

# From Double Standard to Double Bind: Informed Choice in Abortion Law

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In *Gonzales v. Carhart*,<sup>1</sup> the Supreme Court upheld the constitutionality of the Partial-Birth Abortion Ban Act of 2003,<sup>2</sup> a federal law punishing physicians who intentionally perform a specific abortion procedure. In this Article, I focus on what *Gonzales v. Carhart* had to say about the pregnant woman's choice to have an abortion. I analyze *Gonzales* and other legal developments that undermine women's autonomy and ability to make an informed decision about this medical procedure.

Legislatures create, and courts approve, informed consent requirements for abortion that deviate from those applied in other medical situations.<sup>3</sup> Legal decisionmakers offer two justifications for treating abortion differently. First is the state's interest in protecting potential human life—an interest that supports government efforts to discourage women from having abortions. Second is the state's interest in promoting women's autonomy and psychological well-being. Women facing abortion choices need special safeguards, it is claimed, to protect them from misunderstanding the nature and consequences of their decision and from the regret that might come from having an abortion without understanding important facts about the intervention. But the special-protection rationale imputes to women a psychological vulnerability that lacks evidentiary support. Moreover, the special-protection rationale is sometimes invoked to support measures that diminish, rather than enhance, women's ability to make informed choices about abortion. Indeed, in *Gonzales*, the special-protection rationale became the basis for denying women the opportunity to choose an abortion procedure altogether.<sup>4</sup>

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<sup>1</sup> *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007).

<sup>2</sup> Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531 (Supp. IV 2006)).

<sup>3</sup> See *infra* Parts II, III.

<sup>4</sup> See *infra* text accompanying notes 10–13.

I conclude here that certain distinct informed consent requirements for abortion may be defensible because potential human life is involved, but I reject the claim that women considering abortion are in need of greater protection than are patients making other kinds of serious medical decisions.

### I. *The Gonzales Decision*

*Gonzales v. Carhart* was a 5–4 decision. Writing for the Court majority, Justice Kennedy began the opinion by describing different abortion techniques. In the most common second-trimester abortion procedure, dilation and evacuation (“D & E”), the physician dilates the woman’s cervix and removes portions of the fetus from the uterus.<sup>5</sup> The Partial-Birth Abortion Ban Act prohibits a different late-term procedure called intact D & E.<sup>6</sup> To perform this procedure, the physician dilates the woman’s cervix and then attempts to extract the entire fetus.<sup>7</sup> The fetus’s head often lodges in the cervix, and because dilation is insufficient, the physician must usually crush or otherwise destroy the fetus’s head to remove it.<sup>8</sup> According to the law’s supporters, intact D & E entails the killing of a partially delivered living fetus.<sup>9</sup> Numerous physicians and medical organizations think that intact D & E, in certain circumstances, can be the safest abortion technique for pregnant women, but Justice Kennedy noted that there was enough contrary evidence to support a congressional finding that the ban would not jeopardize women’s health.<sup>10</sup>

Among the Court’s reasons for upholding the ban was the State’s concern about the procedure’s impact on women. Justice Kennedy observed that despite “find[ing] no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”<sup>11</sup> Moreover, to reduce women’s anxiety about undergoing intact D & E, “some doctors may prefer not to disclose precise details of the means that will be used.”<sup>12</sup> Justice Kennedy found it

self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow

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<sup>5</sup> *Gonzales*, 127 S. Ct. at 1620–21.

<sup>6</sup> *Id.* at 1621. This procedure is also referred to as dilation and extraction. *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 1622–23.

<sup>9</sup> *See id.* at 1632–33.

<sup>10</sup> *Id.* at 1635–38.

<sup>11</sup> *Id.* at 1634.

<sup>12</sup> *Id.*

more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.<sup>13</sup>

According to Justice Kennedy and the other members of the majority, the government acts constitutionally when it regulates with the aim of protecting inadequately informed women from regretting their decision to undergo intact D & E.<sup>14</sup> Although this problem could be alleviated by a mandatory disclosure requirement, the majority held that Congress could also alleviate the problem by banning intact D & E altogether.<sup>15</sup> It took this position even though Justice Kennedy admitted that physicians might refrain from disclosing detailed information in other medical situations because “[a]ny number of patients facing imminent surgical procedures would prefer not to hear all details, lest the usual anxiety preceding invasive medical procedures become the more intense.”<sup>16</sup> For the majority, the possibility that patients lack detailed information about intact D & E justified a completely different response than it would in other medical situations—that is, patients’ lack of detailed information typically motivates mandatory disclosure laws, not outright bans on medical procedures.<sup>17</sup>

In a dissenting opinion joined by three other justices, Justice Ginsburg took issue with the majority’s view of a pregnant woman’s choice to have an intact D & E.<sup>18</sup> Besides calling attention to a lack of reliable evidence that women having abortions experience greater regret than do women continuing unwanted pregnancies,<sup>19</sup> she accused the majority of invoking now-rejected stereotypes about women.<sup>20</sup> If the Court was concerned that women’s choices were inadequately informed, she wrote, it should require doctors to provide more information.<sup>21</sup> In Justice Ginsburg’s view, a woman is entitled to learn about the risks of intact D & E and about its safety relative to other abortion techniques that could be used in her case.<sup>22</sup> But the majority chose

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<sup>13</sup> *Id.*

<sup>14</sup> *See id.*

<sup>15</sup> *See id.*

<sup>16</sup> *Id.*

<sup>17</sup> *See, e.g., infra* note 28 (describing questionable safety of dental fillings containing silver or mercury and noting that some states require disclosure, but no states yet ban the use of such fillings).

<sup>18</sup> *See Gonzales*, 127 S. Ct. at 1640–41 (Ginsburg, J., dissenting).

<sup>19</sup> *Id.* at 1648 & n.7.

<sup>20</sup> *See id.* at 1649.

<sup>21</sup> *Id.* at 1648–49.

<sup>22</sup> *See id.* Justice Ginsburg pointed out that the existence of alternative abortion tech-

instead to “depriv[e] women of the right to make an autonomous choice, even at the expense of their safety.”<sup>23</sup> Justice Ginsburg wrote that the majority’s reasoning “reflect[ed] ancient notions about women’s place in the family and under the Constitution—ideas that have long since been discredited.”<sup>24</sup>

As Professor Sonia Suter notes in this Volume,<sup>25</sup> although Justice Kennedy claims to be concerned about the possibility that women might not be sufficiently informed about intact D & E, “a statute cannot promote informed consent by eliminating any possibility of consent.”<sup>26</sup> Nor does Justice Kennedy’s purported concern about women’s well-being justify the *Gonzales* decision; to the contrary, he and the majority uphold a ban that “removes the possibility of a procedure that many respectable medical groups believe is medically necessary for some women.”<sup>27</sup>

In the remainder of this Article, I examine how the Supreme Court and legislative bodies justify abortion restrictions in the name of protecting women’s interests in making informed choices about the procedure. In some instances, I contend, the restrictions have little to do with protecting women’s interests and are instead guided by the view that abortion is an immoral choice for women.

