

ARTICLES

THE ABORTION INFORMED CONSENT DEBATE: MORE LIGHT, LESS HEAT

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One of the most notable developments in American abortion policy is the expansion of state abortion informed consent policies. South Dakota, for example, now requires physicians to state that the abortion will “terminate the life of a whole, separate, unique, living human being.” Oklahoma law prohibits a medical provider from performing an abortion unless she has first performed an ultrasound, “display[ed] the ultrasound images so that the pregnant woman may view them,” and provided a verbal description thereof. Such laws have faced significant criticism from medical ethicists and legal scholars, who argue that the laws are ideologically motivated and fundamentally inconsistent with the doctrine of informed consent.

While recognizing the potentially dubious nature of these new requirements, this Article contends that the current articulation of the argument from informed consent does not serve critics’ purposes as effectively as they might hope. Contrary to popular belief, the doctrine of informed consent provides limited guidance about appropriate procedures in the clinical context—including what information must be disclosed, how it should be disclosed, and the motivations of the discloser. Rather, as this Article demonstrates, informed consent is and has always been a socially constructed doctrine, one highly dependent on implicit value judgments that are just now being made explicit in the context of elective abortion.

By emphasizing a more nuanced understanding of informed consent, this Article aims to defuse and civilize the heated debate surrounding the new breed of abortion disclosure requirements. More

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importantly, it offers critics the opportunity to bolster their challenges to some of the most problematic provisions, such as those requiring disclosure of disputed factual information, those requiring disclosure of non-medically material information in the clinical context, and those requiring patients to view information or images against their will. Finally, it encourages critics to shift their emphasis from informed consent-based arguments towards potentially more persuasive arguments grounded in public policy and constitutional theory.

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INTRODUCTION

Issues surrounding the regulation of abortion are among the most pressing in modern American health care policy. The passage of the Patient Protection and Affordable Care Act (PPACA), for example, was delayed in no small part due to concerns that government funds might be used to pay for elective abortions or that state insurance exchanges might include insurance plans that cover abortions. In this long-standing policy debate, abortion opponents are taking a new approach. At both the state and the federal levels, legislators have proposed bills that impose specific informed consent and disclosure requirements upon medical providers who treat women seeking abortions. South Dakota, for example, now standardizes the informed consent language that physicians must use, requiring disclosure that the abortion will “terminate the life of a whole, separate, unique, living human being.”¹ Oklahoma prohibits a medical provider from performing an abortion unless he has first performed an ultrasound, “display[ed] the ultrasound images so that the pregnant woman may view them,” and provided a verbal description of what the ultrasound depicts.²

In adopting the language of informed consent to support these proposals, legislators face significant criticism from the academic community, which has decried these laws as biased and overtly ideological. Scholars of law, medicine, and ethics argue that the new disclosure requirements are fundamentally inconsistent with the doctrine of informed consent, which obligates physicians to provide patients with sufficient information to make autonomous and educated decisions about their medical care.³ Even some courts have criticized these new laws as vio-

¹ S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (2004); see also *Planned Parenthood v. Rounds*, 650 F. Supp. 2d 972, 976–77 (D.S.D. 2009) *aff’d in part, rev’d in part sub nom. Planned Parenthood v. Rounds*, --- F.3d ---, 2011 WL 3862585 (8th Cir. 2011) (upholding constitutionality of the “relationship disclosure”).

² OKLA. STAT. tit. 63, § 1-738.3d (2004). Enforcement of this law, however, has been temporarily enjoined since May 2010 in connection with a legal challenge by Nova Health Systems. See Tim Talley, *Judge Extends Order Blocking Oklahoma Abortion Law*, ASSOCIATED PRESS, July 20, 2010, <http://www.cnsnews.com/node/69613>.

³ See, e.g., Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599 (2007); Robert M. Godzeno, *The Role of Ultrasound Imaging in Informed Consent Legislation Post-Gonzales v. Carhart*, 27 QUINNIPIAC L. REV. 285, 323 (2009) (describing abortion disclosure laws as “not really informed consent” laws); Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL’Y REV., Fall 2007, at 6–8 (“[T]he use of the informed consent process in this way clearly runs counter to fundamental ethical principles that have long guided the practice of medicine.”); Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 225–26 (2009); Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, 39(5) HASTINGS CTR. REP., Sept.–Oct. 2009, at 21; Chinue Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of States Developed Abortion Counseling Materials*, GUTTMACHER POL’Y REV., Fall

lating traditional theories of informed consent.⁴ In article after article, authors refer to abortion disclosure requirements as “‘informed consent’ laws,” using scare quotes to highlight the apparent contradiction in terms.⁵

Despite the potentially dubious nature of these new laws, arguments from informed consent—at least as they are currently framed—do not provide the most effective challenge to abortion informed consent laws.⁶ This Article demonstrates that the ethical theory of informed consent actually provides very limited guidance about appropriate procedures in the clinical context. In fact, most guidance about how to approach the informed consent process has developed in the context of empirical research and clinical practice. While such sources clearly illustrate the merits of certain disclosure procedures as compared to others, they also reveal the richness and flexibility of both the theory and practice of informed consent, which is rarely reflected in many commentators’ idealized conceptions of informed consent.⁷

Unfortunately, contemporary writers—including legislators—often use the phrase “informed consent” as shorthand for a concept that readers are presumed to, but may not in fact, understand. Not surprisingly, the language of the recent health reforms falls into this trap as well. PPACA does not define informed consent or recognize the flexibility inherent in its application; it references informed consent only once, in a prohibition

2006, at 6; Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351 (2008).

⁴ See *Acuna v. Turkish*, 930 A.2d 416, 423 (N.J. 2007) (holding that physicians have no common law duty to inform women seeking abortions that an embryo is “a complete, separate, unique and irreplaceable human being” and that terminating an early pregnancy involves “actually killing an existing human being”).

⁵ See, e.g., Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 1 (2008) (“I suggest that the sort of emotional information that many states now provide in their ‘informed consent’ statutes can lead to such inappropriate emotional influence and thus should be examined more closely than heretofore.”); Zita Lazzarini, *South Dakota’s Abortion Script—Threatening the Physician-Patient Relationship*, 359 NEW ENG. J. MED. 2189, 2189–90 (2008) (“The ‘informed consent’ law was passed in 2005 [in South Dakota.]”); Manian, *supra* note 3, at 226 (“Abortion law invokes and then misuses ‘informed consent’ terminology.”); Richardson & Nash, *supra* note 3, at 6 (“States have been enacting ‘informed consent’ mandates specific to abortion for decades . . .”).

