544–47 (discussing the limited damages that would be awarded in a wrongful abortion case, as compared to other suits).

142. See Diehr, *supra* note 4.

143. Cf. CAL. CIV. CODE § 43.6(b) (2019) (“The failure or refusal of a parent to prevent the live birth of his or her child shall not be a defense in any action against a third party, nor shall the failure or refusal be considered in awarding damages in any such action.”); *Troppe v. Scarf*, 187 N.W.2d 511, 519–20 (Mich. Ct. App. 1971) (rejecting the argument, in a case involving a pharmacists’ malpractice in failing to provide contraceptives, that the family should have mitigated its damages by placing the child for adoption); *Sherlock v. Stillwater Clinic*, 260 N.W.2d 169, 176 (Minn. 1977) (rejecting the argument that parents should have mitigated their damages by aborting an unplanned pregnancy arising from a failed vasectomy).

144. See Buck, *supra* note 31, at 923; Dixon, *supra* note 10, at 32–34, 40–45.

145. See KAHNEMAN, *supra* note 26, at 88, 363–70 (discussing the influence of framing on human choices); Diehr, *supra* note 4, at 1289.

146. See Bijma et al., *supra* note 90, at 85.

147. See Dixon, *supra* note 10, at 42–43.

148. See Frati et al., *supra* note 4, at 352 (“We would like to stress that the duty to inform should be tempered by maternal desire. The role of information assumes particularly complex meaning when the choice of the mother affects others (the unborn baby or newborn, father, siblings), including the physician whose conduct has influenced this choice.”); Korenromp,

Indeed, some states have recognized a therapeutic privilege allowing providers to withhold information from the patient if, in the provider's assessment, the disclosure would do more harm to the patient than good.¹⁴⁹

One must question whether any particular woman can give informed consent for the abortion in such circumstances, especially if she is pressed for a prompt decision, independent of other personal, medical, or spiritual advisors, and especially if she was predisposed to reject abortion in such cases prior to the emotional shock of the diagnosis or prognosis.¹⁵⁰ That being said, an attorney would hesitate to sue a doctor alleging lack of informed consent when consent is documented because (1) it is difficult to overcome the legal significance of a signed consent form, (2) the court may determine that a competently performed abortion is not a legally cognizable injury despite an inadequate disclosure, and (3) the amount of the monetary award, if the claim is successful, would be extremely uncertain.¹⁵¹

In short, the medical provider could justify an attempt to eliminate the family's reasonable hope of a decent life for this child so as to induce the woman to accept the abortion promptly, in part to mitigate the risks of liability or other formal or informal punishment. This justification can be used to excuse gross infringements of patient autonomy through misinformation, incomplete information, or pressure tactics.¹⁵² In fact, academic studies show many women that have chosen to continue the

supra note 135, at 20, 22, 26, 34–35, 40, 43, 46, 50, 54, 60, 66, 69, 76, 82, 85–86, 94–95, 110, 126–27, 132–37, 140.

149. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972); *Logan v. Greenwich Hosp. Ass'n*, 465 A.2d 294, 300 (Conn. 1983); *Cuc Thi Ngo v. Queen's Med. Ctr.*, 358 P.3d 26, 38 n.14 (Haw. 2015); *Hondroulis v Schumacher*, 553 So. 2d 398, 413 (La. 1989); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 700 (Minn. 1977); *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967).

150. *Bijma et al.*, *supra* note 90, at 85; *Buck*, *supra* note 31, at 918–21; *Diehr*, *supra* note 4, at 1301–02; *Dixon*, *supra* note 10, at 4. See Emma F. France et al., *What Parents Say About Disclosing the End of Their Pregnancy Due to Fetal Abnormality*, 29 MIDWIFERY 24, 25, 27, 30 (2013) (noting that some interviewed after terminating a pregnancy due to an adverse prenatal diagnosis “chose [to disclose the situation to others using] language to convey their perceived lack of choice over the decision.”).

151. See *Buck*, *supra* note 31, at 919; *Curran*, *supra* note 10, at 135–39, 149–54, 157.

152. See *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (“The physician’s privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.”).

pregnancy despite the adverse diagnosis are disappointed with the manner in which the diagnosis was delivered and in the subsequent support provided.¹⁵³

While one might assume this would only be a concern in states that permit suits for the birth of a child with special needs, the influence of these suits extends beyond the border of those states. Some practitioners may not know their state laws and operate on the assumption that they can be sued. Individual providers that develop defensive medical practices in a jurisdiction that permits such suits may not adapt those practices when they move to a new state, or when state law changes. Providers who treat patients from other states may be subject to suit under the rules of the other state.¹⁵⁴ Moreover, educational institutions and national professional associations may promote a national standard of practice based in part on the risk of lawsuits in the hostile jurisdictions.¹⁵⁵ Matthew Diehr points, for instance, to the practice guidelines promulgated by the American College of Obstetricians and Gynecologists in 2007, recommending that all pregnant women should be screened to determine if the pregnancy is afflicted with certain congenital conditions, including Down syndrome and other conditions that cannot be treated in utero.¹⁵⁶ As such, even in states that prohibit such lawsuits, practitioners may still be influenced to practice defensive medicine in response to poor prenatal diagnoses.

In summary, addressing any adverse prenatal fetal diagnosis with the family poses complex practical challenges for medical providers, but the current medicolegal arrangement encourages providers to promote abortion in cases of an adverse prenatal diagnoses, even at the cost of informed decision-making. As noted, the diagnosis may not be accurate, but even if it is reliable, the providers often cannot provide a reliable and specific prognosis as to how this particular child will be affected by the condition detected. Both the nature and severity of the child's future functional limitations are typically in doubt. Nevertheless, legal and professional obligations and risks, and the emotional dynamics of the situation, encourage providers to persuade the woman to terminate the pregnancy, even if the diagnosis or prognosis is doubtful or speculative. After all, errors of specificity—that is, recommending abortion based on a false-positive

153. Lalor et al., *supra* note 90, at 81.

154. *Cf.* Lab. Corp. of Am. v. Hood, 911 A.2d 841, 842–43 (Md. 2006) (applying Maryland law to a wrongful birth case against North Carolina medical laboratories); *Fonda v. Wapner*, No. 109244/09, 2012 N.Y. Misc. LEXIS 667, at *33–34 (N.Y. Sup. Ct. Feb. 15, 2012) (applying Colorado law to a Philadelphia physician that practices in New York in a wrongful birth case), *aff'd*, 103 A.D.3d 510 (N.Y. App. Div. 2013).

155. Diehr, *supra* note 4, at 1304–12, 1317–18.

156. *Id.*

diagnosis or on an erroneously adverse prognosis—carry a small risk of real-world consequence for the medical provider compared to errors of sensitivity—failing to detect and disclose an adverse condition while abortion is still an option. Medical providers are better off predicting the worst possible outcome, purposefully extinguishing the reasonable and legitimate hopes of the family. If the pregnancy is aborted, everyone can assume the provider's predictions were accurate, excusing the family's decision. Moreover, if the woman continues the pregnancy, the outcome will not be worse than the provider predicted, mitigating the perception of a bad outcome attributable to the provider. Even in jurisdictions that prohibit such lawsuits, practitioners may be influenced by the public policy of the states that allow such suits, whether through ignorance of the local law, personal practices not specifically adapted to a particular state's policy, or national practice standards designed to protect practitioners in hostile jurisdictions.¹⁵⁷

157. Johnson provides an excellent commentary:

The doctor may be wrong about what the law requires or prohibits, yet the doctor's understanding of the law is honestly asserted. Non-expert individuals dealing with an extensive body of rules that govern their actions on a daily basis do not ordinarily seek legal counsel and instead rely substantially on informal, word-of-mouth sources. At a very early point, the time and expense required to secure a more authoritative description of the law simply makes the effort impractical and unbearable. Any rule-oriented system, in which the specific rules are not easily accessible to those bound by them, will experience a similar informal, underground communication network.

In their clinical decision making, physicians are more likely to turn to physician colleagues for advice rather than referring to journal articles or other decision supports. This same pattern may operate in their seeking advice as to the legal requirements for their practice, crowding out counsel from persons with more legal expertise. Intuitively as well, one has to believe that doctors trust other doctors more than they do lawyers.