## II. Informed Consent to Medical Interventions

Abortion is one of the few medical procedures governed by specific statutory informed consent requirements.<sup>28</sup> The general doctrine

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niques effectively means that the Partial-Birth Abortion Ban Act “saves not a single fetus from destruction.” *Id.* at 1647.

<sup>23</sup> *Id.* at 1649.

<sup>24</sup> *Id.*

<sup>25</sup> Sonia Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514 (2008).

<sup>26</sup> *Id.* at 1579.

<sup>27</sup> *Id.* at 1579.

<sup>28</sup> A few federal and state statutes address mandatory disclosure in other medical situations. The Patient Self-Determination Act, for example, requires that patients be informed of their rights under state law to make medical treatment decisions and to make advance directives. 42 U.S.C. § 1395cc(f)(1) (2000). There is also a federal law—designed to prevent hospitals from transferring unstable patients for financial reasons—that requires hospitals to inform patients of the risk of transfer and secure their agreement to a transfer. *Id.* § 1395dd(c)(1)(A)(i). Various states, too, have laws requiring physicians to disclose specific risks in certain treatment contexts. BARRY R. FURROW ET AL., *HEALTH LAW* 336–37 (2d ed. 2000). The state statutory requirements generally fit the common-law model of informed consent in that they mandate disclosure of known risks. *See id.* at 336.

Professor Robert Post discusses an interesting example of state-imposed disclosure require-

of informed consent developed as a matter of common law, with courts emphasizing the individual's right to control what happens to her body and to be protected from unwanted physical intrusions.<sup>29</sup> To preserve these individual interests, the law requires physicians proposing a medical intervention to give patients certain facts about the intervention. The rationale is that individuals cannot give a valid consent without understanding the potential health consequences of their choices.<sup>30</sup>

Although courts initially demanded that physicians disclose only basic information about a proposed medical intervention, over time the requirements became more extensive.<sup>31</sup> Today, courts generally require physicians to tell patients about their diagnosis, the nature of the proposed intervention, its risks and expected benefits, and any acceptable alternatives to the proposed intervention, as well as the risks and expected benefits associated with those alternatives.<sup>32</sup> In some jurisdictions, courts require physicians to disclose what a *reasonable physician would disclose* in similar circumstances; in other jurisdictions, physicians must disclose what a *reasonable patient* in similar circumstances *would want to know*.<sup>33</sup> Under both standards, the facts to be disclosed are based on existing medical knowledge about particular risks, success rates, and acceptable alternatives.<sup>34</sup>

A 2007 New Jersey Supreme Court case illustrates how the common-law doctrine of informed consent applies to abortion. In *Acuna v. Turkish*,<sup>35</sup> a woman who had undergone an abortion brought a mal-

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ments that, in some ways, parallels the abortion situation. See Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 982–83, 987–88. There is a debate over the safety of so-called dental amalgams: dental fillings that contain silver and mercury. *Id.* at 947, 987. Although expert opinion appears to be divided on whether dental amalgams present a material risk to patients, *id.* at 987, three states have passed statutes requiring dentists to distribute information describing the safety of different materials that they can use to fill cavities and deliver other restorative treatments. *Id.* at 982–83 nn.197–99 (Maine, New Hampshire, and California). There are also differences, however, between the disclosure requirements in the abortion and amalgam situations. See *infra* note 127.

<sup>29</sup> FURROW ET AL., *supra* note 28, at 315.

<sup>30</sup> See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 77–78 (5th ed. 2001) (noting that consent requirements reduce risk and avoid exploitation and unfairness).

<sup>31</sup> See *id.* at 81 (describing professionals' obligations to disclose a "core set of information" but highlighting one instance where the California Supreme Court required a physician to disclose any personal interests that may have affected the physician's judgment).

<sup>32</sup> See JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 53–61 (2d ed. 2001).

<sup>33</sup> FURROW ET AL., *supra* note 28, at 318–19.

<sup>34</sup> *Id.* (explaining the need for expert medical testimony under both standards).

<sup>35</sup> *Acuna v. Turkish*, 930 A.2d 416, 418 (N.J. 2007).

practice suit against the physician who performed the procedure. The plaintiff claimed that she had not given informed consent to the abortion because the physician failed to disclose “the scientific and medical fact” that an embryo estimated to be between six and eight weeks’ gestational age “was a complete, separate, unique and irreplaceable human being,” and that abortion involves “killing an existing human being.”<sup>36</sup>

In reinstating the trial court’s dismissal of the case, the New Jersey Supreme Court linked the informed consent doctrine to the “patient’s right of self-determination, the right to intelligently decide whether to choose or decline a particular medical procedure.”<sup>37</sup> According to the court, the doctrine imposes on physicians a duty to provide pregnant women seeking abortion “*only* with material medical information, including gestational stage and medical risks involved in the procedure.”<sup>38</sup> Because the doctrine fails to support a requirement for physicians to convey “moral, philosophical, and religious beliefs,” the court rejected the plaintiff’s claim.<sup>39</sup> Moreover, the court refused to create a new duty to disclose such beliefs, given that “[t]here is not even remotely a consensus among New Jersey’s medical community or citizenry that plaintiff’s assertions are medical facts.”<sup>40</sup>

*Acuna* relies on two background constraints shaping common-law informed consent mandates. First, the common-law approach requires physicians to disclose medical information, not ethical and religious perspectives that might affect a patient’s choice. The latter perspectives are considered to be values and preferences that the individual brings to the medical encounter, rather than information that falls within the physician’s area of expertise. Second, the common-law doctrine requires disclosure of facts accepted by a reasonable portion of the medical community. The law governing abortion disclosure requirements at times ignores these constraints, however.

### III. *Informed Consent in Abortion Law*

Abortion is morally and politically controversial, so it is not surprising that the woman’s decisionmaking process has come under legislative scrutiny. Many members of Congress and state legislatures oppose abortion and enact measures to restrict it. These measures

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<sup>36</sup> *Id.* at 418.

<sup>37</sup> *Id.* at 424–25.

<sup>38</sup> *Id.* at 428.

<sup>39</sup> *Id.* at 418.

<sup>40</sup> *Id.*

often come in the form of rules governing the information women receive before deciding whether to have an abortion. The Supreme Court initially rejected mandatory disclosure laws that failed to conform to the traditional informed consent doctrine, but more recently has been willing to uphold such rules.

A. *From Thornburgh to Casey*

In a departure from the general requirements governing informed consent to medical interventions, states often impose distinct requirements for informed consent to abortion. Since *Roe v. Wade*<sup>41</sup> was decided in 1973, state legislatures have enacted statutes purportedly aimed at informing women's choices about abortion.<sup>42</sup> During the 1970s and 1980s, federal courts found many of these laws unconstitutional.<sup>43</sup>

In *Thornburgh v. American College of Obstetricians and Gynecologists*,<sup>44</sup> for example, the Supreme Court struck down a Pennsylvania law that required physicians to give all women considering abortion printed information that covered not only the health risks of abortion and pregnancy, but also the physician's name, the "fact that there may be detrimental physical and psychological effects which are not accurately foreseeable," and the estimated gestational age of the fetus.<sup>45</sup> The law required as well that women be informed of the possibility that they could obtain funding to cover the medical costs of continuing the pregnancy and financial support from the father if they decided to keep the child.<sup>46</sup> Finally, the law required that women be informed that Pennsylvania printed and could supply additional materials for their review—materials that included a detailed description of the "characteristics of the unborn child at two-week gestational increments from fertilization to full term"<sup>47</sup> and programs to assist single mothers and women placing children for adoption.<sup>48</sup>

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<sup>41</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>42</sup> Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 6–7 (2008) (noting that as of February 2008, thirty-three states had passed informed consent laws).