⁶ In this Article, references to “abortion disclosure laws” and “abortion informed consent laws” are interchangeable. This language was chosen because of its common usage; it is not intended for this phrasing to either validate or disparage these laws. This Article also uses the phrase “the argument from informed consent” to reference the argument that abortion disclosure laws are problematic because they are inconsistent with the doctrine of informed consent.

⁷ For a similar argument in an entirely different legal context (civil procedure), see Scott Dodson, *The Complexity of Jurisdictional Clarity*, 97 VA. L. REV. 1, 3–4 (2011) (“[A]lthough judges and commentators often invoke jurisdictional clarity and appear committed to it, jurisdictional doctrine is . . . neither clear nor simple”).

against promulgation of “any regulation that . . . violates the principles of informed consent and the ethical standards of health care professionals.”⁸ Overly simplified references to informed consent like this only reinforce the erroneous assumption that the medical and legal communities agree on how the physician–patient relationship should be structured.

This Article contends that when viewed as a whole, the doctrine of informed consent does not impose nearly as significant a barrier to abortion disclosure laws as many critics claim. To cite just a few examples, even the ethical theory of informed consent recognizes that physicians may, in some cases, legitimately attempt to persuade their patients to reach one decision rather than another. As a principle of tort law, moreover, informed consent inherently takes into account social values when determining the scope of the information that physicians ought to disclose. Finally, the doctrine of informed consent, as a practical matter, gives physicians broad discretion in determining how to communicate with their patients. In light of these considerations, perhaps the new abortion disclosure laws should be viewed not as anomalies, but rather as explicit manifestations of the sort of value judgments that have long been implicit in the law and doctrine of informed consent.

To be clear, this Article in no way seeks to defend the recent flood of politically-motivated amendments to abortion informed consent laws. It is extremely disconcerting when a state’s ideological messages are permitted to overtake the sphere of physician-patient communication. This is particularly true for both the physician, whose ethical obligation and legal right to voice medical opinions is at issue, and the patient, whose right to reproductive choice is implicated. This Article has an intentionally narrow focus in that it takes aim solely at the current articulation of the argument from informed consent in ethical and legal literature.

By emphasizing a more nuanced understanding of the doctrine of informed consent, this Article aims to defuse and civilize the heated debate that has surrounded this new breed of abortion disclosure requirements. While this approach may not allow for sweeping generalizations about the legitimacy of abortion informed consent laws as a whole, it will help both proponents and critics of such laws strengthen their arguments to more accurately reflect underlying doctrine. In particular, it offers critics of abortion disclosure laws the opportunity to bolster their challenges to some of the most problematic provisions, such as those requiring disclosure of disputed factual information, those requiring physician, rather than state, disclosure of non-medically material information, and those requiring patients to view information or images against their will. Perhaps more importantly, the analysis in this Article may

⁸ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1554, 124 Stat. 119, 259 (2010).

encourage critics of abortion disclosure laws to shift their focus from informed consent-based arguments towards potentially more persuasive arguments grounded in public policy and constitutional theory.

I. ABORTION DISCLOSURE LAWS AND INFORMED CONSENT-BASED OBJECTIONS

As of this writing, abortion-specific informed consent laws—also called “Women’s Right to Know Laws”—have been passed in over thirty states.⁹ Many more have recently been proposed.¹⁰ While details vary, the most controversial provisions relate to required disclosure of specific risk factors, mandatory ultrasounds, and standardized physician scripts. This Section briefly describes these and other provisions commonly found in abortion disclosure laws as well as the most common informed consent-based objections thereto.

A. *Recent Informed Consent Legislation in the Abortion Context*

Informed consent laws targeted specifically at the abortion procedure frequently include some, or all, of the following provisions.

1. Specific Risk Factors

The doctrine of informed consent, as a matter of both medical ethics and common law, requires that a physician disclose the risks associated with a given procedure. Many state legislatures have supplemented this general common law requirement with statutes that require disclosure of the association between abortion and specific risk factors, including the risk of psychological problems and suicide,¹¹ breast cancer,¹² and harm to subsequent pregnancies or future infertility.¹³ At least ten states also

⁹ See Gold & Nash, *supra* note 3 at 8.

¹⁰ See, e.g., Unborn Child Pain Awareness Act of 2010, H.R. 5276, 111th Cong. (2010). See generally *infra* Section I.A.

¹¹ See, e.g., WIS. STAT. ANN. § 253.10 (West 2009); S.D. CODIFIED LAWS § 34-23A-10.3 (2004); S. 793, 95th Gen. Assemb., Reg. Sess. (Mo. 2010). See generally GUTTMACHER INST., *State Policies in Brief: Counseling and Waiting Periods for Abortion* (Aug. 2011), http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (“7 of the 19 states that include information on possible psychological responses to abortion describe only negative emotional responses.”).

¹² See, e.g., MINN. STAT. ANN. § 145.4242 (West 2005); MISS. CODE ANN. § 41-41-33 (2008); TEX. HEALTH & SAFETY CODE ANN. § 171.012 (West 2009); Ind. S.B. 0457 (proposed Jan. 12, 2011). See generally GUTTMACHER INST., *supra* note 11 (“6 of the 7 states that include information on breast cancer inaccurately assert a link between abortion and an increased risk of breast cancer.”).

