Changes Expected in Reproductive Health Policy

BY MARY ELLEN SCHNEIDER
New York Bureau

One of the early moves of President Barack Obama may be to stop action on a controversial federal abortion regulation issued during the final weeks of the Bush administration, observers say.

The regulation withholds federal payment and funding from providers who do not certify that they do not discriminate against physicians and midlevel providers who refuse to perform abortion or sterilization procedures.

The regulation has been stirring controversy among abortion rights advocates since it was first proposed in August 2008. They contend that the regulation is overly broad and as a result would decrease access to reproductive health services, including contraception. Meanwhile, supporters, such as the Christian Medical Association, say the Bush administration's approach is balanced and helps clear up misconceptions about the conscience protections already in place under existing law.

If President Obama chooses to stop the regulation he has a few options, said Janet Crepps, deputy director of the U.S. Legal Program at the Center for Reproductive Rights. He could formally rescind the regulation by going through the federal rule-making process, which would involve giving notice and allowing for public comment. Mr. Obama also could immediately suspend enforcement of the regulation. Or he could choose to work with Congress on a way to block the regulation through legislation, Ms. Crepps said.

Democrats in Congress have indicated their willingness to act to reverse the regulation. At the end of the last session of Congress, Sen. Patty Murray (D-Wash.) and then-Sen. Hillary Clinton (D-N.Y.) introduced a bill that would stop all action on the regulation.

Aside from addressing the conscience refusal issue, reproductive health advocates expect that the Obama administration's health care agenda may include changes to expand access to emergency contraception, increase funding for family planning, and take a more comprehensive approach to sex education.

"We certainly have a pent-up agenda," said Susan Cohen, director of government affairs at the Guttmacher Institute, a nonprofit research and education organization focused on sexual and reproductive health.

One area in which Ms. Cohen and her colleagues hope to see some action early in the Obama administration is increasing funding for Title X, which provides federal funds for family planning and preventive screening services. The National Family Planning and Reproductive Health Association estimates that if Title X funding had kept pace with medical inflation since 1980, it would be funded at $759 million today, instead of its current $283 million budget.

Sex education is another area ripe for a change in course under a Democratic president and Congress. During the Bush administration, the federal government invested millions in abstinence-only education. Many reproductive rights advocates say policy makers should look at evidence favoring a comprehensive sex education approach, which includes teaching teens about contraception as well as abstinence. President Obama should eliminate funding for abstinence-only sex education and shift those funds to comprehensive sex education, said Dr. Suzanne T. Poppema, chairwoman of the board of Physicians for Reproductive Choice and Health.

Reproductive rights advocates also are hopeful that the new president will eliminate the Mexico City policy or "global gag rule," which bars nongovernmental organizations that receive U.S. funds from performing abortions or providing referrals for abortion overseas.

Dr. Poppema also said that the Obama administration should take action to expand access to emergency contraception. Mr. Obama could expand the number of women who could obtain emergency contraception by directing the Department of Defense to add the medication to its formulary and instructing the Justice Department to mandate that emergency contraception be made available to all victims of sexual assault. The Food and Drug Administration also should reopen its consideration of over-the-counter access for emergency contraception, which is currently available without a prescription only to women aged 18 years and older.

Though the new Congress will be controlled by Democrats, the majority are not uniformly in favor of abortion rights, Ms. Crepps said. However, a solid majority favor family planning, and she predicted that they can make some headway in expanding access to contraceptives as one way to prevent abortions.

But those who oppose abortion rights are concerned that with Democrats in control of both Congress and the executive branch, there will be a greater chance of passing legislation that would codify abortion rights. Dr. Gene Rudd, senior vice president of the Christian Medical Association, said that one of his major concerns is that Democrats will move forward with the Freedom of Choice Act, which has previously failed to gain traction. "It's a watershed event," he said. ■

LAW & MEDICINE

Assumption of Risk

Question: A patient consults her physician for a painful wrist, which is treated with indomethacin. The patient has developed skin rashes caused by various medications in the past, but she does not inform the doctor about this. Shortly after starting indomethacin, she develops Stevens-Johnson syndrome. In regard to an assumption of risk defense, which of the following is true?