Doctors value clinical experience rather than rules and guidelines in treatment decision making. This heuristic may operate in the context of assessing legal risk and developing responsive behaviors as well. Thus, the stories told by doctors about their own or others' experiences with the law take on even more power in part because they fit the learning and evidence-gathering patterns generally familiar in medicine. In addition, stories told within physician groups are likely to amplify extremes in terms of the rendition of the facts of the case, as well as the view that the system is offensive and unfair.

III. MELENEY-DISTASSIO V. WEINSTEIN

Many of the concerns described in the preceding section are illustrated, by example or counterexample, through the Connecticut case of *Meleney-Distassio v. Weinstein*, a recent “wrongful abortion” lawsuit.¹⁵⁸ In this case, the plaintiffs, a husband and a wife, sued the wife’s OB-GYN and a consulting physician alleging the providers were liable for recommending that the wife obtain an abortion.¹⁵⁹ The couple had previous difficulties conceiving and bringing a pregnancy to term.¹⁶⁰ During the pregnancy at issue in the lawsuit, a 3D ultrasound reportedly confirmed the fetus was developing club feet.¹⁶¹ The physicians were concerned this was the harbinger of a serious fetal chromosomal abnormality, called Trisomy 18 syndrome.¹⁶²

Trisomy 18 syndrome is a relatively common defect in a particular chromosome—that is, an aberration in the person’s DNA.¹⁶³ It can cause one or more serious and potentially fatal congenital physical malformations.¹⁶⁴ These might include, for instance, openings in the abdomen so the internal organs are not contained, heart defects, and urinary tract defects preventing

When the rule is miscommunicated, it will have an impact quite different from that intended, possibly to the disadvantage of the patient, the doctor, and the public. Legal standards applicable to the medical practice tend to be complex or fact-sensitive and, thus, are particularly resistant to accurate mouth-to-mouth-to-mouth communication on the grapevine. Yet, this informal communication network is the source of choice for physicians for much of their information and learning about legal requirements that affect their practice.

Johnson, *supra* note 9, at 994–95.

158. For other examples of wrongful abortion lawsuits arising from erroneous prenatal diagnoses, see *Johnson v. United States*, 810 F. Supp. 7 (D.D.C. 1993) (HIV diagnosis); *Breyne v. Potter*, 574 S.E.2d 916 (Ga. Ct. App. 2002) (Down syndrome diagnosis); *Martinez v. Long Island Jewish Hillside Med. Ctr.*, 512 N.E.2d 538 (N.Y. 1987) (microcephaly or anencephaly diagnosis); *Zadrozny*, *supra* note 110 (intersex diagnosis).

159. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *1 (Conn. Super. Ct. Nov. 20, 2014).

160. *Id.* at *3–4.

161. See *Neubert, Pepe & Monteith, P.C. Obtains Defense Verdict in Groundbreaking Wrongful Fetal Termination Case*, NEUBERT PEPE & MONTEITH P.C. (Nov. 2016), <http://www.npmlaw.com/wp-content/uploads/2016/11/Shevell-Stockman-Maiocco-1116.pdf> [hereinafter *NPM Advisory*].

162. *Id.*

163. Anna Cereda & John C. Carey, *The Trisomy 18 Syndrome*, ORPHANET JOURNAL OF RARE DISEASES 1 (Oct. 23, 2012), <https://ojrd.biomedcentral.com/track/pdf/10.1186/1750-1172-7-81>.

164. *Id.*

the bladder from being voided in utero.¹⁶⁵ Pregnancies affected by Trisomy 18 often end in miscarriage or stillbirth due to these congenital malformations, especially if the fetus is male.¹⁶⁶ Most parents who receive a Trisomy 18 prenatal diagnosis choose an elective abortion.¹⁶⁷

The lawsuit alleged that on June 14, 2010, when the wife was twenty-one weeks pregnant, the consulting physician performed an amniocentesis, drawing amniotic fluid to test it for signs of the chromosomal abnormality.¹⁶⁸ The following day, the laboratory issued a report to the physicians indicating that the initial test result was positive for Trisomy 18.¹⁶⁹ The report, however, came with the warning that no irreversible therapeutic action should be taken based on this preliminary result.¹⁷⁰ A second, more reliable test was pending.¹⁷¹

Connecticut law provided, “No abortion may be performed upon a pregnant woman after viability of the fetus except when necessary to preserve the life or health of the pregnant woman.”¹⁷² At twenty-one weeks, viability was likely imminent.¹⁷³ The law further specified, “The decision to terminate a pregnancy prior to the viability of the fetus shall be solely that of the pregnant woman in consultation with her physician.”¹⁷⁴

The lawsuit alleged that on June 15, 2010, the OB-GYN contacted the wife by telephone and advised her the test result indicated a serious chromosomal defect that would result in fetal suffering and death before or shortly after birth.¹⁷⁵ The suit alleged that the OB-GYN urged the woman to terminate the pregnancy immediately, before the law precluded her from doing so, and the doctor provided the woman contact information for a clinic that could perform the elective abortion.¹⁷⁶ A prompt telephone call by the woman showed the clinic could not perform the abortion immediately, and so the consulting physician referred the woman to another physician, who

165. *Id.* at 1, 3.

166. *Id.* at 3–5.

167. *Id.* at 2–3.

168. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *4 (Conn. Super. Ct. Nov. 20, 2014).

169. *See id.* at *4.

170. *Id.*

171. *Id.*

172. *Id.* at *1–2, n.1 (quoting CON. GEN. STAT. § 19a-602(b)).

173. *Id.* at *2, *5.

174. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *1–2, n.1 (Conn. Super. Ct. Nov. 20, 2014) (quoting CON. GEN. STAT. § 19a-602(a)).

175. *Id.* at *1, *4.

176. *Id.* at *5.

performed the abortion on June 16, 2010.¹⁷⁷ The plaintiffs alleged they were not provided the laboratory report, nor was the laboratory's warning that discouraged irreversible action communicated to them.¹⁷⁸

On June 16, 2010, the laboratory allegedly called the consulting physician and reported that it had experienced technical difficulties in the initial test, and the results of that test were not reliable.¹⁷⁹ The physician immediately called the doctor that was to perform the abortion to communicate the news to the wife, but the abortion had already been performed.¹⁸⁰ A final report issued by the laboratory on June 22 concluded there were no detectable chromosomal abnormalities, noting the first test was considered preliminary because of the risk of false positives.¹⁸¹ The plaintiffs alleged the consulting physician later advised them the pregnancy would likely have resulted in the birth of a healthy boy, had they not aborted the pregnancy.¹⁸² The couple filed a lawsuit in September 2012, but the suit was dismissed on procedural grounds in February 2013.¹⁸³ The couple refiled the lawsuit the following June.¹⁸⁴

In a largely unprecedented decision, the trial court allowed both the husband's claim as well as the wife's claim against the physicians to proceed, over the defendants' objections as to the husband's standing to sue.¹⁸⁵ The state law, after all, vested the decision to undergo the abortion in the pregnant woman alone, and the physician had no professional duty to the husband.¹⁸⁶

177. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2013 Conn. Super. LEXIS 2375, at *2–3 (Conn. Super. Ct. Oct. 16, 2013).

178. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *5–6 (Conn. Super. Ct. Nov. 20, 2014).

179. *Id.*; *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2013 Conn. Super. LEXIS 2375, at *3 (Conn. Super. Ct. Oct. 16, 2013).

180. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *5 (Conn. Super. Ct. Nov. 20, 2014); *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2013 Conn. Super. LEXIS 2375, at *3 (Conn. Super. Ct. Oct. 16, 2013).

181. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2013 Conn. Super. LEXIS 2375, at *3 (Conn. Super. Ct. Oct. 16, 2013).

182. *Id.*

183. *Meleney-Distassio v. Weinstein*, No. FSTCV126015461S, 2013 Conn. Super. LEXIS 266, at *5, *23 (Conn. Super. Ct. Feb. 1, 2013).