<sup>43</sup> *See id.* at 2–3.

<sup>44</sup> *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

<sup>45</sup> *Id.* at 760, 772.

<sup>46</sup> *Id.* at 760–61.

<sup>47</sup> *Id.* at 761.

<sup>48</sup> *See id.*

In *Thornburgh*, the Supreme Court held that Pennsylvania's informational requirements were facially unconstitutional.<sup>49</sup> The Court rejected Pennsylvania's claim that the mandatory information was designed to ensure that women made informed decisions about abortion.<sup>50</sup> The Court suggested that the law's approach was inconsistent with the general aims of informed consent to medical treatment.<sup>51</sup> Instead of a means of delivering relevant health information, the mandatory printed materials were "nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician."<sup>52</sup> According to the Court, the fetal-description requirements were inflammatory and punitive, not informative.<sup>53</sup> The mandate to distribute the printed material would also force physicians to give patients information that might be "irrelevant and inappropriate;" for example, it "may be cruel as well as destructive of the physician-patient relationship" to make a woman seeking an abortion either in a life-threatening situation or where her pregnancy has resulted from rape learn about the father's child support obligation and assistance available to her if she continues her pregnancy.<sup>54</sup>

*Thornburgh* found fault as well with the requirement to tell women about every risk associated with the abortion procedure they were considering, including possible but unforeseeable harms from abortion.<sup>55</sup> According to the Court, "[t]his type of compelled information is the antithesis of informed consent. That the Commonwealth does not, and surely would not, compel similar disclosure of every possible peril of necessary surgery or of simple vaccination, reveals the antiabortion character of the statute and its real purpose."<sup>56</sup>

In *Thornburgh* and other cases, federal courts limited the states' ability to deviate from the traditional doctrine of informed consent in mandatory disclosure laws governing abortion.<sup>57</sup> The courts generally required states to follow the common-law model of informed consent, in which physicians were expected to disclose to individual patients

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<sup>49</sup> *Id.* at 764.

<sup>50</sup> *Id.* at 760.

<sup>51</sup> *See id.* at 764.

<sup>52</sup> *Id.* at 762.

<sup>53</sup> *Id.* at 762 & n.10.

<sup>54</sup> *Id.* at 763.

<sup>55</sup> *Id.* at 764.

<sup>56</sup> *Id.*

<sup>57</sup> *See* Blumenthal, *supra* note 42, at 2 n.6 (reviewing cases).



medical facts relevant to the interventions they were considering.<sup>58</sup> Until the early 1990s, courts held that state laws requiring doctors to distribute information aimed at discouraging women from choosing abortion were unacceptable attempts to interfere with women's freedom of choice.<sup>59</sup>

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,<sup>60</sup> however, the Supreme Court changed course. *Casey* adopted a much more lenient approach to state laws governing informed consent in abortion procedures. According to *Casey*, pregnant women have a constitutional right to choose abortion before the fetus is viable, and the State may not impose an undue burden on a woman's exercise of that right.<sup>61</sup> At the same time, *Casey* recognized the government's legitimate interest in promoting respect for human life from the beginning of pregnancy.<sup>62</sup> This government interest, the Court wrote, could justify abortion restrictions having an "incidental effect of making it more difficult or more expensive to procure an abortion."<sup>63</sup>

In *Casey*, the Court considered a Pennsylvania law that included informed consent requirements substantially similar to those that were rejected in *Thornburgh*.<sup>64</sup> But this time, the Court upheld the requirements. According to *Casey*, it was permissible for states to incorporate into their mandatory disclosure literature material that "expresses a preference for childbirth over abortion."<sup>65</sup> The Court held that such an approach failed to present a substantial obstacle to women seeking an abortion and thus did not violate the undue burden standard.<sup>66</sup>

According to *Casey*, Pennsylvania's mandatory disclosure law would ensure that a woman's choice to have an abortion was "mature and informed."<sup>67</sup> From the Court's perspective, Pennsylvania's disclosure requirements advanced two substantial government interests: the protection of (1) potential human life, and (2) the pregnant woman's health, specifically, her psychological well-being.<sup>68</sup>

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<sup>58</sup> See FURROW ET AL., *supra* note 28, at 319–36 (discussing factors to be disclosed).

<sup>59</sup> See Blumenthal, *supra* note 42, at 3–4.

<sup>60</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

<sup>61</sup> *Id.* at 846, 874.

<sup>62</sup> *Id.* at 870–71.

<sup>63</sup> *Id.* at 874.

<sup>64</sup> See *id.* at 881–87.

<sup>65</sup> *Id.* at 883.

<sup>66</sup> *Id.* at 887.

<sup>67</sup> *Id.* at 883.

<sup>68</sup> *Id.* at 882.

In *Casey*, the Court explicitly overruled *Thornburgh* and similar decisions that had labeled unconstitutional state mandates for physicians to supply “truthful, nonmisleading information” about the abortion procedure.<sup>69</sup> According to *Casey*, it was permissible to require physicians to notify the pregnant woman of the fetus’s estimated gestational age and “the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term.”<sup>70</sup> The Court indicated that it was also permissible for the State to require doctors to provide information about how abortion would affect the fetus, even though that information was not directly relevant to the woman’s health.<sup>71</sup> Finally, the Court pointed out that in contrast to the Pennsylvania law invalidated in *Thornburgh*, this one had an exception for physicians who “reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient.”<sup>72</sup> For all of these reasons, the Court concluded, Pennsylvania’s mandatory consent requirement was “a reasonable measure to ensure an informed choice,” even though it “might cause the woman to choose childbirth over abortion.”<sup>73</sup>

In linking Pennsylvania’s mandatory disclosure requirements to the pregnant woman’s health, *Casey* also referred to a woman’s potential regret: “In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.”<sup>74</sup> This language resembles Justice Kennedy’s comments in *Gonzales v. Carhart* about women undergoing intact D & E.<sup>75</sup> The concern about potential regret, however, led to different outcomes in the two cases. In *Casey*, the woman’s potential regret justified making available to her supplementary informa-

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<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 882–83.

<sup>71</sup> *Id.* at 882. To support this point, the Court noted that it would be constitutional for a state to require physicians to give kidney transplant recipients information about risks to the donor, as well as risks to the recipient. *Id.* at 882–83.

<sup>72</sup> *See id.* at 883–84.

<sup>73</sup> *Id.* at 883. At the same time, the Court wrote that “the means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it.” *Id.* at 877.

<sup>74</sup> *Id.* at 882.