¹³ See, e.g., TEX. HEALTH & SAFETY CODE § 171.012 (West 2009); MISS. CODE ANN. § 41-41-33 (2008); S.D. CODIFIED LAWS § 34-23A-10.3 (2004); WIS. STAT. ANN. § 253.10 (West 2009); Mo. S. 793. See generally GUTTMACHER INST., *State Policies in Brief*, *supra* note 11.

include information about the gestational age at which fetuses may be able to feel pain.¹⁴

2. Gestational Age and Fetal Development

Most states require, as part of the informed consent process, that the physician disclose the probable gestational age of her fetus to the woman seeking an abortion.¹⁵ Physicians may also be required to describe or provide a state brochure describing the stages of fetal development, including the anatomical and physiological descriptions of the fetus at each stage.¹⁶ As part of this process, some states provide illustrations, photographs, or even videos.¹⁷

3. Ultrasound and Auscultation Requirements

Closely related to laws requiring disclosure of probable gestational age and fetal characteristics are those that prohibit a physician from providing an abortion unless she has first performed an ultrasound.¹⁸ Some require that the physician describe or show the ultrasound image to the

¹⁴ See, e.g., S. 793, 95th Gen. Assemb. (Mo. 2010); ARK. CODE ANN. § 20-16-1104 (2005); GA. CODE ANN. § 31-9A-3 (2000). See generally GUTTMACHER INST., *supra* note 11; Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111 (2008). In a striking development, a number of states have recently passed the Pain-Capable Unborn Child Protection Act, which prohibits abortion after the twentieth or twenty-first week of pregnancy, on the basis of evidence suggesting that fetuses are able to feel pain by that point. See S. 1165, 61st Leg. (Idaho 2011); H.R. 1210, 117th Gen. Assemb. (Ind. 2011) (enacted); H. 2218, Sess. of 2011 (Kan. 2011) (enrolled); Leg. B. 1103, 101st Leg. (Neb. 2010) (enacted); H.R. 1888, 53rd Leg. (Okla. 2011) (enacted).

¹⁵ See, e.g., TEX. HEALTH & SAFETY CODE § 171.012 (West 2009); S. 793, 95th Gen. Assemb. (Mo. 2010). See generally Blumenthal, *supra* note 5, at 6 n.29; GUTTMACHER INST., *supra* note 11 (identifying 32 states with gestational age disclosure requirements).

¹⁶ See, e.g., TEX. HEALTH & SAFETY CODE § 171.016 (West 2009). See generally Blumenthal, *supra* note 5, at 6 n.30.

¹⁷ See, e.g., KY. REV. STAT. ANN. § 311.725 (West 2006) (“The materials shall include, for each of the two (2) of four (4) week increments specified in this paragraph, a pictorial or photographic depiction of the zygote, blastocyte, embryo, or fetus.”); MICH. COMP. LAWS ANN. § 333.17015 (2001) (requiring a “medically accurate depiction, illustration, or photograph and description” of the fetus at each stage of development); UTAH CODE ANN. § 76-7-305.5 (West 2008) (requiring that the Department of Health produce an “informational video”); MO. REV. STAT. § 188.027 (2005) (“The physician who is to perform or induce the abortion . . . [must] present[] the woman, in person, printed materials provided by the department, which describe the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from conception to full term, including color photographs or images of the developing unborn child at two-week gestational increments.”).

¹⁸ See, e.g., AZ. REV. STAT. § 36-2301.02 (LexisNexis 2000) (found unconstitutional in *Tucson Women’s Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004)); LA. REV. STAT. ANN. § 40:1299.35.2 (2008), S. 528, 2010 Reg. Sess. (La. 2010) (enacted); N.D. CENT. CODE § 14-02.1-01 (2009); OKLA. STAT. ANN. § 1-738.3d (2004) (temporarily enjoined in July 2010); H.R. 15, 80th Reg. Sess. (Tex. 2011). In May 2010, the Florida House passed a bill requiring that women have an ultrasound before getting an abortion; the governor, Charlie Crist, vetoed the bill. Bill Kaczor, *Crist Vetoes Florida Abortion Ultrasound Measure*, ASSOCIATED PRESS,

woman.¹⁹ For example, an Oklahoma law, which is currently under judicial review, provides that while a patient is permitted to “avert[] her eyes” or “refuse[] to look” at the ultrasound images, a medical provider will be liable for damages if she does not display the images to the patient.²⁰ Louisiana has a similar provision.²¹ Some states also require physicians to offer women the opportunity for fetal auscultation—that is, listening to the fetus’ heartbeat in utero.²²

4. Standardized Language

South Dakota has taken the lead in crafting standardized informed consent language that physicians must use when consulting with patients who are seeking abortions. In 2005, legislators in South Dakota passed a law requiring physicians to make a “biological disclosure” that “the abortion will terminate the life of a whole, separate, unique, living human being”; a “relationship disclosure” that “the pregnant woman has an existing relationship with that unborn human being”; and a “medical risk disclosure” describing the known medical risks and “statistically significant risk factors” of the abortion procedure, including “increased risk of suicide ideation and suicide,” before providing an abortion.²³ These disclosure requirements were challenged on constitutional grounds, and in 2009, the U.S. District Court for the District of South Dakota upheld

Jun. 11, 2010, http://www.msnbc.msn.com/id/37645422/ns/politics-decision_2010/t/crist-vetoed-fla-abortion-ultrasound-measure/.

The presumed purpose of these requirements is to allow the physician to determine approximate fetal age, which may have an impact on the choice of abortion procedures. See generally Kevin Sack, *In Ultrasound, Abortion Fight Has New Front*, N.Y. TIMES, May 27, 2010, at A1; American College of Obstetricians and Gynecologists (ACOG), *Medical Management of Abortion*, ACOG PRAC. BULL. 67 (Oct. 2005) (noting that prior to abortion, “[g]estational age should be confirmed by clinical evaluation or ultrasound” to determine which abortion procedure is likely to be most effective).

¹⁹ See, e.g., MO. REV. STAT. § 188.027 (2005); S. 793, 95th Gen. Assemb. (Mo. 2010).

²⁰ OKLA. STAT. ANN. tit. 63, § 1-738.3d (2004).

²¹ LA. REV. STAT. ANN. § 40:1299.35.2 (2008); S. 528, Reg. Sess. (La. 2010). According to proponents, “it is strictly optional whether the woman chooses to view the ultrasound, to hear an explanation or to receive a print.” Peter J. Smith, *Louisiana Ultrasound Law Challenged in Federal Court*, LIFESITENEWS, Aug. 9, 2010, <http://www.lifesitenews.com/news/louisiana-ultrasound-law-challenged-in-federal-court>.

²² See MO. REV. STAT. § 188.027 (2005); N.D. CENT. CODE § 14-02.1-04 (2009); S. 793, 95th Gen. Assemb. (Mo. 2010); KAN. STAT. ANN. § 65-6709 (2006); H.R. 15, 80th Reg. Sess. (Tex. 2011) (requiring fetal heart auscultation and simultaneous verbal description thereof). In support of a similar “heartbeat” bill in Ohio, two fetuses “testified” as their mothers were scanned by an ultrasound machine before the Ohio legislature. According to media reports, while one of the fetuses had a clear heartbeat, the other’s was “only faintly audible and hard to distinguish.” Aaron Marshall, *Ultrasound Images of Two Fetuses Shown to Lawmakers During “Heartbeat Bill” Hearing*, CLEV. PLAIN DEALER (Mar. 2, 2011), http://www.cleveland.com/open/index.ssf/2011/03/ultrasound_images_of_two_fetus.html.