A. A patient has a legal duty to reveal to the physician all relevant medical history.

B. Assumption of risk is no longer a valid rule of law.

C. Assumption of risk is an affirmative defense in a tort action and constitutes a complete bar to recovery.

D. Assumption of risk is synonymous with contributory negligence.

E. Giving informed consent is tantamount to assumption of risk.

BY S.Y. TAN, M.D., J.D.

Answer: C. If a plaintiff is fully aware of the risk to which he or she is exposed, and voluntarily accepts that risk, there will be no recovery of damages if harm results. Known as assumption of risk, it constitutes a complete bar to recovery. This defense has two main elements: a patient's full awareness of the risks, and his or her consent to waive all claims for damages.

In contrast, contributory negligence, which usually serves as a partial rather than complete bar to recovery, arises when negligence by the plaintiff played a part in the resulting injury.

Informed consent is when, after being apprised of the risks and alternatives, a patient gives the physician permission to proceed with diagnosis and treatment. However, this principle says nothing about a patient bearing the risk of harm arising out of negligence or incomplete disclosure by the physician.

The Restatement of Torts defines assumption of risk to mean that the plaintiff fully understands the risk and nonetheless chooses voluntarily to take it (§496-C). One court put it this way: "The doctrine of assumption of the risk of danger applies only where the plaintiff, with a full appreciation of the danger involved and without restriction from his freedom of choice, either by circumstances or coercion, deliberately chooses an obviously perilous course of conduct so that it can be said as a matter of law he has assumed all risk of injury" (*Myers v. Boleman,* 260 S.E. 2d 359, Ga, 1979).

The assumption of risk defense has been asserted most prominently in sports activities such as boxing, where serious injuries are an integral known risk. Other examples include foolhardy actions, such as "where one tries to beat a rapidly approaching train across the track, to engage in drag racing or to walk upon a frozen pond where the ice is thin" (*Myers* case, *supra*).

A physician is expected to obtain a complete medical history, but although the patient is expected to be cooperative, he or she does not have to affirmatively volunteer medical information. A doctor cannot readily invoke this doctrine as a defense simply because the patient has not provided a complete medical history. Thus, in the question above (modified from *Hayes v. Hoffman*, 296 S.E.2d 216, Ga. 1982), the doctor's assumption of risk defense will likely fail. In the scenario described at the beginning of this column, the patient cannot be assumed to have understood fully the risk of not disclosing her drug allergies. She certainly did not anticipate developing something as serious as Stevens-Johnson syndrome. In a similar case where a patient developed anaphylaxis from using a sulfa-containing drug, an appeals court held that the trial judge erred by instructing the jury that a patient who fails to disclose relevant medical history to a physician has assumed risk of harm (*Hawkins v. Greenberg*, 283 S.E. 2d 301, Ga, 1981).

But in other situations, an assumption of risk defense may be used successfully. For example, a patient voluntarily and actively sought unorthodox herbal treatment for breast cancer after refusing all conventional therapy. She received full disclosure of the nature of the experimental treatment protocol, and the court therefore rejected her subsequent claim for damages. By giving informed consent to nonconventional experimental therapy in this case, the patient was in effect assuming the risk of harm (*Schneider v. Revici,* 817 F.2d 987, 2nd Cir. 1987).

In English law, the assumption of risk defense is called *volenti non fit injuri* (Latin for "to a willing person, no injury is done"). However, knowledge of risk does not necessarily imply consent. For example, a plaintiff who accepted a ride from a drunk driver sustained injuries in a subsequent accident. The court ruled that *volenti* did not apply unless the drunkenness was so extreme and so obvious that accepting the ride was equivalent to walking on the edge of an unfenced cliff. ■

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