<sup>75</sup> *See Gonzales v. Carhart*, 127 S. Ct. 1610, 1634 (2007).

tion about abortion and her other options, but in *Gonzales*, it justified removing the abortion choice altogether.<sup>76</sup>

### B. Current State Legislation

After *Casey* affirmed that states could require physicians to supply pregnant women with material designed to discourage abortion as a means of ensuring that women's choices were "mature and informed," state legislatures moved to do just that. According to Professor Jeremy Blumenthal, twenty-nine states now have informed consent mandates that can be reasonably interpreted as designed to discourage women from having an abortion.<sup>77</sup> A 2007 analysis by the Guttmacher Institute found that twenty-three states had passed abortion disclosure laws requiring physicians to convey information not ordinarily covered by the informed consent doctrine.<sup>78</sup>

To advance their objective of expressing a preference for childbirth over abortion, some states mandate disclosure of abortion information not ordinarily required by the informed consent doctrine; this information can be grouped into three categories: (1) risk information that is unsupported by medical evidence, (2) graphic material about the fetus, and (3) information regarding assistance to women deciding whether to continue their pregnancies.

The first category, risk information that is unsupported by medical evidence, departs from the traditional approach to informed consent by mandating the disclosure of risk statements that conflict with accepted medical knowledge. For example, some states require clinicians to warn women that abortion is linked to an increased risk of breast cancer—a claim that has been rejected by medical authorities.<sup>79</sup>

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<sup>76</sup> For a discussion of the Supreme Court's regulation-to-promote-choice approach and its relationship to the disability rights critique of selective abortion to avoid the birth of disabled children, see Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 HARV. J.L. & GENDER 425, 427, 441–44 (2006). By conceptualizing mandatory disclosure as a necessary counterweight to the financial as well as societal pressures facing women—such as, for example, the burden of unwanted pregnancy or the stigma of unwed motherhood—Bagenstos suggests that the Supreme Court has opened the door to more drastic abortion restrictions that the state characterizes as necessary "to remove private or societal threats to free choice." See *id.* at 449.

<sup>77</sup> Blumenthal, *supra* note 42, at 7.

<sup>78</sup> Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL'Y REV., Fall 2007, at 6, 7–8.

<sup>79</sup> See *id.* at 11 (reporting that both the National Cancer Institute and a panel convened by the British government concluded that having an abortion is not correlated with an increased risk of breast cancer, but noting that six states require disclosure to women seeking an abortion that the data linking abortion to breast cancer are inconclusive and that a link may exist); Alexi A. Wright & Ingrid T. Katz, *Roe Versus Reality—Abortion and Women's Health*, 355 NEW ENG. J. MED. 1, 3 (2006); Collaborative Group on Hormonal Factors in Breast Cancer, *Breast Cancer*

Some states also require clinicians to tell women about possible or unforeseeable psychological harms associated with abortion.<sup>80</sup> Such harms, often referred to as postabortion syndrome, are based primarily on anecdotal reports collected by pro-life individuals and organizations.<sup>81</sup> Mainstream medical groups and empirical studies find little evidence to support claims related to this syndrome.<sup>82</sup>

The second category of information in mandatory disclosure laws is graphic material about the fetus. Like Pennsylvania, many states require clinicians to tell the pregnant woman the estimated gestational age of the fetus she is carrying.<sup>83</sup> Many also require clinicians to give women printed information about, as well as pictorial images of, fetal development.<sup>84</sup> Others require that such information at least be offered to women.<sup>85</sup> As Blumenthal observes, Utah delivers this information in an especially vivid way.<sup>86</sup> In Utah, women must be given printed material and an informational videotape that, among other things, describes “the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, accompanied by pictures or video segments.”<sup>87</sup> The descriptions include “information about brain and heart function and the presence of external members and internal or-

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*and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83,000 Women with Breast Cancer from 16 Countries*, 363 LANCET 1007, 1014 (2004).

<sup>80</sup> Blumenthal, *supra* note 42, at 8–9.

<sup>81</sup> See Post, *supra* note 28, at 961–66.

<sup>82</sup> For example, a prospective cohort study of 13,261 women with unplanned pregnancies found similar total rates of psychiatric disorder among those women who had had an abortion and those who had not. Anne C. Gilchrist et al., *Termination of Pregnancy and Psychiatric Morbidity*, 167 BRIT. J. PSYCHIATRY 243, 248 (1995). For compilations and brief summaries of the literature casting doubt on the existence of postabortion syndrome or the alleged serious psychological risks of abortion, see *Gonzales v. Carhart*, 127 S. Ct. 1610, 1648 n.7 (2007) (Ginsburg, J., dissenting); Post, *supra* note 28, at 963 n.111; Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1011 n.92. See also Gold & Nash, *supra* note 78, at 11; Nada L. Stotland, Commentary, *The Myth of the Abortion Trauma Syndrome*, 268 J. AM. MED. ASS’N 2078, 2079 (1992). But see Blumenthal, *supra* note 42, at 10–11 nn.53–56 (citing studies indicating that selected groups of women are at greater risk of developing psychological disorders after abortion than the overall group of women undergoing abortion). The studies that Blumenthal cites could support a requirement to inform women of this specific finding, but not a requirement to inform them that women undergoing abortions are, as a general matter, at greater risk of experiencing psychological problems than women who do not have abortions.

<sup>83</sup> Blumenthal, *supra* note 42, at 7 & n.32 (compiling state statutes).

<sup>84</sup> *Id.* at 7–8.

<sup>85</sup> *Id.* at 8 n.33.

<sup>86</sup> See *id.* at 8.

<sup>87</sup> UTAH CODE ANN. § 76-7-305.5(1)(b) (2003 & Supp. 2007).

gans” during the relevant developmental stage.<sup>88</sup> The videotape must also “show an ultrasound of the heart beat of an unborn child” at various gestational ages.<sup>89</sup> In imposing these requirements, states are responding to the Court’s observation in *Casey* that “most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision.”<sup>90</sup>

The third category of state-mandated information concerns assistance to women deciding whether to continue their pregnancies. Many states require clinicians to tell women about medical and financial benefits available to them if they decide against the abortion they had been considering.<sup>91</sup> These measures are designed to affect the woman’s evaluation of the risks and benefits accompanying her medical options. By ensuring that women are aware of programs to reduce the burdens associated with single motherhood and adoption, states seek to make the choice of continued pregnancy more appealing.<sup>92</sup>

In 2005, the South Dakota legislature enacted an informed consent law that represents the strongest state effort to date to use informational materials to discourage the abortion choice.<sup>93</sup> To promote

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<sup>88</sup> *Id.* A physician is excused from providing this, or any other information mandated by section 76-7-305(2) of the Utah Code, if the pregnancy was due to rape or incest, if it threatens the woman’s life, if the woman is fourteen years of age or younger, if the abortion is being done to prevent the birth of a child with “grave defects,” or if the physician “reasonably believed” that the information would have a “severely adverse effect” on the pregnant woman’s mental or physical health. *Id.* § 76-7-305(7).