²³ S.D. CODIFIED LAWS § 34-23A-10.1(1) (2004).

only the required biological disclosure.²⁴ In its 2011 review of the district court's decision, the Eighth Circuit Court of Appeals also upheld the "relationship disclosure."²⁵ Other states have followed South Dakota's lead: North Dakota law requires that a physician tell her patient, at least twenty-four hours before providing an abortion, that the abortion "will terminate the life of a whole, separate, unique, living human being."²⁶ In 2010, Missouri passed a law requiring abortion providers to present patients with a state brochure that includes the following statement: "The life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being."²⁷

5. Information about Abortion Alternatives

Many states require that physicians who counsel women about abortion also describe the various alternatives to abortion—including childbirth and adoption—and the risks of childbirth and pregnancy.²⁸ Many states also require physicians to provide contact information for crisis pregnancy counseling centers that supply women with additional information about abortion alternatives.²⁹ Recently, South Dakota became the first state to pass legislation requiring women to obtain a consultation at a pregnancy help center before consenting to abortion.³⁰

²⁴ See *Planned Parenthood v. Rounds*, 650 F. Supp. 2d 972, 976–77 (D.S.D. 2009) *aff'd in part, rev'd in part sub nom.* *Planned Parenthood v. Rounds*, --- F.3d ---, 2011 WL 3862585 (8th Cir. 2011). The South Dakota District Court had initially enjoined enforcement of this law, finding that the required disclosures violated physicians' First Amendment rights. An en banc panel of the Eighth Circuit then reversed this decision, remanding the case back to the district court for further deliberations. *Planned Parenthood v. Rounds*, 530 F.3d 724 (8th Cir. 2008). In August of 2009, the district court reconsidered the case in light of the 8th Circuit's decision. Although it upheld the biological disclosure, it held that the relationship and medical risk disclosures were unconstitutional.

²⁵ *Planned Parenthood v. Rounds*, --- F.3d ---, 2011 WL 3862585 (8th Cir. 2011).

²⁶ N.D. CENT. CODE § 14-02.1-02 (2009).

²⁷ MO. REV. STAT. § 188.027 (2005); S. 793, 95th Gen. Assemb. (Mo. 2010).

²⁸ See generally Gold & Nash, *supra* note 3 (discussing state abortion counseling policies). Another scholar has suggested that, as an extension of this policy, physicians who treat pregnant women also ensure that their patients fully explore even the presumably uncontroversial decision to continue with a pregnancy (presumably by mentioning abortion as an alternative). See Sylvia A. Law, *Silent No More: Physicians' Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. REV. L. & SOC. CHANGE 279, 297 (1994).

²⁹ See, e.g., ALA. CODE §26-23A-4(a) (2002). See generally, Gold & Nash, *supra* note 3, at 9, 12.

³⁰ H.J. 1217, 86th Leg. Sess. (S.D. 2011) requires that "prior to the day of any scheduled abortion the pregnant mother must have a consultation at a pregnancy help center at which the pregnancy help center shall inform her about what education, counseling, and other assistance is available to help the pregnant mother keep and care for her child, and have a private interview to discuss her circumstances that may subject her decision to coercion," and that the woman's physician must obtain written confirmation of the woman's consultation prior to signing the consent for the abortion. On June 30, 2011, the United States District Court for the District of South Dakota granted a preliminary injunction against the implementation of this requirement, on the grounds that the plaintiffs had demonstrated a substantial likelihood of

6. Information about Social Support Programs

Most states require that physicians who counsel women seeking abortions provide them with information describing the financial and social support services available to women with children, including medical assistance, Temporary Assistance for Needy Families (TANF), and financial support from the father of the child.³¹ Typically, this information appears in a state-sponsored brochure.³²

7. Mandatory Waiting Periods

Finally, many states require a twenty-four-hour waiting period between the informed consent process and the abortion procedure.³³ Recent legislation in South Dakota extends this period to seventy-two hours.³⁴

B. A Taxonomy of Informed Consent-Based Objections to Abortion Disclosure Laws

Critics have raised a number of objections to the laws described above, and among them raised questions concerning neutrality, factual accuracy, materiality, emotional impact, the likelihood of misleading patients, and discriminatory assumptions about women. What each of these criticisms has in common is the overarching concern that abortion disclosure laws are different in kind from traditional informed consent laws—and, more importantly, that they actually contradict the values underlying the doctrine of informed consent. This Section provides a taxonomy of the most common arguments from informed consent, and forms the foundation for the analysis in Section III.

Generally speaking, there are two categories of informed consent-based objections to abortion disclosure laws. First, many scholars object to the content of the required disclosures. Abortion disclosure laws may be objectionable because of the nature of the information communicated; perhaps some kinds of information simply should not be shared as part of

success on the merits. *Planned Parenthood v. Daugaard*, --- F. Supp. 2d ----, 2011 WL 2582731 (D.S.D. 2011).

³¹ See, e.g., IND. CODE ANN. § 16-34-2-1.1(a)(2) (West 2011); TEX. HEALTH & SAFETY CODE § 171.012 (West 2009); see also Gold & Nash, *supra* note 3, at 9, 12; Dresser, *supra* note 3, at 1611.

³² See Gold & Nash, *supra* note 3 at 9, 12.

³³ See, e.g., ARIZ. REV. STAT. ANN. § 36-2153 (2009); GA. CODE ANN. § 31-9A-3 (2000); KAN. STAT. ANN. § 65-6709 (2009); KY. REV. STAT. ANN. § 311.725 (West 2006); MICH. COMP. LAWS ANN. § 333.17014 (West 2001); MINN. STAT. ANN. § 145.4242 (2005); MISS. CODE ANN. § 41-41-33 (2008); MO. REV. STAT. § 188.039 (2010); N.D. CENT. CODE § 14-02.1-02 (2009); OKLA. STAT. ANN. tit. 63, § 1-738.12 (2004); 18 PA. CONS. STAT. ANN. § 3205 (2010); S.C. CODE ANN. § 44-41-330 (2010); UTAH CODE ANN. 1953 § 76-7-305 (West 2008).

