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Against Silence: Why Doctors are Obligated to Provide Abortion Information

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AGAINST SILENCE: WHY DOCTORS ARE OBLIGATED TO PROVIDE ABORTION INFORMATION

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INTRODUCTION

As a lawyer, I have long been interested in the gap between law and the books and law in practice. In 2008, this curiosity led me to Latin America, where I began studying the impact of the world's most restrictive abortion bans. My first stop was Chile, which at the time banned abortion under all conditions—there was not even an exception to save women's lives. Raised on the history of what happened when abortion was illegal in the United States prior to *Roe v. Wade*, I knew asking doctors to share their experiences was one way to gauge the impact of abortion bans. I went to Chile expecting to hear stories of women dying from the consequences of unsafe abortions. The doctors I interviewed quickly disabused me of that idea by firing up their old desktop computers, and with a few clicks showing me how simple it was to buy abortion medicine from guys in backpacks, right on the city's main street.

Clearly medication abortion had transformed what "illegal abortion" looked like on the ground. From Chile, I went to El Salvador, which not only had a law banning abortion without exception, but also had a government committed to prosecuting the crime. For a decade, I studied the impact of El Salvador's abortion ban, learning how abortion bans work in practice. Abortion rates remain high in El Salvador, regardless of the law. Indeed, an estimated 1 in 3 pregnancies

in El Salvador end in abortion—a rate that far exceeds rates seen in countries with liberal abortion laws.[1] As in Chile, medication abortion plays a pivotal role.[2]

The Salvadoran doctors showed me the range of ways in which doctors find themselves on the frontlines when abortion is criminalized. The law limits and complicates their options when treating pregnant patients. Doctors find themselves conscripted into the abortion war as arms of the state, pressured to report patients they suspect of having deliberately ended their pregnancies. For Salvadorans, safe abortion turns on access to pills and on access to information about how to use them. The law also produces health crises, particularly in their most vulnerable patients, who are less likely to have access to information about abortion medication. The single biggest cause of maternal mortality in the country—3 in 8 maternal deaths—is suicide among pregnant teens.[3]

Because of this background, I was prepared for much of what would happen in the U.S. when, in the wake of the *Dobbs*[4] decision, states began criminalizing abortion. I knew that abortion would continue in the U.S. regardless of the restrictive laws. I knew that the impact of the bans would fall disproportionately on the most vulnerable Americans—those most likely to struggle accessing the abortions that they need. I also knew that doctors would be on the front lines, and that the easiest way for me to get insight into how U.S. abortion bans operate on the ground would be to ask doctors.

This essay describes some of the early findings from my ongoing study of how U.S. doctors are responding to laws criminalizing abortion. After providing an overview of the research project, I will hone in on one of the most troubling findings that emerged—specifically the reluctance of clinicians to share abortion information. Once I've described why abortion information matters so much, particularly to vulnerable patients, I will explain why doctors are duty bound to such information. Finally, I will discuss the various fears that are leading doctors

* Katharine & George Professor of Law, Santa Clara University. For collaboration and insight, I am deeply indebted to my friend and colleague, Lisa Lehmann, M.D., Ph.D. (Harvard Medical School and Harvard T.H. Chan School of Public Health), and also to my friend and fantastic research assistance, Leah Faibisoff, J.D., Ph.D. (Santa Clara University Class of 2023). Many thanks to participants at the Rothenberg lecture from which this essay is adapted, and to Stephanie Vangellow and the Univerisity of Maryland Law Review staff for their help with the adapting process!

1. Michelle Oberman, *What will and won't happen when abortion is banned*, 9 J. L. & BIOSCIENCE 1, 15–17 (2022).

2. *See generally* MICHELLE OBERMAN, HER BODY, OUR LAWS: ON THE FRONTLINE OF THE ABORTION WAR FROM EL SALVADOR TO OKLAHOMA (2018) (discussing research in Latin America).

3. Michelle Oberman & Irina Raicu, *The Teenage Victims of Abortion Bans*, SLATE (June 29, 2022, 5:45 AM), https://slate.com/technology/2022/06/the-youth-mental-health-crisis-and-the-end-of-roe.html.