<sup>89</sup> *Id.* § 76-7-305.5(4). Utah also requires that each pregnant woman be told that “she has the right to view an ultrasound of the unborn child, at no expense to her.” *Id.* § 76-7-305(2)(b)(v). Other states mandate information about ultrasound as well, in what two authors characterize as “another way to attempt to personify the fetus.” Gold & Nash, *supra* note 78, at 10.

<sup>90</sup> See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

<sup>91</sup> See Gold & Nash, *supra* note 78, at 9 tbl. cols.12 & 16.

<sup>92</sup> For a description of other information mandated by abortion-specific informed consent laws, see Gold & Nash, *supra* note 78, at 7–12.

<sup>93</sup> See S.D. CODIFIED LAWS § 34-23A-10.1 (Supp. 2007). The law reflects the findings of the South Dakota Task Force to Study Abortion. See REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 38–40 (2005), available at [http://www.voteyesforlife.com/docs/Task\\_Force\\_Report.pdf](http://www.voteyesforlife.com/docs/Task_Force_Report.pdf) (concluding that “the deliberate avoidance of a candid understandable disclosure that the child already exists and that the procedure will terminate the child’s life, precludes an informed decision with regard to the woman’s right to a relationship with her child”). The Task Force’s Report presents a drastically different picture of abortion’s effects on women than that found in mainstream medical publications. See Post, *supra* note 28, at 962–64, 962 n.110, 963 n.111; Siegel, *supra* note 82, at 1011 & n.92. Indeed, the Chairperson of the South Dakota Task Force to Study Abortion criticized the report, subsequently writing that it was “not based on sound scientific research” and contained “misleading, and in some areas, completely false information.” Marty L. Allison, S.D. Campaign for Healthy Families, South Dakota Medicine: My View (July 2006), <http://www.sdhealthyfamilies.org/statementma101606.php>.

voluntary and informed consent to abortion, South Dakota directs physicians to give women a written statement asserting that “the abortion will terminate the life of a whole, separate, unique, living human being.”<sup>94</sup> This statement, according to the law, shall also claim that “the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota.”<sup>95</sup> The statement asserts as well that “her existing relationship and her existing constitutional rights with regards to that relationship will be terminated” if she has an abortion.<sup>96</sup> The mandatory statement also describes “statistically significant risk factors to which the pregnant woman [choosing abortion] would be subjected,” including depression, “related psychological distress,” and an “increased risk of suicide ideation and suicide.”<sup>97</sup> Women must verify in writing that they understand this material, and physicians also must certify that their patients understand it.<sup>98</sup>

The courts are now considering whether South Dakota’s mandatory disclosure law meets *Casey*’s demand for “truthful, non-misleading information.”<sup>99</sup> In 2005, a federal district court issued a preliminary injunction preventing the law from going into effect, after determining that those challenging the law’s constitutionality had a

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<sup>94</sup> § 34-23A-10.1(1)(b). This assertion is similar to the statements that the New Jersey Supreme Court excluded from the common-law disclosure duty. *See* text accompanying notes 35–40. The fetus belongs to the human species as a scientific matter, but as Post observes, the pregnant woman is likely to think that the statement means that by undergoing an abortion “she is ending the life of a member of the human community who otherwise deserves life.” Post, *supra* note 28, at 958. Moreover, the fetus is not separate from the pregnant woman in a physical sense; if it were, the moral conflict between preserving potential life and the woman’s bodily integrity would not exist. *See id.* at 959 & n.101.

<sup>95</sup> § 34-23A-10.1(1)(c).

<sup>96</sup> § 34-23A-10.1(1)(d). As Post observes, the claims about rights protected by the U.S. Constitution are “arguably false.” Post, *supra* note 28, at 960 n.104.

<sup>97</sup> § 34-23A-10.1(1)(e).

<sup>98</sup> § 34-23A-10.1(1), (2). Unlike the Pennsylvania law that *Casey* upheld, the South Dakota law fails to give physicians discretion to refrain from disclosing information that could adversely affect patients, as might occur if women having abortions to avoid serious health threats were forced to listen to or read information about financial assistance available to women continuing their pregnancies.

<sup>99</sup> Soon after *Casey* was decided, Professor Martha Field, questioning where the outer boundaries of *Casey*’s “undue burden” or “undue interference” backstops might lie, anticipated a related set of questions about mandatory disclosure: “At what point do attempts to persuade become obstacles? Could the legislature require that a woman seeking an abortion be told that the state considers abortion to be morally wrong, that the woman should be ashamed of herself, and that abortion is the moral equivalent of murder?” Martha A. Field, *Abortion Law Today*, 14 J. LEGAL MED. 3, 15 (1993).

fair chance of prevailing on the merits.<sup>100</sup> The court found that South Dakota's mandate went "much further than the informed consent statute upheld in *Casey*," for it compelled physicians "to enunciate the State's viewpoint on an unsettled medical, philosophical, theological, and scientific issue, that is, whether a fetus is a human being."<sup>101</sup> Because the law lacked a provision permitting physicians to disagree with the required statements, the court also found that the statements given to women seeking an abortion were "unconstitutional compelled speech, rather than reasonable regulations of the medical profession."<sup>102</sup>

In affirming this decision, a divided three-judge panel of the United States Court of Appeals for the Eighth Circuit cited another possible constitutional defect in the legislation. This court was skeptical of the claim that the law seeks to ensure that women make thoughtful decisions about abortion:

Forcing [a woman] not only to read, but to sign each page of a statement containing the state's moral and philosophical objections to the procedure she has planned and intends to undergo, and forcing her doctor to certify that she "understands" these objections, does little to promote independent decision making and may actually exacerbate any adverse psychological consequences of the procedure.<sup>103</sup>

The court noted that there was a good possibility that South Dakota's requirements were sufficiently onerous to qualify as an impermissible obstacle to the woman's exercise of her right to choose an abortion.<sup>104</sup>

In June 2008, however, the full appeals court reversed the earlier court decisions. By a 7–4 vote, the court vacated the preliminary injunction preventing the law from going into effect.<sup>105</sup> The court majority held that the district court applied too lenient a standard in determining that those challenging the law had a sufficient chance of prevailing on the merits. Before blocking enforcement of a "duly enacted state statute," such as South Dakota's informed consent law,

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<sup>100</sup> *Planned Parenthood of Minn. v. Rounds*, 375 F. Supp. 2d 881, 887–88 (D.S.D. 2005), *vacated en banc*, No. 05-3093, 2008 U.S. App. LEXIS 13564 (8th Cir. June 27, 2008).

<sup>101</sup> *Id.* at 886–87.

<sup>102</sup> *Id.* at 887; *see also* Post, *supra* note 28, at 952–80 (arguing that the South Dakota law raises First Amendment issues by mandating disclosure of ideological and misleading information).

<sup>103</sup> *Planned Parenthood of Minn. v. Rounds*, 467 F.3d 716, 727 (8th Cir. 2006), *vacated en banc*, No. 05-3093, 2008 U.S. App. LEXIS 13564 (8th Cir. June 27, 2008).

<sup>104</sup> *See id.* at 727.