³⁴ H.J. 1217, 86th Reg. Sess. (S.D. 2011).

the informed consent process.³⁵ The second category of objection to abortion disclosure laws is independent of the content of the required disclosure. Critics who take this perspective argue that, regardless of what information the state is asking the physician to disclose, the mere fact of state involvement in the informed consent process is somehow objectionable.³⁶ Most objections are of the former kind.

1. Bias and Lack of Neutrality

The primary objection that commentators have raised about modern abortion informed consent laws is that they are biased towards one outcome. According to critics, proponents of these laws have a pro-life (or anti-choice) agenda, and support disclosure requirements only because they are likely to dissuade women from having abortions.³⁷ With respect to mandatory ultrasound requirements, for example, Carol Sanger writes,

³⁵ For content-based arguments, it may be irrelevant from the patient's perspective whether the physician chooses to communicate the information due to his own personal beliefs, or whether he is forced to communicate this information by state law.

³⁶ Just as the standard of care by which physicians are judged is usually defined by professional custom rather than legislative fiat, critics say the process of informed consent should also be left to medical discretion.

³⁷ See, e.g., Blumenthal, *supra* note 5, at 22 ("There is little question that the goal of many of these informed consent laws is dissuading women from pursuing abortions[.]"); Dresser, *supra* note 3, at 1616 ("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."); Manian, *supra* note 3, at 237 ("Consent to medical treatment means more than mere consent to bodily contact; it means respect for patient capacity for self-determination given accurate, unbiased information."); Richardson & Nash, *supra* note 3, at 6 (noting that abortion disclosure requirements are often "patently inaccurate or incomplete, lending credence to the charge that states' abortion counseling mandates are sometimes intended less to inform women about the abortion procedure than to discourage them from seeking abortions altogether."); Neal Devins, *How Planned Parenthood v. Casey (Pretty Much) Settled the Abortion Wars*, 118 YALE L. REV. 1318, 1341 (2009) ("[M]andatory ultrasound laws seek to 'personify the fetus' and, in so doing, 'dissuade the woman from obtaining an abortion.'"); Reva Siegel, *The New Politics of Abortion: An Quality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, at 1023–29 (2007); Tobin, *supra* note 14, at 148 (suggesting that the legislative history of fetal pain disclosure laws suggests that their aim is to "shock women choosing abortion into abandoning that choice"); Arthur Caplan, *Calling Out All The Hypocrites*, CHI. TRIB., Sept. 6, 2009, http://articles.chicagotribune.com/2009-09-06/news/0909050207_1_abortion-doctors-obama-plan ("It is very clear that the point of [the Oklahoma ultrasound requirement] and similar laws is to discourage women from having abortions. By showing a woman a picture of her fetus and making her listen to a description of what she is looking at, those who oppose abortion hope to discourage women from choosing abortion by making them identify with the fetus they are carrying.").

Some proponents of abortion informed consent law, of course, reject these descriptions. They deny that there is any bias or intent to steer women away from abortion, and focus on the benefits of information to the woman's autonomous decision-making, regardless of what choice she makes. Others acknowledge that their goal is to dissuade women from having abortions; however, they claim that whatever bias exists is necessary to balance out pre-existing pro-abortion bias. See, e.g., Daniel Avila, *The Right to Choose, Neutrality, and Abortion Consent in Massachusetts*, 38 SUFFOLK U. L. REV. 511 (2004).

“[t]he core and motivating belief is that a woman who sees her baby’s image on a screen will be less likely to abort.”³⁸ Another example of bias is the disclosure of risk factors associated with abortion without parallel disclosure of the risk factors associated with childbirth—the natural alternative to abortion.

Such bias is problematic, according to commentators, because both the ethical and legal doctrines of informed consent demand neutrality in the disclosure process.³⁹ The goal of informed consent is to strengthen patient autonomy, and critics of these laws argue that it is impossible to foster autonomy when the information is presented to the patient in a non-neutral way.⁴⁰ If a state or a physician is presenting accurate but biased information, with the intention of persuading the patient to choose one outcome over another, then arguably her decision-making process is not autonomous.

2. Factual Accuracy

Objections about factual accuracy arise in the context of state-mandated disclosure of risk factors supposedly associated with abortion, like the risk of breast cancer, infertility, and suicide as well as disclosure of factual information about the fetus’ capacity to feel pain. Many researchers and even some courts⁴¹ assert that such disclosures are simply incorrect—that there is, in fact, no statistically significant correlation between abortion and the various risk factors identified by statute.⁴²

³⁸ Sanger, *supra* note 3, at 397 (“[U]ltrasound images of one’s own fetus are not intended as neutral information. State legislatures are in agreement on this point; this is why the statutes are enacted.”).

³⁹ *See, e.g.*, Richardson & Nash, *supra* note 3 (“Informed consent [is] the concept that individuals have a right to receive relevant, accurate, and unbiased information prior to receiving medical care so they can make sound decisions regarding treatment[.]”); *see also* Dresser, *supra* note 3, at 1620 (noting that the accepted model of medical decision-making asks for a “straightforward and dispassionate description” of the intervention). It is worth noting that even the legal doctrine of informed consent has historically recognized the value and necessity of neutrality. It was not until the Supreme Court’s 1992 decision in *Casey* that American law made accommodations—in the abortion context only—for states to voice their value judgments about medical procedures. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992). *See also* Dresser, *supra* note 3, at 1615 (“The Supreme Court now accepts disclosure laws as a legitimate means of discouraging abortion[.]”).

⁴⁰ Manian, *supra* note 3, at 251 (arguing that allowing physicians to disclose biased information contradicts the purposes of informed consent).

⁴¹ *See, e.g.*, Planned Parenthood v. Rounds, --- F.3d ---, 2011 WL 3862585 (8th Cir. 2011) (holding that requiring doctors to describe “all known medical risks” of abortion, including “increased risk of suicide ideation and suicide,” was unconstitutional).