184. See Superior Court Case Look-up, *FST-CV13-6018746-S, Meleney-Distassio, Anne, Michael Distassio et al. v. Weinstein, MD, David et al.*, ST. OF CONN. JUD. BRANCH, <http://civilinquiry.jud.ct.gov/CaseDetail/PublicCaseDetail.aspx?DocketNo=FSTCV136018746S>.

185. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *6–7 (Conn. Super. Ct. Nov. 20, 2014).

186. *Id.* at *37–38; CONN. GEN. STAT. § 19a-602(a) (2019).

The Court concluded, however, the husband's claim was derivative of the physicians' duty to the wife.¹⁸⁷

The trial lasted five weeks.¹⁸⁸ The defendants' expert testified the initial test of the amniotic fluid was 99.99992% accurate, presumably if the proper protocols had been followed.¹⁸⁹ In other words, the physicians reasonably relied on the initial test, despite it being considered preliminary and less accurate than the final test. On November 2, 2016, the jury deliberated for two hours before returning a verdict in favor of the defendants.¹⁹⁰

The Author has no information indicating the physicians in the case were motivated by a desire to avoid legal liability or some other improper motives, or that they did anything that merited liability, but the case illustrates many of the concerns addressed above. First, the case shows a physician's risk of being sued, and the adverse consequences even when the physician prevails in the case. The events underlying the suit occurred in June 2010. The initial suit was filed in September 2012. The jury pronounced its verdict in November 2016, a full six years after the incident and four years after the suit was initially filed. The trial alone lasted five weeks. The defendants' names will forever be associated with this precedent-setting case, which, though unpublished, is available on such databases as Lexis and Westlaw. One can imagine the toll such litigation takes on a medical provider, and the reasons a medical provider would wish to avoid a lawsuit, regardless of its outcome.

Moreover, taking the verdict on its face, the suit did not arise because the providers did anything wrong, but rather because the circumstances made it appear that the providers may have done something wrong, with grave consequences. Had the plaintiffs established the providers' liability, the verdict may have been substantial.¹⁹¹ This chance to recover substantial damages was likely an incentive to a plaintiffs' attorney to prosecute the case, even though liability was far from certain. One can also imagine the emotions of the husband and wife that may have influenced them to pursue the suit. Assuming the allegations of fact in the suit are generally accurate, the plaintiffs had several prior unsuccessful attempts to bring a pregnancy to

187. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *37–38 (Conn. Super. Ct. Nov. 20, 2014).

188. *NPM Advisory*, *supra* note 161.

189. *Id.*

190. *Id.* at 2; *Defendant's Verdict Form*, <http://civilinquiry.jud.ct.gov/GetDocket.aspx> (search in search bar for "FST-CV13-6018746-S"; then click on "Verdict for Defendant") (last visited Oct. 29, 2019).

191. See *supra* note 129. But see Perry & Adar, *supra* note 137, at 544–47 (arguing that the damage awards for wrongful abortion would be relatively small in most jurisdictions).

term.¹⁹² They brought this pregnancy halfway to term only to receive a dreadful diagnosis that induced them to abort the pregnancy.¹⁹³ Almost immediately after the abortion, they learned the information they trusted was potentially wrong, and within a week of the abortion, the diagnosis was reversed.¹⁹⁴ A couple that experienced this could be strongly motivated to sue.

The case also presents a circumstance in which the parties are reasonably likely to have very different recollections of the key facts. The central question is what information was communicated to the woman about this test, the test results, and the actions she should take (if any) in light of the test results. Some information was likely communicated to her in conjunction with the ultrasound showing club feet, indicating this could be a sign of a fatal fetal diagnosis. The rest of the information may have been communicated to her shortly before the amniocentesis or in the telephone call regarding the test results. One can imagine the emotional state of the woman at these times. Likewise, given the fickleness of memory and the desire to avoid liability, it is plausible both the providers' and the family's accounts of the information communicated may be erroneous in part.

One easily sees in this scenario the difficult position of the physicians. They had what appeared to be a reliable, preliminary test result confirming their previous suspicions of a serious, incurable, and probably fatal, fetal anomaly. State law precluded abortion in such cases after fetal viability, which was imminent. They had to disclose the results. They had to discuss the option of abortion. They had to do so promptly, while abortion was still a legal option. They had to determine how to frame the discussion—what to disclose and how to present it. No matter what they might say, they were at risk of a lawsuit if the mother elected to bring the child to term. What makes this case extraordinary is that the physicians were sued *despite* the mother electing to terminate the pregnancy, because of the chance fact that the laboratory determined, despite the abortion, that the initial test result was erroneous.

This case certainly demonstrates the practical consequences of imperfect information. Assuming the test produces a false positive in only 8 of every 10,000,000 instances, consistent with the claim the initial test was 99.99992% accurate, the likelihood that this positive test result was a false positive was at

192. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2014 Conn. Super. LEXIS 2861, at *3–4 (Conn. Super. Ct. Nov. 20, 2014).

193. *Id.* at *4.

194. *Meleney-Distassio v. Weinstein*, No. FSTCV136018746S, 2013 Conn. Super. LEXIS 2375, at *3 (Conn. Super. Ct. Oct. 16, 2013).

least 500 to 1—if the test procedures were properly followed.¹⁹⁵ The available information does not disclose the “technical difficulties” that led the laboratory to conclude the June 15 report was unreliable, even prior to the laboratory completing the second test. The laboratory may have detected a human or equipment error. However, technical difficulties, human error, equipment errors, and failures of laboratory protocol are unavoidable risks that a physician could consider in presenting test results and his or her recommendations.¹⁹⁶ Such risk could greatly reduce the reliability of the test result.

The presentation of this case in this manner, however, has a notable downside. This case apparently involved the abortion of a relatively healthy fetus based on an erroneous prenatal diagnosis. The attorneys for one of the physicians called the lab’s error “sad and shocking.”¹⁹⁷ One might assume it was “sad” because a healthy fetus was aborted on a mistaken diagnosis. The corollary might be that it would not be “sad” if the fetus in fact had the Trisomy 18 syndrome. This line of reasoning, however, may judge any fetus with the Trisomy 18 syndrome as more worthy of being aborted than a healthy fetus. As discussed below, such eugenic and discriminatory social attitudes demean all those living with the Trisomy 18 syndrome. As such, it is important to note that abortion in such instances is still elective abortion. The option to continue the pregnancy should not be discounted. While miscarriages or stillbirths are common as affected pregnancies progress, many children with Trisomy 18 are born alive.¹⁹⁸ Depending in part on the

195. This calculation presumes that the odds of a pregnancy being afflicted by a Trisomy 18 defect is 1 in 2,500, consistent with the available data. Cereda & Carey, *supra* note 163, at 2. If so, then 10,000,000 tests would produce approximately 4,000 true positives and 8 false positives, or about 500 true positives for every false positive. That being said, factors such as the mother’s age affect the likelihood that the particular pregnancy is afflicted by a Trisomy 18, affecting this calculation. *Id.* Moreover, the detection of clubfeet in the ultrasound increased the probability that this pregnancy was a risk for a Trisomy 18 defect, as compared to a random sample population. Thus, while a positive test result may be erroneous in approximately 1 of 500 cases based on a random sampling, the doctors had to consider the additional information they had in assessing whether it was likely that this positive result was a false positive. Unless most pregnancies tested using this method had similar indicators that the condition was present, the evidence of the clubfeet could greatly increase the odds that this was a true positive—so long as the test procedures had been followed. It is not uncommon, however, for attorneys to mislead juries, or be misled themselves, through flawed probabilistic logic.

196. *E.g.*, Zadrozny, *supra* note 110 (allegation that human error caused an erroneous diagnosis of an intersex fetus).

197. *NPM Advisory*, *supra* note 161.