<sup>105</sup> *See Planned Parenthood Minn., N.D., S.D. v. Rounds*, No. 05-3093, 2008 U.S. App. LEXIS 13564 (8th Cir. June 27, 2008).

courts must find that the challengers are “likely to prevail” on the merits.<sup>106</sup> According to the majority, those challenging the South Dakota law failed to meet that standard.

Citing *Casey* and *Gonzales*, the majority determined that to succeed on the merits, challengers would have to show that South Dakota’s law required disclosure of “untruthful, misleading, or not relevant” information.<sup>107</sup> Like the district court, the majority focused on South Dakota’s requirement to tell women that abortion ends “the life of a whole, separate, unique human being.” In evaluating this requirement, the district court failed to consider a separate statutory provision defining “human being” as “an individual living member of the species *Homo sapiens*, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation.”<sup>108</sup> Taken together, the majority found, the provisions set forth permissible biological information, rather than impermissible ideological information, about the embryo and fetus.

The dissenters not only disagreed with the majority’s application of the standard for preliminary injunctions, but they also disagreed with its claim that the two statutory provisions are free of ideology. In their view, both provisions are “constitutionally flawed,” for they “conflict with the Supreme Court’s admonition that a state may not adopt one theory of the beginning of life.”<sup>109</sup> They also said that the majority erred in failing to consider the constitutionality of other provisions in the law, including the requirement to disclose psychological risks that have not been established. Because these provisions do not qualify as “factually accurate medical information” and instead impose the state’s “substantive value judgments on attending physicians and their patients,” the majority should have affirmed the district court’s injunction order.<sup>110</sup>

In sum, the law’s treatment of informed consent to abortion is unusual, to say the least. Legislatures impose disclosure requirements in the name of promoting women’s understanding of the medical procedure they are considering. Through their mandatory disclosure laws, state legislatures expand the informed consent doctrine to incorporate information that goes beyond what is mandated in other medi-

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<sup>106</sup> *Id.* at \*13.

<sup>107</sup> *Id.* at \*28.

<sup>108</sup> S.D. CODIFIED LAWS § 34-23A-1(4) (Supp. 2007).

<sup>109</sup> *Planned Parenthood Minn., N.D., S.D.*, 2008 U.S. App. LEXIS 13564, at \*60.

<sup>110</sup> *Id.* at \*84. The case was remanded to the district court for further proceedings, which could include additional claims regarding the need for a preliminary injunction. *Id.* at \*39.



cal situations. Some states require that information to be delivered using vivid language and images that are absent from the ordinary consent process. And through its 2005 law, South Dakota is seeking to impose informed consent demands that are even more unconventional, by requiring doctors to give women one position on the moral status of the developing fetus—a position not shared by many people in the United States.<sup>111</sup>

#### IV. *Paternalism in the Guise of Informed Consent to Abortion*

Abortion disclosure laws separate women deciding about abortion from people deciding about other kinds of medical interventions. The Supreme Court now accepts disclosure laws as a legitimate means of discouraging abortion, and states mandate disclosure of information that is foreign to common-law informed consent requirements. *Gonzales v. Carhart* portrays women as unusually fragile and unable to make informed choices about intact D & E. These developments are inconsistent with the values that support the traditional informed consent doctrine.

##### A. *The Evolution of Informed Consent Requirements*

Over time, the Supreme Court has become more receptive to legislative efforts to influence women's choices about abortion. The Court's decision in *Casey* to allow states to incorporate advocacy into the informed consent process coincided with an emerging strategy adopted by the pro-life movement. Professor Reva Siegel describes how groups opposed to abortion rights sought to gain support for their cause by broadening their arguments for abortion restrictions.<sup>112</sup> Instead of presenting the abortion issue as primarily a conflict between the pregnant woman's self-determination interests and the state's interest in protecting developing human life, abortion rights opponents began speaking of abortion as a threat to both women and their potential children.<sup>113</sup> Certain restrictions were justified, they said, by the need to protect women from harmful choices to end their pregnancies.

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<sup>111</sup> See Robert J. Blendon et al., *The Public and the Controversy over Abortion*, 270 J. AM. MED. ASS'N 2871, 2872 (1993) (reviewing more than 100 U.S. public opinion surveys about abortion and reporting that in one survey, about half of the respondents equated the fetus to a person and half did not); cf. BONNIE STEINBOCK, *LIFE BEFORE BIRTH: THE MORAL AND LEGAL STATUS OF EMBRYOS AND FETUSES* 42–88 (1992) (exploring the centrality of “the moral status of the unborn” to the abortion debate).

<sup>112</sup> See Siegel, *supra* note 82, at 1008–09, 1023.

<sup>113</sup> See *id.*

Abortion opponents offered informed consent laws as a safeguard aimed at protecting women.<sup>114</sup>

Certain state legislatures embraced this reasoning.<sup>115</sup> Implicit in many of the state informational requirements is the notion that abortion is a dangerous and morally suspect choice for pregnant women. To keep women from making this choice, legislatures require women to receive graphic material about the fetus as well as about claimed risks to their own health—risks that are unsupported by the weight of medical evidence. With abortion, informed consent has been transformed from a doctrine designed to promote freedom of choice and individual control over one's body to a tool for inducing women to make the choice that the legislature believes would be morally appropriate.

More recently, the woman-protective approach became the basis for another unconventional application of the informed consent doctrine. In *Gonzales v. Carhart*, Justice Kennedy invoked the doctrine to uphold a congressional action that completely eliminates an abortion choice. According to Justice Kennedy, intact D & E is a disturbing medical procedure and it was reasonable for the Court to infer, despite finding “no reliable data to measure the phenomenon,” that “some women come to regret their choice to abort.”<sup>116</sup> He further speculated that women could become even more traumatized if they later discovered what the intact D & E procedure really entails.<sup>117</sup> Women might have chosen the procedure ignorant of its disturbing features, he wrote, because physicians were afraid that their patients would be disturbed by a graphic description like the one included in Justice Kennedy's opinion.<sup>118</sup> In Justice Kennedy's view, the Partial-Birth Abortion Ban Act was an acceptable means to protect some women from the devastating consequences of an inadequately informed choice to have an intact D & E. In other words, because some women might choose to have an intact D & E without being fully informed, and some of those women might later regret their uninformed choice, Congress could deny all women the opportunity to make that choice.

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<sup>114</sup> See *id.* at 1009–11.

<sup>115</sup> See *supra* Part III.B.

<sup>116</sup> *Gonzales v. Carhart*, 127 S. Ct. 1610, 1633–34 (2007).

<sup>117</sup> *Id.* at 1634.

<sup>118</sup> See *id.* In reaching this conclusion, Justice Kennedy either ignored or dismissed as ineffective the numerous state mandatory disclosure laws governing abortion.

