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MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Abortion Counseling, Liability, and the First Amendment

Katie Watson, J.D., and Michelle Oberman, J.D., M.P.H.

When a clinician tells pregnant patients that they can't have an abortion because state law prohibits it, what's the clinician's next sentence? In the 16 U.S. states with bans on the provision of all or most abortions in effect, clinicians may feel compelled to say nothing. Consider the case of Deborah Dorbert, who asked to end her pregnancy after learning that her fetus had Potter's syndrome and was sure to die.[1] Her doctor told her she was "too late" for Florida's ban, so she endured agony-filled months before delivering a baby that died within minutes. Yet surely Dorbert's doctor knew she had other options. Dorbert said, "The thing that scared us [about having an abortion in another state was] we didn't know if we'd go to jail. . . . We couldn't have anything happen to us, because we have another child." She and her husband also "didn't have the money to travel." Why didn't her doctor refer her to a free legal helpline such as If/When/How, whose attorneys would have confirmed that travel posed no legal risk to Dorbert? Why didn't her doctor provide information about funds such as the National Abortion Federation's Hotline Fund, which helps patients pay for abortion care?

Dorbert's doctor is not alone: 1 year after *Roe v. Wade* was reversed, KFF (formerly the Kaiser Family Foundation) reported that in states that ban abortion provision, 78% of Ob/Gyns don't make out-of-state referrals, and 30% don't inform their patients about online resources that explain their abortion options. In states that ban abortion provision after a designated point in gestation (ranging from 6 to 22 weeks), 44% of Ob/Gyns don't refer, and 10% don't offer information.[2]

Clinicians have long been duty-bound to provide all-options counseling,[3,4] and today's complex legal landscape for abortion care increases patients' need for clinicians' guidance. Clinicians know that their patients' health and well-being require access to accurate information, yet those practicing in restrictive states may worry that providing abortion counseling puts them in legal jeopardy.[5,6] Sometimes physicians are guided by hospital counsel, who may not fully appreciate the medical imperative for, and the low legal risk posed by, all-options counseling. In other instances, hospital attorneys who fully understand these facts may nevertheless direct employees and physician contractors not to share information about abortion. Each of these stances is ethically problematic. Like physicians required to practice evidence-based medicine, lawyers must give advice based on the most accurate information obtainable with due diligence,[7] and hospitals must honor the rights and needs of the people they serve and without whom they would not exist — their patients. In addition, physicians must be permitted to shoulder individual risk even when their institution is committed to avoiding corporate risk.

Clinicians have an ethical obligation to practice to the full extent of the law when patient care requires it. But the risk posed by sharing abortion information in states with bans is largely untested. This legal confusion works to the advantage of abortion opponents, providing clinicians with an incentive to alter standard-of-care medical practice such as all-options counseling without requiring states to enact more controversial laws or pursue unpopular prosecutions. The impact on patients may be devastating.

In most instances, abortion counseling does not violate any law, as we explain below. But when confronted with legal uncertainty, it's important to remember that the American Medical Association (AMA) exhorts clinicians to do what's ethically right, even when it's illegal. The preamble to the AMA Code of Ethics states, "When physicians believe a law violates ethical values or is

unjust.... ethical responsibilities should supersede legal duties." After *Roe v. Wade* was reversed, the AMA issued a report citing this passage and adding, "Guidance throughout the Code underscores physicians' duty of fidelity to patients and to promote access to care, as well as responsibility to support informed decision making in keeping with patients' individual goals and preferences as autonomous moral agents."[8] At its November 2022 meeting, the AMA amended Ethics Opinion 4.2.7 on abortion, deleting the phrase "under circumstances that do not violate the law" in its description of when it is ethical to perform abortions.[9]

We believe clinicians must resist the fear-driven impulse to refrain from providing abortion information. At the same time, professional organizations and hospitals should support them by developing explicit patient-counseling requirements affirming that these health-protective discussions and referrals are standard-of-care medicine. By assessing the small legal risks of sharing abortion information, we aim to help clinicians "right size" their fears and adopt an informed approach that maximizes patient well-being. This article is not intended as a substitute for legal advice. Every state has its own body of laws, and clinicians and patients seeking personalized guidance should either speak to their own lawyers or contact the Abortion Defense Network, which offers free legal advice (https://abortiondefensenetwork.org).

RISK OF PROSECUTION AS AN ACCOMPLICE

Clinicians may fear that if they provide abortion information they could be prosecuted as an accomplice to a crime. Imagine a clinician practicing in a state that has criminalized abortion provision who informs a patient about clinics in other states that provide abortion care legally, using the patient's preferred method, at the patient's stage of pregnancy, and also shares online resources such as aidaccess.org, plancpills.org, and ineedana.com, which help patients obtain medication by mail for self-managed abortion. If the patient goes on to have an abortion, is the clinician an accomplice to an illegal abortion? This prospect is worrisome, because accomplices can typically be convicted of the crime they helped someone else commit: an accomplice to robbery is guilty of robbery.[10] Yet two important obstacles to prosecution make this fear largely unfounded.