198. Cereda & Carey, *supra* note 163, at 3.

gravity of the child's physical condition, a family may elect anything from palliative care to extraordinary interventions.¹⁹⁹ In some cases where the child's condition is incompatible with prolonged life, the family may accept that fact and spend what little time they have with the infant without medical intervention, or with limited medical intervention.²⁰⁰ Sixty to seventy-five percent of the infants born alive with Trisomy 18 syndrome survive the first twenty-four hours; forty to sixty percent survive a week; twenty-two to forty-four percent live at least six months; and five to ten percent celebrate their first birthday.²⁰¹ An article by Anna Cereda and John C. Carey briefly highlights with images three instances of individuals with the Trisomy 18 syndrome: a two-year-old boy who was "quite stable medically, gaining weight, sitting up, and participating in the many activities of his family"; a sixteen-year-old girl who was "very healthy" whose "favorite pastime" was feeding herself, and who walked with assistance and could climb stairs on her own; and a young lady who, despite having "full [T]risomy 18 in early childhood and in adolescence," lived to nineteen years old "and achieved multiple milestones, including sitting and walking in a walker."²⁰² Simply put, even in the case of a Trisomy 18 defect, the family can elect to try to continue the pregnancy to term, to build a relationship with the child, to love the child and accept the child regardless of the child's chromosomal condition.²⁰³ Indeed, in some cases, the child may survive to return the love. Put another way, there is still room for hope.

IV. THE SOCIAL AND MORAL COSTS OF THIS ARRANGEMENT

From a strictly utilitarian perspective, social harms stemming from encouraging the abortion of children with special needs are not particularly obvious. Detecting serious medical conditions in utero and avoiding the economic and social costs attending those cases seems to be a social good.²⁰⁴ Likewise, many families would experience extreme financial and emotional

199. *Id.* at 5–7.

200. See Igniter Media, *99 Balloons*, YOUTUBE (Apr. 3, 2007), <https://www.youtube.com/watch?v=th6Njr-qkq0>.

201. Cereda & Carey, *supra* note 163, at 5.

202. *Id.* at 2, 8.

203. *E.g.*, Igniter Media, *supra* note 200.

204. See, *e.g.*, Hensel, *supra* note 7, at 178; David T. Morris, *Cost Containment and Reproductive Autonomy: Prenatal Genetic Screening and the American Health Security Act of 1993*, 20 AM. J.L. & MED. 295, 301–03 (1994); Say, *supra* note 14, at 255–56; see also Dixon, *supra* note 10, at 12.

difficulties in caring for a child with serious special needs.²⁰⁵ Autonomy and self-determination in such reproductive decisions are typically proffered as a social good.²⁰⁶ Some suggest that the child, at least in some cases, has a right to be aborted—that a life with disabilities, or with severe disabilities, is not worth living.²⁰⁷ This Part, however, presents several reasons why our medicolegal system should not encourage the abortion of special needs children as it does.

First, a system that incentivizes a doctor's distortion of the truth in communicating with a patient to mitigate the risk of personal or professional harm to the doctor should strike any person of integrity as a social evil.²⁰⁸ This is not to portray medical providers as lacking moral fiber; the system is dysfunctional.

Second, even assuming abortion is a morally neutral act, our society typically regards free and informed choice as a positive good.²⁰⁹ Systemic incentives for a medical provider to persuade a mother to choose abortion infringe on the woman's ability to make a free and informed choice.²¹⁰ Pressure for a prompt decision prior to an adjustment to the new, adverse reality obstructs free choice.²¹¹ A prognosis that emphasizes the worst-case scenario, rather than the range of probable scenarios, may undermine an

205. *E.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-57, CHILDREN WITH DOWN SYNDROME: FAMILIES ARE MORE LIKELY TO RECEIVE RESOURCES AT TIME OF DIAGNOSIS THAN IN EARLY CHILDHOOD (Oct. 2010), <https://www.gao.gov/assets/320/311235.pdf> (finding that the total average medical expenditures for children with Down syndrome, from birth through early childhood, was an average of five times higher than the expenditures for children without Down syndrome).

206. *See* Belsky, *supra* note 44, at 267; Dixon, *supra* note 10, at 12; Frati et al., *supra* note 4, at 339–40; Hensel, *supra* note 7, at 190–91.

207. *E.g.* Belsky, *supra* note 44, at 243–44; Foutz, *supra* note 4, at 496–97; Hensel, *supra* note 7, at 181.

208. *Cf.* Belsky, *supra* note 44, at 246 (arguing that genetic counselors have the obligation to impart all medical information to parents deciding whether to terminate a pregnancy due to the risk the child will have special needs). Studies indicate the care of women who continue the pregnancy despite an adverse diagnosis may be compromised when healthcare professionals view termination of the pregnancy as the more appropriate decision. Lalor et al., *supra* note 90, at 87.

209. *See* Curran, *supra* note 10, at 135–38; *cf.* Belsky, *supra* note 44, at 267–68 (arguing that the right to abort a child diagnosed as potentially having special needs “should be respected by the medical provider as the decision of both parents and child, and accorded legal protection through pecuniary sanction”).

210. *See* Dixon, *supra* note 10, at 46–50, 53–54; Hensel, *supra* note 7, at 191; Diehr, *supra* note 4, at 1301–02, 1307–08.

211. Buck, *supra* note 31, at 918–19; Dixon, *supra* note 10, at 4, 39–40.

informed choice.²¹² A decision made in emotional or physical isolation from other personal, medical, or spiritual advisors is not always a free or informed choice.²¹³ While many of these scenarios may not give rise to a legally enforceable right of action against the medical provider, they are still objectionable on moral or ethical grounds.²¹⁴

Related to this point, psychology and behavioral economics studies indicate that we tend to perform poorly in tasks of affective forecasting—evaluating our ability to cope with or to adjust to adverse developments in our lives.²¹⁵ We tend to overestimate the duration and severity of negative emotions associated with foreseen persistent adversities.²¹⁶ This seems to arise from three interacting cognitive biases: focalism, which is the tendency, when evaluating an anticipated change, to focus more on what will change with the foreseen adversity than on what will stay the same; immune neglect, which is the failure to envision the effect of one's own coping skills; and the failure to predict adaptation, whereby personal values evolve with changes in circumstances.²¹⁷ A prognosis emphasizing the worst-case scenario likely has a disproportionate impact on a person's decision-making with respect to his or her estimation of long-term happiness.²¹⁸ Imagining the worst-case scenario can increase focalism and the immune neglect and inhibit imagining adaptations.²¹⁹ Emotional disturbances can increase the effect of these cognitive biases.²²⁰ Drs. Jodi Halpern and Robert M. Arnold explain:

[F]ear can rivet attention on the most frightening aspects of a situation . . . or convince a person that a possible threat is inevitable. Distress can block memories of better times, limiting one's ability to form more hopeful beliefs about the future. Patients who are afraid and upset project these intense feelings onto the future, and anxiety can undermine

212. See Buck, *supra* note 31, at 918–921; Diehr, *supra* note 4, at 1307–08.

213. Cf. Buck, *supra* note 31, at 918–921 (discussing factors that undermine a patient's informed consent).

214. See generally Brown, *supra* note 4, at 870 (discussing the various standards used in lack of informed consent cases and gaps in the protections afforded); Curran, *supra* note 10.

215. E.g., KAHNEMAN, *supra* note 26, at 101–03, 402–06; Daniel Kahneman, *Evaluation by Moments: Past and Future*, in CHOICES, VALUES, AND FRAMES 693, 702–07 (Daniel Kahneman & Amos Tversky eds., 2000); Halpern & Arnold, *supra* note 29, at 1710.

216. KAHNEMAN, *supra* note 26, at 101–03, 402–06; Kahneman, *supra* note 215, at 702–07; Halpern & Arnold, *supra* note 29, at 1709.