⁴² *See, e.g.*, L.L. Bartholomew & D.A. Grimes, *Focus on Primary Care: The Alleged Association Between Induced Abortion and Risk of Breast Cancer: Biology or Bias?*, 53 OBSTETRICAL & GYNECOLOGICAL SURV. 708 (1998) (concluding that there is fair evidence that abortion does not increase the risk of breast cancer); Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. AM. MED. ASS’N. 947 (2005) (concluding that fetal perception of pain is “unlikely” before the third trimester); Trine Munk-Olsen et

Factual accuracy is of paramount importance to both ethical and legal theories of informed consent. The purpose of informed consent is to provide patients with information that is relevant to their medical decision-making; it goes without saying that this information must be accurate in order to be valuable to patients. No reputable modern practitioner would condone the use of misinformation to persuade a patient to reach the “correct” decision. Even the Supreme Court’s 1992 *Casey* opinion, arguably the single greatest recent expansion of the legal doctrine of informed consent,⁴³ insisted that the information provided in the informed consent process be “truthful and not misleading.”⁴⁴

3. Materiality and Medical Relevance

Many disclosures required by modern abortion informed consent statutes are challenged on the grounds that they are immaterial to a reasonable patient’s decision or that they lack medical relevance.⁴⁵ Materiality challenges have been made against requirements that physicians display and describe ultrasound images to a woman seeking an abortion,⁴⁶ that they provide her with information about the characteristics of a fetus at various stages of development, and that they use standardized

al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 *NEW ENG. J. MED.* 332 (2011) (finding that the prevalence of mental health problems increases after childbirth, but not after abortion); G. E. Robinson et al., *Is There An “Abortion Trauma Syndrome”?* *Critiquing the Evidence*, 17 *HARV. REV. PSYCHIATRY* 268 (2009) (finding methodological problems among empirical studies drawing a connection between abortion and later psychological trauma); see also Katherine DeLellis Henderson et al., *Incomplete Pregnancy is Not Associated with Breast Cancer Risk: The California Teachers Study*, 77 *CONTRACEPTION* 391 (2008); Gillian K. Reeves et al., *Breast Cancer Risk in Relation to Abortion: Results from the EPC study*, 119 *INTERNAL J. CANCER* 1741–45 (2006); Tobin, *supra* note 14, at 143–48 (relating to fetal pain provisions); American College of Obstetricians and Gynecologists, *Induced Abortion and Breast Cancer Risk*, ACOG COMM. OP. NO. 434 (June 2009) (noting that early studies had “significant methodological problems,” and concluding that “there is no association between induced abortion and breast cancer”).

⁴³ See Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure* 8 (Univ. Mich. Law Sch. Empirical Studies Ctr., Paper No. 9, 2010), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=1119&context=UMichlwps>.

⁴⁴ *Casey*, 505 U.S. at 885–87. But see *Eubanks v. Schmidt*, in which a Kentucky court interpreted *Casey*’s “truthful and not misleading” requirement to mean only that “the pamphlets themselves” meet that requirement, and not that “every statement made by every agency identified [in the pamphlet] be truthful and nonmisleading.” 126 F. Supp. 2d 451, 459 (W.D. Ky. 2000).

⁴⁵ See, e.g., Dresser, *supra* note 3, at 1604; see also Allyson M. Rucinski, *Finding the Middle Ground: Acuna v. Turkish and the New Jersey Supreme Court’s Reaffirmation of a Doctor’s Role Under the Doctrine of Informed Consent in the Digital Age*, 29 *PACE L. REV.* 797 (2009) (arguing that the New Jersey Supreme Court in *Acuna* took the right approach by looking to medical materiality).

⁴⁶ See, e.g., Sanger, *supra* note 3, at 400–01 (describing an ultrasound scan as not “just information.”).

language describing the moral status of the fetus.⁴⁷ One might also raise materiality objections against mandatory disclosures of information about financial and social resources available to women who choose to continue with the pregnancy.

Materiality objections come in two forms. The first form argues that the information required by abortion disclosure statutes is not material to a reasonable patient's medical decision. For example, critics argue that, in deciding whether to have an abortion or to continue with her pregnancy, a pregnant woman is not likely to consider a visual depiction of her fetus as relevant to her decision-making process.⁴⁸ The patient-based materiality objection is grounded, once again, in the ethical principle that informed consent should facilitate a patient's autonomous decision-making. If a patient does not consider a piece of information material or relevant to her decision, her physician has no ethical obligation to disclose it. The problem, of course, with the patient-specific standard of disclosure, which medical ethics may require, is that it is very difficult to implement in practice. Most modern physicians do not have enduring relationships with their patients such that they can know what information is relevant to any particular patient; moreover, the modern medical system does not facilitate or reimburse such discussions with new patients. It is for reasons of administrative efficiency like this that courts, as a legal matter, uniformly reject the subjective patient standard. To the extent that tort law considers patient preference as relevant to the content of medical disclosure, it looks to the needs and expectations of a reasonable patient. Physicians are not held liable for failing to disclose information that a reasonable patient would not consider relevant, even if the unique patient bringing the lawsuit has atypical preferences.

The second form of materiality objection asserts that disclosure of ultrasound images, standardized language, financial information, and the like are not necessary because physicians are only required to disclose medically material information during the informed consent process. The physician is an expert in medical care and is expected to provide accurate information about the nature of a procedure, its risks, and its

⁴⁷ See, e.g., Lazzarini, *supra* note 5 (arguing that new abortion informed consent requirements should be problematic to physicians because they require the disclosure of ideological information); see also Rucinski, *supra* note 45 ("[S]ome states have taken it upon themselves to over-legislate in the area of abortion by requiring doctors to make excessive disclosures that are arguably moral, philosophical, or religious in nature.").