4. *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022).

to pull back from sharing abortion information, assessing both their merit and their implications for healthcare at an individual and profession-wide level.[5]

I. CASE STUDY

Working with Dr. Lisa Lehmann,[6] a doctor and ethicist at Harvard Medical School, I designed a qualitative investigation into the impact of abortion bans on doctors.[7] We located our study in a state that had newly banned abortion outside of a very narrow exception for what the law terms "life-threatening medical emergencies." We chose this particular state because it has a combination of factors that we knew would quickly illuminate the tensions doctors were likely to experience under the new laws. There are several high-quality, even world-renowned health care institutions, all likely to find themselves on the radar of an activist conservative state legislature committed to abolishing abortion. The state also has a long history of entrenched racism, poverty, and an insufficient social safety net–all factors that drive abortion demand. Finally, the state is interesting because abortion is legal in nearby states, meaning that it remains accessible for those who have the knowledge and the means to travel.

Our research largely focused on doctors practicing in the vicinity of a mid-sized city (2-3 million people). We used our professional and personal networks to identify prospective participants. To protect the identities of those consenting to be interviewed, we designed a fully anonymized protocol, which is why I am not disclosing the location of our study. We also obtained an NIH certificate of confidentiality which protects the findings from discovery, or any use against the participants. Interviews were taped and then transcribed, and the original recordings were deleted.

We worked hard to build a diverse pool of participants. In the end, we interviewed twenty-five clinicians across a range of practice areas—addiction medicine, adolescent medicine, emergency medicine, reproductive endocrinology, maternal fetal medicine, and obstetrics—and working in a number of settings: rural, suburban, urban, academic medicine, private practice, and religiously-affiliated hospitals. The pool was also generally diverse and included doctors across a range of genders, ethnicities, races, class backgrounds, and religions.

5. This a lightly edited version of my Rothenberg Lecture, presented at the University of Maryland in February, 2023. Those seeking a more formal, detailed analysis of this topic might refer to my full-length article, Doctors' Duty to Provide Abortion Information, (Forthcoming, 2023).

6. Lisa Lehmann, M.D., Ph.D., is a physician at Brigham and Women's Hospital, Boston, MA, and Associate Professor of Medicine at Harvard Medical School and Associate Professor of Health Policy and Management at Harvard T.H. Chan School of Public Health, Boston, MA.

7. Ethics Approval Statement: Human Subjects Research for this article was approved by Santa Clara University's Institutional Review Board, IRB protocol 22-04-1768.

That said, one important voice was missing from our sample. When asked, none of the doctors we interviewed supported the new abortion ban. Each professed a belief that women should have the legal right to end unwanted pregnancies.[8] This means that none of our doctors would be "conscientious objectors," opting out of providing any abortion-related care on the grounds that doing so violated their moral beliefs. As a result, although there are many interesting questions one might ask about the duties and rights of conscientious objectors where abortion is illegal, I will not be addressing them here. Instead, my research describes how laws criminalizing abortion can impact the clinical care provided by those who think their patients should be able to choose abortion.

I arrived in early July, 2022, just days after the new abortion law went into effect. Our participants were shell-shocked and frightened. Some felt they were taking a risk simply by meeting with me. Many echoed some version of one doctor's worry: "[N]o physician wants to be the one that is the example. You know, that's going to jail and losing their license and their ability to support their family and practice in their community."[9] One of our clinicians remarked, "I mean, that is the whole point of all of this—to make people scared. That's what a terrorist does. In fact, these, you could equate to, these are no different than domestic terrorist policies."[10]

It quickly emerged that the new law had already impacted the abortion-related care these doctors provided. Both in the sorts of ways that make national headlines, like cases involving miscarriage management, but also in a way that largely seems to have escaped notice. The abortion ban was changing how the doctors talked to their patients about their options. It had altered the scope of the health information that doctors were willing to share with their patients who wanted or needed an abortion. And while it is possible that doctors were over-reacting in the immediate aftermath of abortion becoming criminalized, as the months have passed, it is clear that the concerns they raised, and the justifications they provided for their reactions, remain unchanged.

II. WHY ABORTION INFORMATION MATTERS

To explain why abortion information matters, I need to back up a little. To start, we must recognize that abortion is a core component of comprehensive reproductive health care. We are so charged in this country by the political debate over abortion that we often lose sight of the reality that, at its foundation, abortion care is essential treatment that saves women's lives and safeguards their dignity

8. This result was not for want of trying. We employed a range of creative and persistent efforts at recruitment, but perhaps understandably, doctors were wary of talking, even off the record.