217. Halpern & Arnold, *supra* note 29, at 1708–10.

218. KAHNEMAN, *supra* note 26, at 88, 101–03, 263–370, 402–06.

219. Halpern & Arnold, *supra* note 29, at 1709–10.

220. *Id.* at 1710.

the reflectiveness needed to recognize such projections and address them.²²¹

It appears this is true for women that experience adverse prenatal diagnoses. While distress is high following the discovery of the fetal anomaly, the distress tends to decline to near normal levels by the time the pregnancy reaches full term for those that continue the pregnancy.²²²

Third, abortion in such circumstances has well-documented adverse psychological risks that should be fairly disclosed by the provider recommending the abortion.²²³ The risks include a sense of guilt, distress, and damaged relationships.²²⁴ Moreover, one study showed that of women who elected to terminate a pregnancy due to an adverse prenatal diagnosis, forty-six percent were experiencing pathological levels of post-traumatic stress and twenty-eight percent were experiencing depression four months after the termination.²²⁵ The symptoms continued for another year for nearly half of the affected women.²²⁶ Predictors of these adverse psychological consequences included self-efficacy, high level of doubt during decision-making, lack of partner support, religious beliefs, and advanced gestational age.²²⁷ Granted, women who choose to continue a pregnancy despite an adverse prenatal diagnosis may also experience depression and distress, but as noted above, the distress tends to decline to near normal levels by the time the pregnancy reaches full term, as compared to pregnant women without adverse prenatal diagnoses.²²⁸ While some of the adverse psychological effects of termination are likely the result of the social stigma concerning abortion,²²⁹

221. *Id.*

222. Anne Kaasen et al., *Maternal Psychological Responses During Pregnancy After Ultrasonographic Detection of Structural Fetal Anomalies: A Prospective Longitudinal Observational Study*, PLS ONE (Mar. 28, 2017), <https://doi.org/10.1371/journal.pone.0174412>.

223. See France et al., *supra* note 150, at 25, 30 (noting the lack of guidelines or protocols on the matter); Marijke J. Korenromp et al., *Adjustment to Termination of Pregnancy for Fetal Anomaly: A Longitudinal Study in Women at 4, 8, and 16 Months*, 201 AM. J. OF OBSTETRICS & GYNECOLOGY 160.e1 (2009); Korenromp, *supra* note 135, at 11; Pitt, McClaren, & Hodgson, *supra* note 89, at 171.

224. France et al., *supra* note 150, at 25, 27, 29–30.

225. Korenromp et al., *supra* note 223, at 160.e4.

226. *Id.*

227. *Id.*

228. Kaasen et al., *supra* note 222; see also Heidi Cope et al., *Pregnancy Continuation and Organizational Religious Activity Following Prenatal Diagnosis of a Lethal Fetal Defect Are Associated with Improved Psychological Outcome*, 35 PRENATAL DIAGNOSIS 761 (2015).

229. See France et al., *supra* note 150, at 25, 27, 29–30; Franz Hanschmidt et al., *Stigma in the Context of Pregnancy Termination After Diagnosis of Fetal Anomaly: Associations with Grief, Trauma, and Depression*, 21 ARCHIVES OF WOMEN'S MENTAL HEALTH 391 (2018).

that is probably not the primary cause.²³⁰ Even still, these adverse psychological risks ought to be considered in evaluating the current practices and system.

Fourth, abortion and policies promoting abortion in cases of poor prenatal diagnoses likely contribute to the marginalization of people with special needs in our society.²³¹ Each person with special needs in our society will interact with or encounter a large number of people, and abortions that eliminate people with special needs reduce the frequency and diversity of those interactions.²³² This presumably contributes to our society's general evaluation of what constitutes "normal," "appropriate," "necessary," and "good" to the disadvantage of those with special needs. These evaluations affect public policy, public or private accommodations, medical treatment, and public or private personal behavior.²³³ For instance, if disabilities are viewed predominantly to be a product of age or tragedy, a young person with special needs will more often be viewed as embodying a tragedy, rather than being viewed as a person that engages the world on different terms.²³⁴ These attitudes can have perverse effects on social expectations concerning those with special needs and their role in our shared society.²³⁵ They may also

230. See generally Korenromp, *supra* note 135. A collection of studies from the Netherlands show high incidents of depression and post-traumatic stress disorder among women, and, to a lesser extent, their partners, who terminated a pregnancy due to a fetal anomaly, including a small fraction with clinical symptoms two to seven years after the termination, even though one of the studies concluded there was low social pressure to carry the pregnancy to term under such circumstances.

231. Bernstein, *supra* note 4, at 320–21; Diehr, *supra* note 4, at 1308; Dixon, *supra* note 10, at 4, 12–21; Frati et al., *supra* note 4, at 350; Erik Parens & Adrienne Asch, *The Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations*, in *PRENATAL TESTING AND DISABILITY RTS.* 3 (Erik Parens & Adrienne Asch eds., 2000).

232. Cf. Diehr, *supra* note 4, at 1309 ("One side effect of the drastically increased number of fetuses with disabilities being aborted would be the necessarily decreased pool of peers for persons born with disabilities.").

233. See Dixon, *supra* note 10, at 8, 12–21. But see Belsky, *supra* note 44, at 245 ("Improvements in genetic technology must advance, even at the expense of social stigma. Tort law is not responsible for the stigma associated with being born with a given handicap; it serves only to encourage prudent behavior through pecuniary penalty. Thus, the exactitude of science, and not the expansion of tort law, will make it increasingly difficult for society to accept the birth of avoidably impaired children."); Hensel, *supra* note 7, at 147–48.

234. See Hensel, *supra* note 7, at 185.

235. Diehr, *supra* note 4, at 1302, 1308–10; see also Frati et al., *supra* note 4, at 340 ("In today's society, there is a widespread feeling that it is not life that should be protected at all costs, but the quality of life.").

impact an expectant parent's willingness to bring a handicapped person into the world.²³⁶

Judging people by their disabilities and conditions—or, perhaps more euphemistically, their quality of life—demeans both their abilities and their subjectivity.²³⁷ It demeans their status as a human person. It demeans the status of all who share the condition. Aborting children in utero because of their condition can be viewed as the moral equivalent of, if not a definite and perverse form of, discrimination on the basis of disability.²³⁸ As many authors have pointed out, wrongful birth and wrongful life lawsuits, which allow a parent or a disabled person to sue a doctor for compensation due to a disability the doctor did not cause, demean all who share the condition at issue. These suits send a public message that abortion—terminating the child's existence—is an appropriate course of care for the disability.²³⁹ This contributes to a general, biased perspective that a person with a disability is less than a normal person, rather than a person who engages the world on different terms.²⁴⁰ This is contrary to the values implicit in our social restraints on discrimination and the constitutional command for equal protection of the laws, even though the value is not extended in law to the protection of unborn children with special needs.²⁴¹

The experiences of a person with disabilities, especially one with disabilities from birth, cannot easily be evaluated by a person without

236. See Halpern & Arnold, *supra* note 29, at 1710 (“[Social] stigma forms a powerful barrier to envisioning adapting to disability. Stigmatizing images of illness and disability depict broken and unfulfilling lives.”).

237. Diehr, *supra* note 4, at 1307.

238. E.g., Ruth Hubbard, *Abortion and Disability: Who Should and Should Not Inhabit the World?*, in *THE DISABILITY STUD. READER* 74 (Lennard J Davis ed., 4th ed. 2013).

239. E.g., Diehr, *supra* note 4, at 1297–1301; Foutz, *supra* note 4, at 488; Frati et al., *supra* note 4, at 350; Hensel, *supra* note 7, at 173; Kennedy, *supra* note 4, at 485; Schuster, *supra* note 4, at 2339–41.

240. Diehr, *supra* note 4, at 1292–94; Hensel, *supra* note 7, at 173.

241. Compare U.S. CONST. amend. XIV, § 1 (“No state shall . . . deny to any person within its jurisdiction the equal protection of the laws.”), and Americans with Disabilities Act of 1990 § 2, 42 U.S.C. § 12101 (2009), with *Roe v. Wade*, 410 U.S. 113, 157–58 (1973) (finding that “the word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.”).

disabilities.²⁴² Not only are the struggles misunderstood, but the joys are also misapprehended.²⁴³ A passage from Harlan Hahn is well worth quoting:

[D]isabled persons do not experience the external environment in the same way as the nondisabled. The focus of attention is different; the concentration of energy is different; the impressions formed in personal interactions are different [M]any of their viewpoints might encompass both positive aspects of everyday life that the nondisabled tend to take for granted—the sensuous touch of a sheet on the skin, the exhilaration of simply moving from here to there, the joy of communicating with a world that once seemed dark or silent.²⁴⁴

Much the same can be said of parenting a child with special needs. As a father of a daughter whose congenital brain malformation in the area of her speech cortex leaves her largely unable to process words, it is remarkable to see her response to music. What must it be like, in this cynical age, to have a brain shaped by music rather than language? The struggles and joys of raising a child with special needs are grossly misunderstood by most who have not shared the experience.