First, to be an accomplice, the act one aids must itself be illegal. Someone who has an abortion in a state where abortion is legal has not committed a crime. Nor is it a crime for a patient to cross state lines to have a legal abortion. Therefore, the clinician who advises their patient about legal abortion in another state cannot be an accomplice to an illegal abortion.

What if this patient opts to self-manage an abortion with information and medication from a website mentioned by the clinician? The language of the law matters here: most state abortion bans criminalize *providing* an abortion, not *having* an abortion, and some bans explicitly exempt the pregnant person from prosecution. If it is not illegal to manage one's own abortion, then it is hard to see how a clinician who shares abortion information becomes an accomplice to providing an illegal abortion. The exceptions may be in South Carolina and Nevada, the only states that explicitly criminalize self-managed abortion.[11]

A zealous prosecutor might avoid this complication by arguing that either the patient or a third party broke a different state law in pursuing a self-managed abortion, such as a law against importing medication. Such a prosecutor might argue that the clinician who provided the patient with abortion information "aided" in the patient's or the pharmacy's crime. This scenario raises a second obstacle to an accomplice prosecution: the state must establish each element of complicity beyond a reasonable doubt, starting with the doctor's intent with regard to the criminal act. Some jurisdictions require the state to prove that the defendant *intended* for the perpetrator to commit the crime[12] — a hard standard to meet when the purpose of all-options counseling is not to encourage patients to have an abortion, but to empower them to make an informed decision and to protect their health regardless of whether they choose to give birth or to end their pregnancy. In other jurisdictions, it is sufficient simply to provide assistance to someone *knowing* they will break the law,[12] but in that case, the prosecution must establish that the clinician knew the patient intended to commit a crime — a challenge, given that the information shared in all-options counseling will include legal options such as traveling out of state or continuing the pregnancy.

There are other hurdles to prosecution, including the prosecutor's obligation to prove that providing publicly available abortion information such as names of websites or clinics constitutes enough assistance (typically called material assistance) to implicate the clinician in any underlying crime. But the court of public opinion may pose the biggest challenge: juries, judges, and voters (district attorneys are typically elected) may not approve of prosecutors seeking to muzzle clinicians. U.S. polls consistently show that the majority of the population — including states that criminalize abortion — believes that abortion should be legal in all or most cases.[13] It is therefore likely that most people would be troubled, if not outraged, by the idea of prosecuting clinicians who simply share factual abortion information with their patients and that this reality will itself deter prosecution.

Our analysis of the low odds of being charged with a crime and even lower odds of successful prosecution, as well as our discussion of civil suits and professional disciplinary action (below), may be cold comfort for clinicians hoping to avoid any possibility of legal complications. But failing to provide all-options counseling cannot be squared with good medicine. An understandable climate of fear has led clinicians to retreat from essential care provision in ways not demanded by the actual content of statutes and even in the absence of enforcement efforts. Clinicians have the power to safeguard patient well-being by not allowing bans on providing abortion to also silence their counseling. We therefore encourage clinicians to resist the chilling effect of these laws and to endure the slight risks involved in asserting their First Amendment rights and the primacy of their patients' welfare. We also applaud the lawsuits filed by Dr. Yashica Robinson and others on July 31, 2023, seeking a ruling that the Alabama anticonspiracy statute referenced by the state attorney general cannot be used to prosecute people who help patients get out-of-state abortions.[14]

INFORMATION SHARING AS A POTENTIAL CRIME

Since it's difficult to prosecute clinicians as accomplices, perhaps some states will consider new bans on the mere sharing of information about abortion. However, federal court rulings upholding clinicians' First Amendment right to share relevant medical information with patients in other contexts suggest that such bans on clinician speech might run afoul of the Constitution. For example, in *Wollschlaeger v. Governor, Florida* (2017), the 11th Circuit Court of Appeals ruled that a Florida statute barring doctors from asking patients whether there was a gun in their home and talking with them about gun safety was an unconstitutional violation of physicians' free speech.[15] Similarly, in *Conant v. Walters* (2002), the 9th Circuit Court of Appeals enjoined (prohibited) the federal government's effort to restrict doctors' licenses on the basis of their having recommended medical marijuana to a patient. The court ruled that doctors who aid and abet the actual distribution and possession of marijuana could be investigated by the government, but those merely offering information about medical marijuana were protected by the First Amendment.[16]

In the 1991 case *Rust v. Sullivan*, the U.S. Supreme Court upheld a federal "gag rule" that conditioned Title X family-planning funding on recipients' refraining from abortion counseling and referrals.[17] But given that *Rust* hinged on government funding, it does not predict how the Court would rule on a future state ban on abortion counseling. As the *Rust* Court explained, "The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternate program which seeks to deal with the problem in another way."[17]

The Biden administration's health and human services (HHS) regulations have gone in the opposite direction: Title X funding is currently conditioned on the provision of all-options counseling, with clinics required to offer patients with a positive pregnancy test "nondirective" information on their options, which includes "providing referrals for abortion upon client request." In March 2023, HHS advised Title X recipients in Tennessee — a state that bans abortion provision — of their obligations to provide robust abortion counseling, including out-of-state referrals, stating, "We understand that in some circumstances, those referrals will need to be made out of state" and threatening to withhold Tennessee's Title X funding if it continued to restrict these referrals.[18] This position suggests to us that the Biden administration is quite confident that counseling about out-of-state abortion options does not run afoul of state law.