9. Interview with W (July 18, 2022) (on file with author).

10. Interview with H (July 8, 2022) (on file with author).

and bodily autonomy. Not only is abortion a safe and effective treatment option, but it is also safer than childbirth.[11] As such, the leading U.S. medical organizations recognize abortion as an essential component of women's health care. [12]

These organizations also recognize that without access to accurate information, patients face elevated risks of negative health outcomes. In 2022, the World Health Organization (WHO) listed the scarcity of access to accurate information first among abortion related problems that jeopardize women's health because it leads them to use unsafe methods.[13] The WHO estimates that there are 39,000 deaths a year along with millions of hospitalizations from unsafe abortions.[14] As I learned in El Salvador the problem of accessing a safe abortion in a place where it's criminalized is dependent as much on access to abortion medicine as it is on abortion information.

If they are to stay safe, American patients seeking abortion need access to trustworthy, accurate information about their options. As of today, patients living in states that have criminalized abortion have several options. First, they can travel to a state where abortion is legal, where they can end their pregnancy legally. However, travel is expensive and hard–even impossible–for some, especially youth, those in rural areas, and those with inflexible work hours or familial obligations. [15] Second, patients can access abortion care using telehealth. There are a number of web-based abortion helplines to connect patients with providers.[16] Finally, patients can access abortion medication through the informal market by buying the medicines online or acquiring them through private networks. This option allows patients to self-manage their abortion outside of the health system.

11. Usha Ranji et al., *Key Facts on Abortion in the United States*, KAISER FAM. FOUND. (Jan. 20, 2023), https://www.kff.org/womens-health-policy/report/key-facts-on-abortion-in-the-united-states/.

12. *Facts Are Important: Abortion is Healthcare*, AM. COLL. OBSTETRICS & GYNECOLOGISTS, https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare.

13. *WHO issues new guidleines on abortion to help countries deliver lifesaving care*, WORLD HEALTH ORG. (Mar 9, 2022), https://www.who.int/news/item/09-03-2022-access-to-safe-abortion-critical-for-health-of-women-and-girls.

14. *Id.*

15. Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSPECTIVES ON SEXUAL AND REPROD. HEALTH 95, (2017) (Defining five categories of barriers: travel-related logistical issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions).

16. *See e.g.* Reprocare, https://abortionhotline.org/ ("Reprocare is a reproductive justice organization that seeks to holistically support access to abortion care in ways that confront economic and racial injustice."); Indeedana.com ("Our goal is to provide a simple, up-to-date, and localized source of information for people seeking abortions."); Abortion Finder, abortionfinder.org. ("Abortion Finder is an easy-to-use search tool built on a database of over 750 verified abortion providers across the country.").

Although multiple websites exist to help patients navigate abortion options, there is widespread confusion about what these options are.[17] A February, 2023 survey found that 50% of adults, and 41% of women ages 18 to 49,[18] are "unsure" whether medication abortion is legal in their state. If we understand confusion about abortion information in the context of the broader problem of health literacy, we can also predict which patients are most likely to struggle to access this information.

Research shows that health literacy varies across a population. Patients who are vulnerable for reasons of poverty, race, geography, and age are significantly more likely to struggle accessing and understanding health information, including abortion information. It bears noting that this is the same segment of the population that is most likely to experience an unwanted pregnancy, and most likely to seek abortions.[19] The data prior to Dobbs shows that 75% of all U.S. abortions went to people living below, or just above the poverty line.[20] This background permits us to understand precisely which population will experience a disproportionately higher need for support if they are to access accurate abortion information.

The lack of access to abortion information is associated with negative health outcomes. We know that those who lack abortion information will attempt riskier methods. We know that they will experience higher rates of medical complications. We also understand that they will bear a higher likelihood of forced pregnancy, which comes with mental health consequences and the life altering consequences of child-rearing.

Finally, whenever we talk about abortion in America, including in the context of abortion information, we must talk about race. U.S. poverty is not color-blind. Instead, at every age, including reproductive age, Black and brown Americans are disproportionately likely to be poor. The racial composition of U.S. abortion rates is largely an artifact of poverty: Black Americans make up approximately 13% of the population, yet 28% of those having abortions.[21]

17. *Id. See also, e.g.*, Aid Access, aidaccess.org; Women Help Women, https://womenhelp.org/; Plan C, https://www.plancpills.org/; Mayday.health, Hey Jane.