Fifth, the challenge of caring for and improving the lives of those with special needs will advance the science of medicine.²⁴⁵ When abortion is an acceptable and encouraged option, there is less pressure to develop more accurate diagnostic methods and better treatments. The abortion of children with special needs also represents the loss of information about the prognosis of people with such conditions. While one might justly recoil from the idea of treating a person with special needs as *simply* a source of medical data, one cannot deny that the battle to treat people with special needs may advance the science of medicine, to the benefit of many.

Sixth, each person with special needs may contribute to society in ordinary, special, or even exceptional ways. While those with special needs

242. See Halpern & Arnold, *supra* note 29, at 1708–10; Kahneman, *supra* note 215, at 703–04 (discussing studies that indicate that people tend to underestimate the long-term mood of paraplegics).

243. Dixon, *supra* note 10, at 55 (analogizing the birth of a child with special needs to planning a trip to Italy and finding that you arrived in Holland—“[i]t is just a different place”); Halpern & Arnold, *supra* note 29, at 1708–10; Hensel, *supra* note 7, at 183–84.

244. Harlan Hahn, *Feminist Perspectives, Disability, Sexuality and Law: New Issues and Agendas*, 4 S. CAL. REV. L. & WOMEN’S STUD. 97, 111 (1994).

245. Dixon, *supra* note 10, at 4.

may require a large amount of care, economic resources, and attention, these costs are incommensurate as compared to even the simple joys that may come with knowing a person with special needs.²⁴⁶ This is not intended to minimize the difficulty, burden, or cost of caring for a person with special needs, but there is no currency that allows for an objective measurement of the economic costs as compared to the intangible benefits of such an interaction.

Finally, embracing the challenge of caring for each person with special needs also affirms the intrinsic value of each person, a value that is not based on what the person contributes or does.²⁴⁷ Caring for those with special needs provides the caregivers an opportunity to learn to love another—to seek the other's good—without regard to the personal return. This capacity and opportunity for altruism is a social good.²⁴⁸

In short, the current system, which incentivizes providers to recommend or even promote abortion in cases of adverse fetal diagnoses, is at odds with several values our society rightly prioritizes. These include integrity, free and informed choice, nondiscrimination, respect for the experience of others, equal protection under the law, scientific advancement, and social altruism. With this in mind, we will turn to potential solutions.

V. POSSIBLE REMEDIES

If the current interplay between law and medicine is negatively impacting society by incentivizing the abortion of children in utero with poor prenatal diagnoses, what can be done to alter that situation? There is no obvious solution, but this final Part surveys some options.

246. Diehr, *supra* note 4, at 1299 (“The rationales courts use both to award and to deny recovery for ‘normal’ children stand in contrast to those articulated by jurisdictions recognizing wrongful birth or wrongful life in the context of a child born with a genetic defect. While courts give heavy emphasis to the inherent benefits of rearing a child in the former, many courts ignore these benefits in the latter. This is despite evidence that many families find life with a child with a disability to be a positive experience.”). *Cf.* Terrell v. Garcia, 496 S.W.2d 124, 128 (Tex. 1973) (“[A] strong case can be made that, at least in an urban society, the rearing of a child would not be a profitable undertaking if considered from the economics alone. Nevertheless, . . . the satisfaction, joy and companionship which normal parents have in rearing a child make such economic loss worthwhile. These intangible benefits, while impossible to value in dollars and cents are undoubtedly the things that make life worthwhile. Who can place a price tag on a child’s smile or the parental pride in a child’s achievement?”); Jackson, *supra* note 4, at 595–600, 606 (discussing the policy reasons to reject an award of damages for the wrongful birth of a healthy or unhealthy child).

247. See Diehr, *supra* note 4, at 1299–1300.

248. See C. Daniel Batson & Adam A. Powell, *Altruism and Prosocial Behavior*, in 5 HANDBOOK OF PSYCHOL. 463 (Theodore Millon & Melvin J. Lerner eds., 2003).

Advocates of abortion rights will correctly note that part of the problem arises from restrictions on late-term, nontherapeutic abortions.²⁴⁹ As noted above, if a poor prenatal diagnosis is made twenty-two weeks into the pregnancy, and the state prohibits nontherapeutic abortions after twenty-four weeks, the law is an external pressure for a prompt decision. Adjustments could be made to these laws to allow greater freedom to make an informed decision without the pressures of time. This would not address the entire problem, but it would address at least one part of the problem.

Opponents of abortion would likely advocate for greater legal restrictions on abortion. These restrictions may include prohibiting abortions targeting fetal anomalies, instituting mandatory waiting periods for abortions, and establishing mandatory disclosures of information prior to providing an abortion. It may include these and other methods to reduce the isolation the woman feels, the pressures on her for a prompt decision, or the risk that the provider will deliver incomplete or inaccurate information.²⁵⁰ Each of these proposals may have merit, if viewed objectively, but they would restrain abortion and will be opposed by many on that basis alone.²⁵¹ They may also interfere, to some degree, in the doctor-patient communications, making them vulnerable to social criticism and prone to constitutional challenges.²⁵²

If mandating disclosure of information is socially or politically unacceptable, disclosures might still be encouraged. For instance, the federal Prenatally and Postnatally Diagnosed Conditions Awareness Act,²⁵³ enacted in 2008, authorized “the awarding of grants, contracts or cooperative agreements” to entities to “collect, synthesize, and disseminate current evidence-based information relating to Down syndrome or other prenatally or postnatally diagnosed conditions” and to “coordinate the provision of, and access to, new or existing supportive services for patients receiving a positive diagnosis for Down syndrome or other prenatally or postnatally diagnosed conditions.”²⁵⁴

249. See Mary Ziegler, 2017 UTAH L. REV. 587, 606–10 (2017).

250. See Diehr, *supra* note 4, at 1315–17; Dixon, *supra* note 10, at 43–44, 48.

251. See Hensel, *supra* note 7, at 173.

252. *E.g.*, Stuart v. Camnitz, 774 F.3d 238, 242 (4th Cir. 2014) (invalidating, on First Amendment grounds, a North Carolina statute requiring physicians to perform an ultrasound, display a sonogram, and describe the fetus to each woman seeking an abortion). *But see, e.g.*, Planned Parenthood of S.E. Penn. v. Casey, 505 U.S. 833, 882 (1992) (allowing states to require the disclosure of truthful, non-misleading information about the nature of the abortion procedure and the attendant health risks and those of childbirth).

253. Pub. L. No. 110-374, 122 Stat. 4051 (2008) (codified at 42 U.S.C. § 280g-8 (2010)).

254. 42 U.S.C.S. § 280g-8(b)(1)(A)–(B) (2010); Diehr, *supra* note 4, at 1315–16; *see also* Mo. Rev. Stat. § 191.923.3 (2007) (creating a similar arrangement).

One might consider tort reform options.²⁵⁵ On one extreme, the causes of action for wrongful birth and wrongful life could be abolished, eliminating much of the concern of legal liability. Disability rights advocates may favor this approach, as wrongful life and wrongful birth reinforce the public perception that nonexistence is preferable to living with special needs.²⁵⁶ One author argues that permitting such suits violates the Americans with Disabilities Act.²⁵⁷ Abolishing such claims, however, may infringe on other social values.²⁵⁸ In addition to the remedial, punitive, and deterrent functions served generally by civil suits against medical providers, discussed in Part I, suits in cases involving poor prenatal diagnoses or children born with special needs help to preserve the social values associated with the mother's right to choose abortion or to choose to continue the pregnancy.²⁵⁹ A medical provider who intentionally or negligently fails to discover or to disclose information pertinent to the decision whether or not to abort the pregnancy may be accused of infringing the rights of the patient or substituting his judgment for hers.²⁶⁰ In fact, statutes prohibiting wrongful birth and wrongful life lawsuits have been challenged, so far unsuccessfully, as unconstitutional restraints on abortion.²⁶¹ Tort reform options short of abolishing the causes of action, such as damage limitations or procedural hurdles in pursuing such suits, will likely affect the number of suits, but may not impact the specter of such suits that drives the practice of defensive medicine.²⁶² Perhaps more creative solutions, such as a right of the parents,

255. A 2014 survey of 600 physicians found that 91% of them believed malpractice reform would reduce unnecessary testing and procedures. *Unnecessary Tests and Procedures in the Health Care System*, PERRYUNDEM RES./COMM. 1, 9 (May 1, 2014), <http://www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf>.