In the early years, the Supreme Court insisted that state abortion disclosure laws conform to the general requirements of the common-law informed consent doctrine. *Casey* ushered in the era of the double standard in which states could emphasize risks of and alternatives to abortion as a means of encouraging women to refuse abortion. With *Gonzales v. Carhart* came a double bind<sup>119</sup>: neither the traditional disclosure standard nor a heightened one offered an adequate means of protecting women's interests. Put differently, the Supreme Court has gone from saying that the government may not require, as part of informed consent, information that is designed to discourage the abortion choice,<sup>120</sup> to saying that the government may require such material so that women will make "mature and informed" decisions and will be protected from later regret,<sup>121</sup> to saying that the government may simply eliminate an abortion choice so that women are protected both from the anxiety that adequate information could provoke and from the regret that could come if later they were to learn that information.<sup>122</sup>

#### *B. Specific Deviations from the Informed Consent Doctrine*

Since *Casey* was decided, legislatures have altered the informed consent doctrine to a degree that is unprecedented. Mandatory disclosure laws governing abortion differ from customary disclosure law in three ways. First, the informed consent doctrine does not require graphic language and vivid pictures designed to discourage patients from choosing a medical intervention. Of course, as Justice Kennedy alluded to in *Gonzales*, it is possible to devise upsetting descriptions of many medical procedures.<sup>123</sup> For example, Arthur Frank has compared chemotherapy and intensive care to torture.<sup>124</sup> Tellingly, in one patient's words, "chemo was hell. Chemo was not therapeutic; it produced illness. I hated it. I cried every time I had it . . . ."<sup>125</sup> Another patient wrote,

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<sup>119</sup> A double bind is "[a] situation in which one must choose between equally unsatisfactory alternatives." AMERICAN HERITAGE COLLEGE DICTIONARY 421 (4th ed. 2002).

<sup>120</sup> *E.g.*, *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 762 (1986).

<sup>121</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882–83 (1992).

<sup>122</sup> *See Gonzales*, 127 S. Ct. at 1634.

<sup>123</sup> *See id.*

<sup>124</sup> ARTHUR W. FRANK, *THE WOUNDED STORYTELLER: BODY, ILLNESS, AND ETHICS* 173–74 (1995).

<sup>125</sup> DEBORAH HOBLER KAHANE, *NO LESS A WOMAN: TEN WOMEN SHATTER THE MYTHS ABOUT BREAST CANCER* 122 (1990).

Hair loss is one of the hardest aspects of chemotherapy, most patients agree, and that's because everything else reprises a familiar, if unpleasant, experience. We've all had sore throats; we've all been tired; we've all thrown up before. But in the natural universe, hair generally doesn't fall out with a sudden, horrifying thud of force. Chemo's hailstorm of hair appears to signal the body that it's in grave danger; the body, in turn, panics . . . and provokes a kind of flight-or-fight response in the psyche.<sup>126</sup>

One could come up with even more terrifying material about chemotherapy and many other medical interventions. But is this the sort of material that physicians must give patients to secure their informed consent? And should the law governing informed consent require doctors to warn patients of risks by showing them pictures or videotapes of people experiencing the pain and distress that accompany so many medical interventions?

Second, the informed consent doctrine does not require physicians to warn patients of health risks that the expert medical community fails to recognize. Yet again, it is possible to collect anecdotal accounts of risks presented by other medical interventions, but at common law, such outliers need not have been disclosed.<sup>127</sup> In contemporary medicine, individual reports of problems that could be linked to medical interventions are insufficient to establish a causal link. Relevant here, medical problems like depression, suicidal idea-

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<sup>126</sup> KATHERINE RUSSELL RICH, *THE RED DEVIL: A MEMOIR ABOUT BEATING THE ODDS* 203–04 (1999).

<sup>127</sup> Cf. *Moore v. Baker*, 989 F.2d 1129, 1133 (11th Cir. 1993) (state law did not compel physician to disclose alternative therapy to carotid endarterectomy in treating coronary blockages where mainstream medical community rejected alternative therapy). In a departure from this rule, one court has interpreted the common-law informed consent doctrine to support a duty to disclose a physician's HIV status, despite evidence suggesting that the risk of transmitting the virus from doctor to patient is remote. *FURROW ET AL.*, *supra* note 28, at 326–27 (discussing *Estate of Behringer v. Med. Ctr. at Princeton*, 592 A.2d 1251, 1283 (N.J. Super. Ct. Law Div. 1991)). This decision has been criticized as inconsistent with the usual evidentiary standards governing risk disclosure. Cf. *FURROW ET AL.*, *supra* note 28, at 327 (questioning whether *Behringer* will be interpreted to stand for the proposition that, contrary to current disclosure requirements, physicians will be required to disclose all conditions possibly affecting their performance, including alcoholism, depression, and anger).

With regard to dental amalgams—another intervention that has been the focus of state legislation on informed consent—Post argues that the information disclosure controversy reflects a division of expert opinion. The controversial laws on amalgams require physicians to disclose risks that some disinterested experts believe are present, while other experts disagree. Post contrasts this situation with South Dakota's statute mandating disclosure of information about postabortion syndrome—a condition that is not recognized by any disinterested medical experts. See Post, *supra* note 28, at 988 & n.210.

tion, and breast cancer are experienced by many women who have not had abortions. To establish that abortion *does* present a risk of such problems, research must indicate that there is a greater incidence of, for example, depression, suicidal ideation, and breast cancer among women having abortions than among women in the general population. Existing data fail to demonstrate any such findings.<sup>128</sup>

Third, the informed consent doctrine does not require physicians to give patients selective information about the moral dimensions of a medical choice.<sup>129</sup> But other medical situations have moral dimensions comparable to those surrounding abortion. For example, some people oppose the removal of life-sustaining treatment from patients in the persistent vegetative state on grounds that this action “will terminate the life of a whole, separate, unique, living human being.”<sup>130</sup> And some people contend that current transplantation policies allow vital organs to be removed from individuals who are not yet deceased.<sup>131</sup> Yet the informed consent doctrine has never been invoked to support a requirement that physicians disclose moral judgments to patients and families making decisions regarding these matters.

Lastly, *Gonzales v. Carhart* takes a step further in treating abortion differently from other medical choices. The informed consent doctrine has never been cited to support a law prohibiting a medically accepted procedure simply because patients may become upset upon hearing what the procedure involves or because they might later regret undergoing it. Yet once again, it would be possible to apply this approach more broadly. The *Gonzales* reasoning about women’s choices to have an intact D & E could cover a variety of medical procedures. If Justice Kennedy is correct that physicians fail to disclose adequate information about other medical procedures in an effort to

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<sup>128</sup> See *supra* notes 79 and 82 and accompanying text (reviewing lack of evidence establishing links). For a similar discussion in the context of breast implants, see Charles Marwick, *Are They Real? IOM Report on Breast Implant Problems*, 281 J. AM. MED. ASS’N 314, 314 (1999) (discussing evidence finding no link between silicone breast implants and serious autoimmune diseases).

<sup>129</sup> See, e.g., *Acuna v. Turkish*, 930 A.2d 416, 427–28 (N.J. 2007) (stating, in the context of abortion, that “the common law doctrine of informed consent requires doctors to provide their pregnant patients seeking an abortion *only* with material medical information”).

<sup>130</sup> This is the language used in South Dakota’s mandatory disclosure law on abortion. S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (Supp. 2007). This view of incapacitated patients was one basis of the controversy in the *Schiavo* case. See generally Rebecca Dresser, *Schiavo and Contemporary Myths About Dying*, 61 U. MIAMI L. REV. 821, 825–26 (2007) (recounting critics’ view that withdrawal of nutritional support from patient not yet brain dead was unacceptable).