18. Grace Sparks et al., *KFF Health Tracking Poll: Early 2023 Update on Public Awareness On Abortion and Emergency Contraception*, KAISER FAM. FOUND. (Feb. 1, 2023), https://www.kff.org/womens-health-policy/poll-finding/kff-health-tracking-poll-early-2023/.

19. Healther D. Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, GUTTMACHER INST. (July 13, 2016) https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters.

20. *Id.*

21. Liza Fuentes, *Inequality in US Abortion Rights and Access: The End of Roe Is Deepening Existing Divides*, GUTTMACHER INST. (Jan. 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides.

Add to this the disturbing pattern of racial disparities when it comes to abortion-related law enforcement. Numerous studies document a pattern of law enforcement that disproportionately targets Black and brown women.[22] Many of these cases originate when doctors breach confidentiality by notifying police about patients who sought treatment for complications of pregnancy loss.[23]

With an eye to all of this, we see that the well-being of the most vulnerable and marginalized Americans is at stake in the challenge of providing access to abortion information.

III. DOCTORS' DUTY TO PROVIDE ABORTION INFORMATION

Informed consent has long been a fraught territory in the US abortion war. Like many states in the decades before *Dobbs*, the state in which our study took place required doctors to share a so-called "informed consent" pamphlet with their patients whenever discussing abortion. This brochure contained unfounded assertions about when life begins, along with discredited claims about the risks of abortion. Our doctors described the strategies they used to ensure that their patients had the information they needed to understand that the State's information was biased, and even false. Said one, *"So I say things like, 'Hello, this book is, you know, mandated by the state. It contains incorrect medical information. Crazy things like 'abortion causes breast cancer,' which is not true.'"*[24]

22. *See Decriminalizing Self-Managed and Supported Non-Clinical Abortion*, IF/WHEN/HOW, https://www.ifwhenhow.org/resources/self-care-criminalized-preliminary-findings/ (providing findings from a multi-year research project to understand who has been targeted by criminalization for self-managing their abortion); Laura Huss, M. Phill, *Self-Managed Abortion is Not Illegal in Most of the Country, but Criminaliziation Happens Anyway*, IF/WHEN/HOW, (Aug. 9, 2022), https://www.ifwhenhow.org/abortion-criminalization-new-research/ (discussing findings from research, 2000-2020); *Arrests and Prosecutions of Pregnant Women, 1973-2020*, NAT'L ADVOC. FOR PREGNANT WOMEN (Sept.18, 2021), https://www.nationaladvocatesforpregnantwomen.org/arrests-and-prosecutions-of-pregnant-women-1973-2020 (documenting race and class bias in the criminalization of behaviors alleged to pose risk to fetus). *See also* Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y AND L. 299, 304-05 (2013) (discussing these findings and the limitations of the research which led the authors to conclude that their findings represent a substantial undercount of cases). *See* Priscilla Thompson & Alexandra Turcios Cruz, *How an Oklahoma Women's Miscarriage Put a Spotlight on Racial Disparities in Prosecutions*, NBC NEWS (Nov. 5, 2021), https://www.nbcnews.com/news/us-news/woman-prosecuted-miscarriage-highlights-racial-disparity-similar-cases-rcna4583. *See also* OBERMAN, HER BODY, OUR LAWS, at 43-67 for a discussion of how reports from doctors to police in El Salvador overwhelmingly involve poor, marginalized women. More generally, see MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD (2020).

23. *See* Jamila Perritt, *#WhiteCoatsForBlackLives—Addressing Physicians' Complicity ib Criminalizing Communities*, 383 NEW ENG. J. MED. 1804 (2020) (explaining why physicians should never report patients to law enforcement authorities).

24. Interview with O (July 12, 2022) (on file with author).

What is noteworthy in this response is the way the doctor steps in as a trusted health intermediary, protecting the patient's best interests by providing accurate abortion information and making sure patients are not misled. This pattern was mentioned by many of the doctors I interviewed—stepping in to make sure that the patient understands the relevant, factually accurate information needed to make an informed healthcare decision.