256. *E.g.*, Diehr, *supra* note 4, at 1287–88, 1295, 1297–98, 1312–14; Hensel, *supra* note 7.

257. *See* Sheth, *supra* note 4, at 661–62.

258. *See generally, e.g.*, Say, *supra* note 14, at 281–89 (arguing against such legislation on the grounds of public health, reproductive autonomy, and allocation of harms).

259. Belsky, *supra* note 44, at 246; Diehr, *supra* note 4, at 1301; *see* Hensel, *supra* note 7, at 172–73.

260. *See* Curlender v. Bio-Science Lab, 106 Cal. App. 3d 811 (1980); Gleitman v. Cosgrove, 227 A.2d 689, 703 (N.J. 1967); Hensel, *supra* note 7, at 167–69; Jackson, *supra* note 4, at 574–75; Kennedy, *supra* note 4, at 491–92.

261. Say, *supra* note 14, at 277–81.

262. *See* Furrow, *supra* note 20 (critiquing standard medical malpractice tort reform efforts). *Cf.* Johnson, *supra* note 9, at 1016 (arguing that immunity statutes may not alter physician behavior, as the physicians may fear imperfect compliance would leave them exposed to liability).

on their own behalf and on the child's behalf, to waive any right to sue for wrongful birth or wrongful life, might have some value.²⁶³

An alternative to making suits impossible or more difficult would be to make suits easier.²⁶⁴ The central concern disclosed in this analysis is that medical providers can offer incomplete or inaccurate information to persuade a woman to choose abortion, because the abortion would decrease the provider's risk of a lawsuit. Facilitating lawsuits in cases where the provider presents incomplete or inaccurate information could restore balance in the providers' risk calculus.²⁶⁵ In theory, one might use existing tort claims in this situation. As illustrated in Part III, "wrongful abortion" claims have been tested in a few jurisdictions. In many jurisdictions, however, an abortion performed competently may not be considered an injury, even if the woman's consent to the procedure was based on inadequate disclosures.²⁶⁶ Moreover, in the leading article exploring wrongful abortion based on negligence, Professors Ronen Perry and Yehuda Adar argue that traditional tort rules do not adequately address all of the social harms arising from wrongful abortion.²⁶⁷ The relatively low damage award would still leave an incentive for providers to err on the side of recommending abortion, and the difficulty of detecting the negligence diminishes the systemic

263. The potential use of such exculpatory agreements in the medical malpractice field received great attention following a discussion of the topic the popular book *Nudge* in 2008. See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* 207–12 (2008). Thaler and Sunstein's recommendation of a waiver, largely on other grounds, has generated substantial discussion in legal literature. E.g., Tom Baker & Timothy D. Lytton, Essay, *Allowing Patients To Waive the Right To Sue for Medical Malpractice: A Response to Thaler and Sunstein*, 104 NW. U. L. REV. 233 (2010). The idea of exculpatory agreements for medical malpractice are far older, though. See Matthew J.B. Lawrence, Note, *In Search of an Enforceable Medical Malpractice Exculpatory Agreement: Introducing Confidentiality Contracts as a Solution to the Doctor-Patient Relationship Problem*, 84 N.Y.U. L. REV. 850, 851 (2009) (referencing and citing prior articles); Havighurst & Richman, *supra* note 31, at 67 (discussing similar contractual arrangements to reduce costs).

264. Perry & Adar, *supra* note 137, at 567–71.

265. *But see* Perry & Adar, *supra* note 137, at 544–47 (arguing that civil suits will not work for this purpose).

266. Cf. Curran, *supra* note 10 (analyzing whether a hypothetical woman who consents to an epidural without complete medical disclosures would have claims under the alternative legal standards employed by various states, and concluding that she often would not if the epidural was competently performed).

267. Perry & Adar, *supra* note 137, at 544–47.

effectiveness of this remedy.²⁶⁸ One might also consider a fraud-based claim, but these claims will have similar limitations.²⁶⁹

A state might better address this scenario, therefore, by expressly authorizing suit if a doctor communicates incomplete or inaccurate information that influences a person to consent to an abortion.²⁷⁰ This solution does not restrain abortions *per se*, and it does not unreasonably restrain doctor-patient communications. It merely requires truthful communications, whatever the truth may be. States could tailor this concept by prohibiting, for instance, only the communication of knowingly false information, or false information with the intent to persuade a person to choose an abortion, or inaccurate information likely to influence the decision of a reasonably prudent patient, or information a reasonably skilled physician would know to be erroneous.²⁷¹ States could determine who has the right to bring the suit: the mother, a representative of the deceased child, the father, or a combination of these. Either the legislature or the judiciary would have to determine what constitutes legally cognizable damages in such cases: physical pain, emotional distress, the cost of medical care, or the loss of companionship, to name a few possible categories.²⁷² One option would be to establish a right to recover attorney fees, expert fees, and costs together with a specified amount, or with the greater of the actual damages or a specified amount. This last approach may help disconnect the sanction from the outcome and attach the sanctions to bad behavior, but the award of attorney fees may provide too great of an incentive to plaintiffs' attorneys in marginal cases. Professors Perry and Adar argue for a similar solution, namely a discretionary civil fine to be appended to civil lawsuits that successfully prove a wrongful abortion.²⁷³

Professional sanctions for providing false information to encourage the abortion of children with special needs may also be feasible,²⁷⁴ but they would be subject to the politics and limited resources of medical boards and disciplinary panels.²⁷⁵ Criminal prohibitions may only increase the practice

268. *Id.*

269. *Cf.* Buck, *supra* note 31 (exploring whether one can sue under the federal False Claims Act for overtreatment due to inadequate disclosures).

270. *Cf.* Belsky, *supra* note 44, at 248 (proposing strict liability for inaccurate genetic counseling resulting in the birth of a special needs child, on the product liability model).

271. *Cf.* Curran, *supra* note 10, at 142–57 (discussing existing reasonable medical practitioner, reasonably prudent patient, and related medical malpractice standards).

272. *See* Buck, *supra* note 31, at 919.

273. Perry & Adar, *supra* note 137, at 571–79.

274. *See id.* at 507, 541–43; Diehr, *supra* note 4, at 1303.

275. McCarthy, *supra* note 18, at 586–93; Perry & Adar, *supra* note 137, at 544–47.

of defensive medicine.²⁷⁶ They also would not likely be useful, except in a symbolic sense, because prosecutors would be reluctant to pursue criminal charges against a doctor for communications with a patient.²⁷⁷ Plaintiffs' attorneys do not have the same reservations. Criminal statutes and professional sanctions may also be subject to First Amendment scrutiny and may be perceived as an unreasonable restraint on the right to abortion, even though they would operate indirectly at best.²⁷⁸ They would likely have to be more narrowly tailored than civil remedies.²⁷⁹

Another option would involve social security programs or other government programs that reduce the burden of caring for children with special needs.²⁸⁰ W. Ryan Schuster, for instance, suggests that no-fault based programs similar to the Virginia Birth-Related Neurological Injury Compensation Program and the Florida Birth-Related Neurological Injury Compensation Association can serve as a valuable substitute for prenatal negligence lawsuits.²⁸¹ Any such program must be judged on its merits, using the dictates of reason and prudence. There often are, however, substantial practical barriers to accessing the resources that are available.²⁸² Parents raising a child with special needs face a steep learning curve to understand Medicaid and other programs that are intended to assist them, not to mention the difficulty of maneuvering through the bureaucracy. Assistance

276. See Maurizio Cantino, *Blame Culture and Defensive Medicine*, 11 COGNITION, TECH., & WORK 248 (2009), https://www.researchgate.net/profile/Maurizio_Catino/publication/220579520_Blame_culture_and_defensive_medicine/links/58f4c998458515ff23b54d53/Blame-culture-and-defensive-medicine.pdf ("A professional system, like that of medicine, that is subject to the constant risk of criminal investigation is not, then, a system that is more careful and attentive; rather, it is a system that reduces the risks of the people who operate within it by seeking greater formal guarantees of protection, thereby compromising the interests of the clients."); Perry & Adar, *supra* note 137, at 537–40, 550–54.

