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POLICY FORUM

Ethical Choice Architecture in Preabortion Counseling

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Abstract

Most women requesting pregnancy termination have already decided to undergo an abortion. Physicians are required to obtain informed consent after offering objective and accurate descriptions of abortion and its risks and benefits. Some jurisdictions also require concurrent counseling and ultrasound viewing. This article discusses potential benefits and harms of providing emotionally charged or biased content about abortions at the time of service, considers what constitutes ethical content, and explores when ethical content should be part of abortion decision making.

Unplanned Pregnancy After *Roe v Wade*

"I'm pregnant."

These 2 words can mean, among other things, delight or disaster for a woman. An unexpected pregnancy can be a source of joy, but an unexpected pregnancy can be devastating when it threatens a woman's life, her social standing, her career, her marriage, or her future. Before 1973, a woman with an unwanted pregnancy was legally obligated to carry it to term in most states, either keeping the baby or giving it up for adoption. Illegal abortions were a third and dangerous option.[1]

The pregnancy choice landscape changed dramatically with *Roe v Wade* in 1973,[2] when safe, legal abortion became a realistic option. Ironically, for some, choice made facing an unexpected pregnancy even more difficult. Even today, whether to continue a pregnancy is one of the most difficult decisions a pregnant woman will ever have to make. To help her decide, she might look for advice and support from a friend, a family member, the baby's father, or a trusted cleric, but rarely will she consult a physician.

Pregnancy counseling services came into existence when women's rights gained momentum in the 1970s. As individual states legalized abortion, abortion services incorporated counseling to help women make an informed choice.[3] Clinicians in state-regulated practices, such as Planned Parenthood, were expected to adhere to professional standards and ethical guidelines, as explicitly stated by a number of professional medical organizations[4]; provide comprehensive and unbiased information;

and offer referrals about parenting, adoption, or abortion in order to express respect for a pregnant woman's right to self-determination.

At the same time, fueled by the prolife movement, there was an increase the number of crisis pregnancy centers seeking to counsel women to carry their pregnancies to term[5] by offering inaccurate content portraying abortion as dangerous and as brutal murder of an unborn child. Because they do not offer clinical services, employ physicians, or charge for their services, crisis pregnancy centers are not regulated by states.[5] They target young women with few resources or who are racial and ethnic minorities under the guise of offering balanced, compassionate counseling and may be located near enough to a legitimate clinic to perhaps be mistaken for one.[5]

Imagine Decision Design

Imagine you are a young woman who just learned she is unexpectedly pregnant. You are in shock. Your world has collapsed, your education and career are now possibly in jeopardy, and you don't have a loving partner with whom raise a child. You would like to terminate your pregnancy and you seek advice. You visit a crisis pregnancy center expecting a referral for an abortion. You walk through the door and are embraced by a caring, sympathetic individual, who reassures you that many women have faced this dilemma and chosen adoption. You will be shown pictures of a fetus at varying ages growing into a baby and invited to consider your fetus' "feelings" and "pain" to convince you that terminating your pregnancy is morally equivalent to infanticide. You are told that abortion is dangerous and might increase your risk of breast cancer.[5] You are offered an ultrasound[5] of the fetus in your uterus, and you hear the fetus' heartbeat. You are shown a video of a woman in labor, who then receives her newborn with gratitude. You feel safe but also guilty enough to start adoption paperwork.

Now picture again that you are a young woman, expectantly pregnant, who chooses to terminate your pregnancy. You visit a clinic and speak to a counselor, who presents all options, including adoption. You are offered details about the abortion procedure and schedule an appointment. When you arrive at the clinic the next week for the procedure, you are told that state law requires you to watch a video and have an ultrasound of your fetus, and you are pressed to engage with content that seems intended to convince you not to terminate your pregnancy. You are overcome by feelings of shame and guilt. Then a physician arrives and discusses the abortion procedure and its risks and alternatives and responds to your questions. You consent to an abortion and undergo the procedure and immediate postsurgical recovery. After leaving the clinic, doubt planted by the video and ultrasound grows into guilt and anxiety over the short-term, and you feel traumatized over the long-term, always worrying that you made the wrong decision. You live with guilt, regret, or anguish.

Choice Architecture and Timing

In both scenarios, a requirement to watch a video after a patient has already made a decision undermines her right to self-determination. It is unethical to steer a person toward a choice that reflects a clinician's or organization's beliefs when those beliefs are not presented during the time when the patient is making an important decision. In the scenarios, the video is presented during the period between decision and action to be intentionally and maximally disruptive, such that it generates self-doubt. When a choice-to-action timeline is disrupted with this intention, it is, I argue, unethical. This is one reason, for example, that do-not-intubate decisions are discussed when a patient is stable, not when a patient struggles for breath.

Choice architecture—a strategy drawn from behavioral economics to assist in decision making—is predicated on research that shows that how a choice is presented can influence the decision that is made. In health care, choice architecture can help clarify options in a way that avoids biases and improves the quality of decision making.[6] *Nudges* are appropriate to steer a patient away from a harmful choice or toward a beneficial choice, such as vaccination or life-saving antibiotics, but it is never ethical to use lies and deception or to explicitly undermine a person's right to self-determination. Crisis pregnancy centers don't use nudges; they lie.[5]

Abortion, though legal, is politically charged, and roughly a third of the public and ob-gyn specialists alike oppose abortion.[7,8] Many states have now passed laws requiring employment of coercive methods in abortion decision disruption. Twelve states have ultrasound requirements, and 3 of these (Louisiana, Texas, and Wisconsin) require clinicians to display and describe the fetal image.[9] Eleven states require that, during counseling, women receive inaccurate information: that abortion medication is reversible, that it increases risk of breast cancer, or that it could affect future pregnancy.[10] Lobbying by prolife groups has generated these laws over time, which were created with political goals, not patient-clinician relationships, in mind.

Decision Disruption

Most women who present to a clinic for pregnancy termination have already made up their minds to have an abortion.[11] Informed consent processes outline risks and benefits, detail options, and offer opportunities for questions and answers. Attempting to persuade a woman to change her mind after informed consent has been given is inappropriate and confusing and unlikely to succeed.[12] Legal approaches to undermining *Roe v Wade* as a precedent that protects safe access to abortion care are intended to undermine patient-clinician relationships, increase a woman's experience of guilt and anxiety, and impose and intensify psychological trauma. Often overlooked is distress these mandates cause to clinicians who are asked to participate in disruptive choice architecture. Videos and ultrasounds are neither effective nor justifiable influences on pregnant women's decisions about whether to continue their pregnancies.

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