The abortion ban complicated the role of trusted intermediary, increasing the amount and complexity of information that the doctors felt their patients needed to make an informed choice about how to proceed. In the words of one of our doctors,

> *"[H]ow we can still provide full options? Like what's the most efficient way to connect someone who needs a termination? What are charity services that could help provide funding? And transportation… because of course who will get left behind again are our patients from rural areas …and people who are poor."*[25]

But the change in abortion's legal status did not alter doctors' ethical obligation to ensure that their patients have access to, and comprehend, the health information they need to make sound decisions consistent with the patient's values and well-being in the abortion context.[26]

The duty to share abortion information arises from each of the four core principals of medical ethics: autonomy, beneficence, non-maleficence, and justice.[27] Basic access to abortion information is vital to autonomy, promoting the patient's ability to chart their own life course. In addition, as we have seen, that lack of access to abortion information is associated with an increased risk of morbidity and mortality, along with a host of negative long-term downstream consequences. As such, the duties of beneficence and non-maleficence require sharing abortion information to safeguard patient well-being.

Likewise, the ethical value of justice is implicated because stratified access to, and understanding of, health information is costly not just for the individual, but for the entire population. Because we know that the poorest Americans will struggle the most in accessing abortion where criminalized, the consequences of being denied the information needed to obtain a wanted abortion include the

25. Interview with B (July 6, 2022) (on file with author).

26. Joanna N. Erdman, *Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach*, 34 HARV. J. L. & GENDER 413, (2011) (making a case for promoting access to abortion information both as a matter of human rights and sound public health policy).

27. Thomas R. McCormick et al., *Principles of Bioethics*, UNIV.WASH.MED., https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/principles-bioethics.

intensification of poverty and a worsening of physical health outcomes for the pregnant person and their offspring.[28]

Any one of these ethical principles would suffice to establish the obligation to provide patients with abortion information. That *all* of these core values apply underscores the fact that, regardless of their personal beliefs about the morality of abortion, clinicians have an ethical obligation to inform patients about their treatment options.

IV. RISKS OF DISCLOSURE

It is clear to me that doctors have an ethical obligation to provide abortion information. But, as a professor of criminal law and health law, it is also clear to me that doing so may be risky. The doctors we interviewed flagged several potential concerns: "getting sued, getting arrested, having a record, losing [one's] license." At the time of our interviews–the first month after the law criminalizing abortion went into effect–these concerns were hypothetical and had yet to materialize. Still, our clinicians took the risks very seriously.

Notably, at least as of now, no state makes it a crime for doctors to share abortion information. Such a law would face headwinds because it would impinge on the clinician's Constitutional right to free speech. In other contexts, courts have rejected state laws such as Florida's effort to bar doctors from sharing gun safety information, citing free speech violations.[29] It would also squarely raise the question of civil disobedience, forcing doctors to determine an

28. The American Academy of Pediatrics call this problem the "medicalization of poverty." Children who experience poverty particularly during early life, are at risk for a host of adverse health and developmental outcomes, lifelong hardship, poor developmental and physical and psychosocial outcomes, significant financial burden, lower school readiness, lower academic achievement, lower job placement rates and ultimately lower life expectancy. *See* Am. Acad. of Pediatrics, *Poverty and Child Health in the United States*, 137 PEDIATRICS 4 (2016).

29. *See, e.g.*, *Wollschlaeger v. Governor of Florida*, 848 F.3d 1293 (11th Cir. 2017). Nonetheless, with model legislation from the National Right to Life proposing to criminalize providing pregnant patients with information about self-managed abortion, it is perhaps only a matter of time before a state attempts to make it a crime to share abortion information. *See Post-Roe Model Abortion Law*, NAT'L RT. TO LIFE, June 15, 2022, https://www.nrlc.org/wp-content/uploads/NRLC-Post-Roe-Model-Abortion-Law-FINAL-1.pdf. *See also* Veronica Stracqualursi, *National Right to Life eyes medication abortion restrictions as next step in post-Roe fight*, CNN, June 27, 2022, https://edition.cnn.com/2022/06/27/politics/national-right-to-life-convention-medication-abortion/index.html (last visited Apr. 14, 2023). In February 2023, a Texas lawmaker introduced a bill that would force internet providers to block access to any website that carries information about abortion medication or tells women how to get an abortion. *See* H.B. 2690, 88th Leg., Reg. Sess. (Tx. 2023), https://capitol.texas.gov/tlodocs/88R/billtext/pdf/HB02690I.pdf#navpanes=0) (last visited Apr. 14, 2023). Many thanks for Professor Dena Davis for bringing the Wollschlaeger case to my attention.