277. Perry & Adar, *supra* note 137, at 540.

278. Cf. *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014) (invalidating, on First Amendment grounds, a North Carolina statute requiring physicians to perform an ultrasound, display a sonogram, and describe the fetus to each woman seeking an abortion).

279. See *id.*

280. Dixon, *supra* note 10, at 56–57; cf. *id.* at 6–8 (noting an anecdotal account of the connection between the woman's lack of economic resources and abortion of children with Down syndrome, and the improvements that might be attributed in part to social services).

281. Schuster, *supra* note 4, at 2364–66; see also Christopher Smith, *It's a Mistake: Insurer Cost Cutting, Insurer Liability, and the Lack of ERISA Preemption Within the Individual Exchanges*, 62 CLEV. ST. L. REV. 75, 112–23 (2014) (discussing the benefits and operation mechanisms of a no-fault compensation system).

282. See *Breaking Down Barriers to Medicaid Innovation: Rethinking Medicaid Waiver Approval*, AM. ACTION F. (Aug. 14, 2014), <https://www.americanactionforum.org/research/breaking-down-barriers-to-medicaid-innovation-rethinking-medicaid-waiver-ap>.

programs, however, that are generally accessible to all those with disabilities—or all those with disabilities in financial need, perhaps—are preferable to large judgment payouts directed to the relatively few successful litigants, payouts influenced by chance events, cheapened by deductions for attorney fees and costs, and secured by litigating in a tax-subsidized court system.²⁸³ The preconditions for assistance through social programs would be the existence of a disability and perhaps financial need, whereas the preconditions for a judgment payout would be a disability, a doctor's apparent negligence, a good lawyer, some persuasive expert witnesses, testimony that the disabled person would have been aborted had the mother known better, and some good luck.²⁸⁴

There are also abundant non-legal options for addressing the situation. There are often community support groups or similar resources available for those facing difficult pregnancies or raising children with special needs.²⁸⁵ These resources can be promoted to remedy the isolation and uncertainty one would reasonably feel in facing a poor prenatal diagnosis. Hospitals can also expand perinatal bereavement and palliative care, parental education, and similar support options, as well as supporting nondirective counseling and being more proactive in preparing an expectant mother and her family for difficult decisions.²⁸⁶ Joan G. Lalor et al. provide several practical tips for medical providers, including facilitating immediate, or at least prompt, communications between the provider and the mother about the nature of the anomaly detected; providing the family supplemental written materials, or directing the family to reliable online information; using images to explain the condition; connecting the families to a fetal medicine specialist promptly, preferably within twenty-four hours; avoiding jargon in communicating about the anomaly; connecting the family to a midwife with experience in adverse prenatal conditions; allowing communications with medical providers between appointments; not excluding the woman's partner from discussions; and arranging for continuity of the caregiver.²⁸⁷ Aligning patients with doctors that share similar moral values would also allow for greater trust and decrease the potential pressures that come with adverse prenatal diagnoses. This may be difficult or impossible, especially where

283. Cf. AM. MED. ASS'N, *supra* note 30, at 2–4 (discussing the costs and error rate in medical malpractice litigation).

284. Diehr, *supra* note 4, at 1303–04.

285. See Carlsson et al., *supra* note 90, at 8.

286. Rocha Catania et al., *When One Knows a Fetus Is Expected To Die: Palliative Care in the Context of Prenatal Diagnosis of Fetal Malformations*, 20 J. PALLIATIVE MED. 1020 (2017); Dixon, *supra* note 10, at 32, 40, 47, 57–58; Lalor et al., *supra* note 90, at 81.

287. Lalor et al., *supra* note 90, at 83–87.

there is a need for specialists, but it is an avenue to consider. Also, clear communication in the doctor-patient relationship about the patient's values, and attention to these values by the provider, would typically benefit all the parties.

In dialoguing directly with those facing a poor prenatal diagnosis for their child, whether as a medical provider, a family member, a counselor, or a friend, false pessimism is no better than false optimism, and potentially much worse in the decision-making process, due to poor affective forecasting and emotional vulnerability.²⁸⁸ It is important to be realistic about the range and probability of possible outcomes, and what is known and unknown about the condition, the prognosis, and the treatment options. Moreover, parents who intended to bring the child to term should be allowed as much time as can be afforded to adjust to the new reality before making a decision. They should be made aware of the highs and lows that come with raising a child with special needs and the range of experiences one will encounter, like fear and powerlessness as your child is wheeled into an overnight emergency surgery, to the joy of a smile when your child hears Patti Page sing "How Much Is That Doggie in the Window."

Drs. Jodi Halpern and Robert M. Arnold offer several practical tips to address the cognitive biases and emotions that lead to poor affective forecasting in medical decisions—that is, the tendency to estimate one's future happiness as more severely impaired by a foreseen medical adversity than it actually will be.²⁸⁹ To address the bias of focalism, Halpern and Arnold recommend identifying the person's point of focus, have the person describe all the similar types of things in that category, and then help the person identify those things in the category that will not (or may not) be impaired.²⁹⁰ To take an extreme case, for a family with a child who is expected to die shortly after birth, the parents are likely to focus on the child's suffering and the future the child will not have. One can help the family refocus on the life, short as it may be, that the child may have with a loving family, experiencing the physical touch, loving words, and warm embrace of family. To address immune neglect—the tendency to discount one's coping mechanisms—a counselor can ask what has helped the person through past adversities, reminding the person of his or her conscious coping mechanism, such as humor, compartmentalization, intellectualization, and sublimation.²⁹¹

288. Halpern & Arnold, *supra* note 29; Kaasen et al., *supra* note 222.

289. Halpern & Arnold, *supra* note 29.

290. *Id.* at 1708–09.

291. *Id.* at 1709–10.

Cognitive behavioral therapy may also help.²⁹² To help the family members recognize their ability to adapt to adversity through adoption of new values, support groups, anecdotes of similarly situated families, and interactive decision aids with narratives may help.²⁹³ To address the emotional distress, Halpern and Arnold suggest empathetic listening, cognitive reframing, gathering social supports, and encouraging peer support groups.²⁹⁴ They also emphasize the need to break down social stigmas related to disabilities.²⁹⁵

Social dialogue about poor prenatal diagnoses may also help curb the pressure families may experience.²⁹⁶ Even those who oppose abortion in principle may find it difficult to decline an abortion when they face an unexpected poor prenatal diagnosis. In a state of extreme emotional disturbance, the rational reasons for rejecting abortion are easily overwhelmed by anxiety, uncertainty, disappointment, and fear. Those who oppose abortion in such cases would do well, therefore, to address this reality in their social communications rather than speaking to the issue only when there is a particular need. A parent's strong emotional response to devastating news cannot easily be subordinated to reason in the moment. It can be subordinated, however, if the person holds a competing value dearly, such as a value connected, in the person's mind, to the person's self-identity or the person's sense of relationship. In other words, the negative emotional response of fear, distress, and uncertainty is best tamed not by reason, but by a stronger emotional adherence to a competing value. It may not be enough to believe in the abstract that abortion is wrong, for instance; one must have a strong *emotional* response against the idea that *I would ever abort my child*. Teaching others *to feel* the value of every life, and in particular the value of those with special needs, is a worthy goal too often ignored by those who oppose abortion in the face of an adverse prenatal diagnosis.

292. *Id.* at 1710.

293. *Id.*

294. *Id.*

295. Halpern & Arnold, *supra* note 29, at 1710.

296. Dixon, *supra* note 10, at 55–58.