This background may explain why states that

ban abortion provision have largely steered clear of banning abortion-related speech. In March 2023, Idaho's attorney general experimented with restricting abortion counseling, issuing an advisory opinion asserting that Idaho law "prohibits an Idaho medical provider from . . . referring a woman across state lines to access abortion services" and threatening to suspend clinicians' licenses on the grounds that such referrals amount to assisting abortion.[19] He made a quick about-face, however, withdrawing his legal guidance after the American Civil Liberties Union and local clinicians sued for constitutional violations, and on July 31, 2023, a federal judge in Idaho issued a preliminary injunction barring him from taking legal action against medical providers who refer patients across state lines for abortion care.[20,21] At least one state ban purports to criminalize sharing abortion information: Oklahoma bars "advising" a pregnant person to take a drug (though only if it's done with the intent "to procure the miscarriage of such woman"), but that law has not been tested in court.[22]

CIVIL LEGAL LIABILITY

Short of criminal prosecution, could civil law interfere with clinicians' ability to share abortion information? Three states have so-called "bounty laws" that allow civilian "vigilantes" to sue, for monetary damages, any person who performs an abortion, or who knowingly aids (helps) or abets (encourages) the performance of an abortion, in violation of that state's law. Texas introduced this concept with Senate Bill 8 in September 2021,[23,24] and Oklahoma and Idaho followed suit.[25,26] Like the relevant criminal laws, these civil laws remain largely untested. The one case to reach a judge was filed against Alan Braid, a San Antonio–based physician, after he wrote an op-ed revealing that he had performed an abortion in violation of the Texas law. In December 2022, a judge dismissed the suit, finding that the "bystanders" who had sued Braid lacked the legal standing to do so and ruling that only people who are directly affected by the abortion services provided may sue.[27]

PROFESSIONAL AND PERSONAL RISKS

Sharing abortion information is consistent with ethical obligations, and in most instances, it does not violate any law. However, the risk calculus may go beyond the letter of the law for clinicians working in unsupportive settings, who could face ill-founded criminal charges or lawsuits. Winning these cases can be an emotionally draining waste of time, although we hope the availability of free legal help from the Abortion Defense Network will eliminate the financial toll of defending oneself. Some clinicians may also face discriminatory or retaliatory action. For example, while the Indiana legislature was debating whether to add exceptions to its pending abortion ban, physician Caitlin Bernard disclosed the fact that she had performed a legal abortion for a 10-year-old rape survivor from Ohio who had crossed state lines for treatment. Bernard was then targeted for harassment by the state attorney general and was brought before the state licensing board, which reprimanded her and fined her $3,000.[28]

The prospect of losing one's job or having one's medical license threatened is daunting, regardless of the low odds of these outcomes. Clinicians who are able to relocate may be heartened to learn that several "haven states," such as Illinois, protect clinicians' ability to practice by providing quick licensure for clinicians penalized for practicing reproductive medicine in ways that are legal in the haven state.[29]

Finally, being "outed" as a provider of abortion information could put one at risk for harassment from abortion opponents. However, because counseling patients about abortion options occurs in the context of a confidential relationship, the odds of being outed are probably low, and being outed does not guarantee harassment — indeed, some clinicians have been surprised to find that it brought primarily positive responses.[30]

CONCLUSIONS

Clinicians practicing in the current legal climate bear an undeniable and deeply unfair burden. Yet the decision to share abortion information is as much an ethical calculus as a legal one. A clinician's failure to share such information forces the patient to bear risks that are more serious and more likely to be realized than any the clinician might face: a later, riskier abortion, or the physical and mental health consequences of forced pregnancy, forced childbearing, and for the overwhelming majority, the life-altering consequences

of child-rearing. For clinicians, then, right-sizing one's own risk assessment and comparing it with the threats to patient health and well-being is an essential ethical analysis.

Nevertheless, no clinician should shoulder this challenge alone. In the face of evidence that some doctors have stopped providing abortion information, the profession as a whole should recognize that patient well-being is unnecessarily threatened and that clinicians need support. We believe that professional organizations in any medical specialty in which clinicians might encounter pregnant patients should adopt explicit policies affirming all-options counseling as the standard of care and obligating clinicians to share abortion information. Hospital ethics committees and risk-management committees should do the same. Affirming an explicit standard of care can help the medical profession safeguard both patients and clinicians, along with its own integrity. Embracing such a norm will, at the very least, ensure that any state taking action against an individual clinician who shares abortion information can rightly be understood to be taking on the profession as a whole.

Disclosure forms provided by the authors are available at NEJM.org.

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