appropriate course of action when their ethical and professional obligations are at odds with the law.[30]

Rather than focusing on direct prohibitions on sharing abortion information, our clinicians worried about being charged as accomplices. As one said, "She tells her next-door neighbor, [and the] next-door neighbor makes sure that I'm on the hook for them."[31] In theory, accomplice liability poses a grave threat because accomplices typically can be convicted of the crime that they helped someone else commit: an accomplice to robbery is guilty of robbery. With various state laws making it a felony to perform an abortion, doctors are understandably concerned.

But upon closer examination, any such prosecution will encounter multiple hurdles, making this fear largely unfounded. Every state has its own version of accomplice liability, but the necessary first step in all cases would require the state to prove that the action—presumably the abortion—was a crime. Yet, particularly in the case where the patient travels to a state where abortion is legal, the patient will not have broken the law.[32] Then, the state must prove beyond a reasonable doubt that the clinician at least knew that the patient intended to break the law.[33] However, a clinician cannot know that their patient will break the law, especially if the information they supplied included legal options for an abortion. Finally, the prosecution must also prove that simply providing abortion information constitutes material assistance. In short, it's a high bar for the prosecution to show that providing abortion information makes the doctor an accomplice to an illegal abortion.

Practically speaking, the risk of prosecution will also turn on a given community's appetite for prosecuting doctors. District attorneys typically are

30. Ethicists Dena Davis and Eric Kodesh address this challenge in their 2014 essay about how doctors should respond when laws conflict with medical ethics: "In situations that pose a conflict between ethical conduct and abiding by an unjust law, an act of civil disobedience may be indicated. A doctor should commit civil disobedience rather than lie to a patient." Dena Davis & Eric Kodish, *Laws that Conflict with the Ethics of Medicine: What Should Doctors Do*?, 44 HASTINGS CTR REP. 11, 13 (2014). Davis and Kodesh go on to suggest that, "if all the affected doctors did this, the law would disappear very soon." *Id.*

31. Interview with I (July 8, 2022) (on file with author).

32. A Missouri lawmaker (Mary Sue Coleman) proposed criminalizing traveling across state lines to obtain a legal abortion, but to date no state has enacted such a law. For a rich, balanced consideration of the federalism challenges in barring residents from states with abortion bans from traveling to legal states in order to obtain abortions, *see* Susan Appleton (SSRN, forthcoming 2023). *See also*, Katherine Florey, *Dobbs and the Civil Dimension of Extraterritorial Abortion Regulation*, N.Y.U. L. REV. (forthcoming 2023) (discussing civil remedies as an alternative or supplement to the criminal prosecution of out-of-state abortions and why current choice of law is not well equipped to resolve abortion issues in the coming civil litigation).

33. Jurisdictions are divided over whether an accomplice must intend that another commit the target crime, or simply know that they intend to do so. *See* Sheif Girgis, *The Mens Rea of Accomplice Liability: Supporting Intentions*, 123 YALE L. J. 266 (2013).

elected officials, so the question they will be weighing is whether the public will support an effort to muzzle the medical profession.

Nonetheless, I imagine that this analysis provides only slim comfort for the doctors who are worried about their job, their reputation, and their livelihood. In states like Texas, with so-called bounty laws,[34] there's a risk of potentially ruinous civil liability. Then there is the potential for downstream negative professional consequences. Doctors who work in hospitals that forbid providers from sharing abortion information risk termination for doing so. In the event of prosecution or a lawsuit, doctors may be forced to shoulder legal fees and reputational damage.[35] It is even conceivable that clinicians practicing in a state with a conservative medical licensing board might risk losing their license to practice medicine. In short, sharing basic abortion information could jeopardize a clinician's career and livelihood.

It bears noting that professional organizations representing the various medical specialties could greatly reduce these risks by clarifying that the standard of care *requires* doctors to share abortion information. Many medical specialties are already on record about the importance of sharing abortion information. For example, in June, 2022, the American Academy of Pediatrics issued a policy statement[36] providing that pediatricians should:

1. Inform the pregnant adolescent of all their options, which include continuing the pregnancy and raising the child; continuing the pregnancy and making an adoption, kinship care, or foster care plan; or terminating the pregnancy.