⁴⁸ To a certain extent these are empirical questions. Challengers of informed consent laws have supported their claims by emphasizing the paucity of lawsuits brought by women claiming their physicians failed to provide them with adequate information before they chose to have an abortion. See, e.g., Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639, 641 (1995); but see Acuna v. Turkish, 930 A.2d 416 (N.J. 2007). One conclusion, however, may be not that these lawsuits are rare, but rather that these suits are rarely successful.

alternatives. But there are many other factors, perhaps relevant to some patients, that physicians need not disclose, either legally or ethically, simply because it is outside the scope of their expertise.⁴⁹ A reasonable patient deciding between two treatments would surely want to know what his insurance company's rate of reimbursement is for each treatment, but we do not require physicians to disclose this information because it is outside the scope of medical relevance. In deciding among procedures, a patient might reasonably consider whether one procedure carries a social stigma; but again, this is not within the physician's area of expertise. Likewise, the fact that social services are available to support single mothers is surely relevant to a woman's abortion decision, but it may not be within the scope of a reasonable physician's knowledge.⁵⁰

4. Value Judgments Masquerading as Facts

Concerns about physician scripts and standardized language are related to the materiality concerns described above. According to critics, when a patient's doctor tells her that abortion ends the life of a "whole, separate, unique, living human being," the patient is likely to be misled into thinking that this is a statement of medical fact, rather than of values.⁵¹ At least one court has supported this view.⁵²

While proponents of such disclosures note that they are scientifically accurate—since a fetus is a developing member of the species *Homo sapiens*, it is a "human being"⁵³—critics point out that the term "human being" is loaded with ideological implications.⁵⁴ The average patient hearing the phrase "human being" is more likely to understand it from a common-sense perspective that incorporates judgments about moral worth, rather than a scientific perspective that describes the genus

⁴⁹ See Law, *supra* note 28, at 302.

⁵⁰ But see *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882–83 (1992) (noting that because health risks include risks to "psychological well-being," disclosures about the consequences of abortion on the fetus are relevant, "even when those consequences have no direct relation to her health," in much the same way that disclosures of the consequences to a kidney donor may be relevant to the recipient).

⁵¹ See, e.g., Lauren R. Robbins, *Open Your Mouth and Say Ideology: Physicians and the First Amendment*, 12 U. PA. J. CONST. L. 155, 181 (2009); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 959 (2007).

⁵² See *Acuna*, 930 A.2d at 425–26 (holding that physicians have no common law duty to make such a disclosure, because there is no consensus in the medical community supporting the position that an embryo "is, as a matter of biological fact—as opposed to a moral, theological, or philosophical judgment—a complete, separate, unique and irreplaceable human being" or that terminating an early pregnancy involves "actually killing an existing human being").

⁵³ See *id.* at 425–26.

⁵⁴ As Judith Jarvis Thomson noted in her paradigmatic essay, "[a] newly fertilized ovum . . . is no more a person than an acorn is an oak tree." Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47, 48 (1971).

and species.⁵⁵ Robert Post, for example, poses a hypothetical where a state legislature defines the word “soul” in an abortion informed-consent statute to mean “DNA.”⁵⁶ Even though the legislative definition refers to a scientifically accurate concept, the average patient hearing the word “soul” is likely to interpret it in normative or ideological terms.⁵⁷

The problem with such disclosure requirements, many argue, is that they blur the boundary between medical information and ideological information. The ethical and legal doctrine of informed consent requires disclosure of material, accurate, non-obvious information needed by patients to make an informed medical decision. When a term like “human being” is “lifted from its glossary context and placed into the mouth of the physician, it loses its supposedly scientific couching” and becomes manipulative.⁵⁸ Instead, critics suggest that if the state wishes to convey a moral, philosophical, or ideological message about the status of the fetus, it ought to do so directly, rather than shielding itself behind the “borrowed authority” of the medical profession.⁵⁹ An approach that favors direct state speech, rather than state-mandated physician disclosure, is less likely to mislead patients about scientific facts and is less likely to impact negatively the relationship of trust between doctors and patients.⁶⁰

5. Emotional Impact and Fear Appeals

Many critics object to disclosures such as ultrasound visuals, fetal heartbeats, images of fetuses at various states of development, and information about fetal pain on the grounds that these types of disclosures are emotionally charged and likely to trigger negative emotional reactions in patients.⁶¹ In his concurrence in *Casey*, Justice Blackmun analogized

⁵⁵ See, e.g., Lazzarini, *supra* note 5, at 2189; Post, *supra* note 51, at 959 (“From a biological perspective, a nonviable fetus is neither ‘whole’ nor ‘separate,’ because it cannot survive outside its relationship with its mother.”); Robbins, *supra* note 51, at 162.

⁵⁶ Post, *supra* note 51, at 959. Moreover, as Post notes, informed consent statutes that require statements to the effect that the fetus is a human being require that physicians disclose “obvious” information, which they are under no legal obligation to do. *Id.* at 954.

⁵⁷ *Id.* Robbins, *supra* note 51, at 162.

⁵⁸ Post, *supra* note 51, at 954; see also Lazzarini, *supra* note 5, at 2189 (same); Rucinski, *supra* note 45 (same).

⁵⁹ Caitlin E. Borgmann, *Judicial Evasion and Disingenuous Legislative Appeals to Science in the Abortion Controversy*, 17 J.L. & POL’Y 15, 15–16 (2008); Rucinski, *supra* note 45; Reva B. Seigel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1760 (2008); see also Thornburg v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747 (1986); Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416 (1983).

⁶⁰ See generally Post, *supra* note 51, at 940 (“[T]here is a First Amendment interest in protecting the integrity of physician patient communications as a channel for the communication of accurate medical information.”).

⁶¹ See, e.g., Blumenthal, *supra* note 5, at 4–5, 23, 25–26; Sanger, *supra* note 3, at 378 (“Although couched in the protective terms of informed consent, these statutes are un-

such requirements to requiring “a visual preview of an operation to remove an appendix,” which he argued “plays no part in a physician’s securing informed consent to an appendectomy,” and “does not constructively inform” medical decision-making.⁶² Critics argue that sharing sensitive visual information with a woman seeking an abortion preys on her emotional vulnerabilities, triggering her to make a decision on the basis of emotion, rather than reason.⁶³

These disclosures are arguably problematic because, although the ethical doctrine of informed consent recognizes that persuasion may be appropriate in some circumstances, it demands that attempts at persuasion be accomplished through rational reasoning.⁶⁴ If, instead, a physician provides emotionally charged information that overwhelms the patient and preys on her fears, it is a form of *arational* persuasion and therefore presumptively impermissible.⁶⁵ Such appeals to fear not only lead to poor decisions,⁶⁶ but also may constitute harassment.⁶⁷

6. Negative and Discriminatory Assumptions about Women

A final argument against abortion informed consent statutes—and one of the few arguments that is content-neutral in nature—is that the mere existence of informed consent laws for abortion reflects offensive and antiquated views about women. Critics have pointed out that abortion is one of very few medical procedures where there is legislation setting out the limits of disclosure in a way that goes beyond common law requirements.⁶⁸ The fact that legislative disclosure requirements exist for abortion, but not for other procedures, they argue, entrenches the

abashedly meant to transform the embryo or fetus from an abstraction to a baby in the eyes of the potentially aborting mother.”).