<sup>131</sup> See PRESIDENT’S COUNCIL ON BIOETHICS, *CONTROVERSIES IN THE DETERMINATION OF DEATH* (forthcoming 2008).

reduce patients' anxiety, then perhaps states should mandate heightened disclosure for those procedures, or even prohibit the procedures altogether to prevent patients from making uninformed decisions that they might later regret.<sup>132</sup> But this would be a clear departure from the traditional legal approach to patient choice, supplanting patient autonomy and medical expertise with paternalistic judgments by the state.

*V. Restoring Integrity to Informed Consent in Abortion Law*

In today's health care world, abortion stands apart from other medical choices. By imposing certain restrictions on abortion decisionmaking, lawmakers have compromised the integrity of the informed consent doctrine. Legal decisionmakers adopt restrictions on individual liberty to make a certain medical choice, but portray those restrictions as measures that safeguard the pregnant woman's autonomy and protect her interests.

The claim that patients' interests are advanced by the Partial-Birth Abortion Ban Act and certain requirements imposed by abortion-specific informed consent laws is hard to square with the accepted model of medical decisionmaking. According to this model, people are entitled to make choices about medical interventions after being given a straightforward and dispassionate description of the relevant intervention, its risks and potential benefits, and available alternatives to the intervention. Although it is easy to devise vivid and disturbing accounts of all sorts of medical interventions, no legislature currently mandates that such accounts be disclosed to patients or bans those interventions to protect patients. Likewise, although it is easy to speculate about physical and psychological risks accompanying a variety of medical interventions, there must be a reasonable evidentiary basis for such risks before doctors are required to warn patients about them. Finally, evidence that women making choices about abortion are more fragile psychologically than people making many other kinds of medical decisions is lacking. It is thus difficult to see why the worry about patients' sensibilities merits denying them access to only one of many possibly disturbing medical interventions.

The misuse of the informed consent doctrine in abortion law is open to criticism because it fails to advance the ethical and policy jus-

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<sup>132</sup> For an in-depth analysis questioning the extent to which patients make the informed choices envisioned by the philosophical and legal accounts of patient autonomy, see CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* 92-99 (1998).

tifications for the doctrine. Government interventions targeting the abortion decisionmaking process also raise constitutional issues. *Casey* permits mandatory disclosure requirements that are “truthful and not misleading.”<sup>133</sup> *Casey*’s standard calls into question state mandates to warn women considering abortion about unfounded hazards, such as an increased risk of breast cancer or serious psychological problems. Mandates to deliver such false and misleading information could qualify as unconstitutional burdens on the pregnant woman’s freedom to choose abortion.<sup>134</sup> State mandates that reflect a stereotype of women as more needy and vulnerable than other patients facing serious medical decisions could violate the Equal Protection Clause.<sup>135</sup> And First Amendment questions are raised by laws requiring physicians to (1) warn women about risks not recognized by the medical community or (2) express moral beliefs about abortion that deviate from the physicians’ own views.<sup>136</sup>

At the heart of the Partial-Birth Abortion Ban Act and deviant informed consent requirements for abortion is a legislative judgment that abortion is not a typical medical decision because of its impact on developing human life.<sup>137</sup> Unlike the claim that pregnant women have a special vulnerability when deciding whether to undergo an abortion, this feature of the abortion choice does set it apart from other medical decisions and could justify some alterations of the common-law informed consent requirements.

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<sup>133</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

<sup>134</sup> Blumenthal contends that even truthful state-mandated information about the fetus and women’s health risks “may nevertheless be misleading when it takes advantage of individuals’ likelihood to be inappropriately persuaded by emotional biases.” Blumenthal, *supra* note 42, at 36. He presents empirical findings from psychology studies showing that people are easier to persuade when “in a fearful or anxious emotional state,” and he argues that certain mandatory information about abortion is likely to elevate women’s anxiety and fear, thus making them more susceptible to the state’s preference for childbirth over abortion. *See id.* at 36–38.

<sup>135</sup> *See Siegel, supra* note 82, at 1031–36, 1041; *see also* Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician’s Role in “Private” Reproductive Decisions*, 63 WASH. U. L.Q. 183, 232–34 (1985) (“When the state singles out abortion patients or female birth-control patients for special protection from their physicians by mandating . . . detailed disclosure requirements, the state perpetuates outmoded and pernicious stereotypes of women as indecisive and incompetent health-care consumers, incapable of obtaining necessary information . . . without paternalistic government intervention.”).

<sup>136</sup> *See Post, supra* note 28, at 954–60, 986–89.

<sup>137</sup> *See Gonzales v. Carhart*, 127 S. Ct. 1610, 1632 (2007) (discussing legislative rationale for Partial-Birth Abortion Ban Act). Although, as Justice Ginsburg observes, the Partial-Birth Abortion Ban Act fails to protect developing human life, for it fails to prohibit other methods of performing late-term abortions. *Id.* at 1647 (Ginsburg, J., dissenting).

From this perspective, the special nature of abortion could support state mandates to inform women of the gestational age of the fetus and to distribute accurate factual material about programs offering assistance to women deciding to continue their pregnancies.<sup>138</sup> It would not support, however, requirements to present slanted ideological claims, graphic descriptions and images, or inaccurate medical information about abortion. If the government requires women to receive material about the moral value of developing human life, that material should describe the range of views people have about the topic. If the government requires women to be given specific material describing abortion risks, disclosure should be limited to risks recognized by a reasonable portion of the medical community.

The vision of patient decisionmaking implicit in *Gonzales* and some states' informed consent rules has implications beyond the abortion context. Seemingly, it would be possible for the state to mandate disclosure of unfounded information, unsettling images, and one-sided moral judgments in many medical contexts. It would be possible to protect patients in many situations from disturbing information and decisions they might regret by eliminating their freedom to choose certain medical interventions. But such a vision is antithetical to the doctrine of informed consent and its underlying values. The debate over abortion's legal status should focus on the basic substantive issue: whether the value of developing human life justifies depriving women of the choice to have an abortion. It is disingenuous to portray abortion bans and mandatory disclosures of one-sided and inaccurate information as policies designed to protect women.

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<sup>138</sup> Here, an analogy can be drawn to the choice of physician-assisted suicide. Oregon, under the Oregon Death with Dignity Act, allows certain terminally ill persons to make this choice, *see* OR. REV. STAT. § 127.805(1) (2005), but the state requires physicians to supplement information about diagnosis, prognosis, risks, and alternatives with counseling "about the importance of having another person present when the patient takes the [lethal dose of] medication." *Id.* § 127.815(1)(c), (g). Oregon also requires physicians to ensure that patients realize they may change their minds and to urge patients to notify their next of kin about the request for a lethal dose of medication. *Id.* § 127.815(1)(f), (h). The supplementary informational requirements are a reasonable response to the special nature of this particular medical decision. In contrast, a requirement to disclose speculative, unsupported information about pain or other risks associated with the procedure would not be an appropriate application of the informed consent doctrine.