2. Be prepared to provide a pregnant adolescent with accurate information about each of these options in a developmentally appropriate manner involving a trusted adult, when possible; support the decision-making process; and assist in making connections with community resources that will provide quality services during and after the pregnancy.

34. TEX. HEALTH AND SAFETY CODE ANN. § 171.201 (1) (2021).

35. In November, 2022, the AMA passed a resolution creating task force to organize a legal defense fund for any physicians who are prosecuted for providing abortions when doing so is the medical standard of care. *AMA announces new adopted policies related to reproductive health care*, AMA, PRESS RELEASE (Nov. 16, 2022), https://www.ama-assn.org/press-center/press-releases/ama-announces-new-adopted-policies-related-reproductive-health-care.

36. Am. Acad. of Pediatrics, *Options Counseling for the Pregnant Adolescents*, 150 PEDIATRICS 1 (2022), Pediatricshttps://publications.aap.org/pediatrics/article/150/3/e2022058781/188340/Options-Counseling-for-the-Pregnant-Adolescent?_ga=2.95399708.1680874852.1673722098-646840235.1673722093%3fautologincheck%3dredirected.

Yet the same declaration undercuts these provisions with the following statement: "The AAP acknowledges the tension that pediatricians may face between their ethical duty to the patient and their duty to observe the law, and that pediatricians may choose not to follow these AAP recommendations when it is illegal to do so."[37]

It is not illegal to share abortion information.[38] But given the uncertainty that surrounds doctors' risks where abortion is criminalized, it is unrealistic to expect clinicians to know what is, and is not illegal. Instead, this provision gives them permission to pull back from any perceived risks. And pull back, they are. One of the doctors we interviewed last summer acknowledged that their patients would struggle to access accurate abortion information:

> We see a pretty diverse patient population …. And I would say the majority of my patients are going to have difficulty navigating that. Because they can't, you know, pull out your smartphone and get on the internet. You know, scroll through all the filters and algorithms. But not everybody has the internet at home. Not everybody has reliable transportation to get somewhere. Not everybody has a safe place they can make that phone call from.[39]

But then they added that, owing to their fear of legal liability, the information they shared would be limited: *"There are other states with different options, but that's something you'd have to explore because I'm not allowed to refer you there, based on the law. And that's how I would counsel somebody."*[40]

In the absence of strong professional norms, clinicians are forced to grapple on an individual basis with these tensions. Abortion crimes effectively permit the state to intervene in the doctor-patient relationship by pressuring doctors to provide sub-optimal care. Such a result cannot help but corrode the integrity of the medical profession as a whole. As the International Code of World Ethics states, "Physicians must take responsibility for their individual medical decisions and must not alter their sound professional medical judgements on the basis of instructions contrary to medical considerations."

V. CONCLUSION

It is worth considering the hierarchy of those placed at risk by this response to laws making abortion illegal. There is the profession itself, as the integrity of the medical profession cannot help but be undermined when fear about

37. *Id.*
38. *Supra* note x.
39. Interview with D (July 6, 2022) (on file with author)
40. *Id.*

professional risks leads doctors to betray their ethical obligations to their patients. There are the individual clinicians, who are being forced to navigate this complicated ethical territory on their own. And there are the patients, whom the state is hoping to trick into believing that they have no choice but to carry an unwanted pregnancy to term.

A profession that fails to set clear definitional boundaries and norms around the provision of abortion information forces individual clinicians to bear the risks of following their ethical duties. And a doctor who fails to provide abortion information forces their patient, the most vulnerable of the three, to bear the risks of harm from abortion bans.

At least in the short run, there is no certain path for avoiding the collision between the legal risks and the ethical obligations surrounding the provision of abortion information. It takes courage and moral fortitude to navigate these uncertain times. But there is no denying that a clinician's silence necessarily undermines the core values that animate the doctor-patient relationship. Indeed, to be silent is to be complicit in the State's endeavor to conscript doctors into serving a system that weaponizes educational economic and health disparities, so as to lead those with less access to information to incorrectly conclude they have no option but to continue an unwanted pregnancy.