⁶² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 936 n.7 (1992) (Blackmun, J., concurring).

⁶³ Sanger, *supra* note 3, at 396–97 (“It [the ultrasound requirement] is less an appeal to reason than an attempt to overpower it”); Blumenthal, *supra* note 5, at 4–5, 23, 25–26 (arguing that even truthful and non-misleading information may restrict a woman’s autonomy by preying on her emotional vulnerabilities).

⁶⁴ See TOM BEAUCHAMP & JAMES CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 133–35 (4th ed. 2009); see also RUTH FADEN & TOM BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 347–52 (1986).

⁶⁵ See Dresser, *supra* note 3, at 1619–21 (“[I]nformed consent doctrine has never been cited to support a law prohibiting medically accepted procedure simply because patients may become upset upon hearing what this procedure involves or because they might later regret undergoing it.”).

⁶⁶ See Blumenthal, *supra* note 5, at 25–26; see also Sanger, *supra* note 3, at 397.

⁶⁷ See Sanger, *supra* note 3, at 400 (stating that an ultrasound “is less like a brochure than it is like a sidewalk abortion protestor,” and is thus harassment masquerading as knowledge).

⁶⁸ See Dresser, *supra* note 3, at 1602.

idea of female incompetence in medical decision-making.⁶⁹ According to Reva Siegel, for example, the selective and procedure-specific way in which the state has interfered with physician discretion is grounded in the ingrained belief that women’s medical decision-making in the abortion context is “coerced or confused” and that women are unable to make rational informed consent decisions without state guidance.⁷⁰ If this is the case, then abortion informed consent statutes are problematic from an ethical and policy perspective because they treat female decision-making differently from male decision-making, thus violating the principle that men and women are equally capable of autonomous choice.

II. INFORMED CONSENT AS A SOCIALLY CONSTRUCTED DOCTRINE

Many of the objections highlighted in Section I.B depend on a conception of informed consent that is fact-based and value-neutral. For the most part, legal and ethical theorists—as well as judges and legislators—tend to view the informed consent process as one grounded in objectivity and impartiality.⁷¹ Indeed, there is a sense of certainty even in the standard litany of informed consent disclosure requirements—“the nature of the intervention, its risks and benefits, as well as of alternatives with their risks and benefits”⁷²—almost as if the content of the required disclosures were etched in stone for each procedure.

Nonetheless, with greater reflection on this vision of informed consent, the less accurate it seems. Certainly, legal norms of informed con-

⁶⁹ See Siegel, *supra* note 59, at 1726; see also Lazzarini, *supra* note 5, at 2191. Bonnie Adams Kapp, executive director of the New Morning Foundation in Columbia, South Carolina, describes the arguments made by proponents of abortion waiting periods as “insulting.” She says, “What is implied, when you think about the statements deeper, is that a woman is casual about the decision to have an abortion.” Dudley Brown, *Sanford Signs Abortion Delay Bill, Gives Pro-Lifers a Win*, GOUPSTATE, Aug. 19, 2010, <http://www.goupstate.com/article/20100819/ARTICLES/8191033?p=1&tc=PG>.

Proponents, of course, suggest that mandatory waiting periods are necessary to ensure that women seeking abortions have the time to come to a well-reasoned decision. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885–87 (1992) (upholding a twenty-four hour waiting period as constitutional, noting that “[t]he idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable.”). *But see* *Planned Parenthood of Del. v. Brady*, 250 F. Supp. 2d 405 (D. Del. 2003) (holding Delaware statute imposing a 24-hour waiting period unconstitutional).

⁷⁰ Siegel, *supra* note 59, at 1726, 1730; see also Lazzarini, *supra* note 5, at 2191 (These statutes “assume[] that women are incapable of making decisions about abortion as competent adults[.]”); Manian, *supra* note 3, at 255 (describing the *Carhart* opinion as treating women as less “trustworthy” decision-makers).

⁷¹ See, e.g., Dresser, *supra* note 3, at 1620 (describing the accepted model of medical decision-making as requiring “[a]ccording to [the accepted medical decisionmaking] model, [that] 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[.]”).

⁷² FADEN & BEAUCHAMP, *supra* note 64, at 283.

sent often deviate from moral norms; perhaps this is to be expected. But even the normative view of informed consent as an ethical ideal recognizes that neutrality, objectivity, and impartiality are often impossible, and sometimes unwarranted. This Section looks to ethics, law, psychology, and medical practice to highlight the various ways in which informed consent is a socially constructed doctrine, dependent on value judgments and social norms, and may be fundamentally incompatible with the idealized vision of many academics and judges.⁷³

A. *What Information is Disclosed?*

A physician seeking his patient's consent to a medical intervention is morally and legally obligated to explain to his patient the information she needs to know to make an informed decision about how to proceed.⁷⁴ Information relevant to this decision-making process includes the nature of the procedure or intervention, its likelihood of success, its material risks, any alternatives—including their likelihood of success and their risks—and the consequences of doing nothing as an option.⁷⁵ Depending on the jurisdiction, the standard for the physician's disclosure obligation under the law may be that of a "reasonable physician" or "reasonable patient": the physician would be liable in tort law if, under the reasonable physician standard, she failed to disclose the information her colleagues customarily disclose, or, under the reasonable patient standard, she failed to provide the information a reasonable patient would deem material.⁷⁶ Physicians generally have no duty to disclose information that would be obvious to the average patient.⁷⁷

Nevertheless, both the ethical standard of informed consent, which looks to materiality of the information to the patient's decision, and the legal standard, which looks to the standard of a reasonable patient or physician, necessarily are dependent on social norms and values.⁷⁸ There is no fixed answer to the question of what risks any given patient

⁷³ There is a wide body of literature relating to the so-called "informed consent gap," that is, the gap between informed consent in theory and in practice. See generally Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994).

⁷⁴ See generally BEAUCHAMP & CHILDRESS, *supra* note 64, at 120–24.

⁷⁵ See, e.g., FADEN & BEAUCHAMP, *supra* note 64, at 283; see also *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (stating that informed consent entails an opportunity to evaluate knowledgeably the options available and risks attendant thereto).

⁷⁶ See, e.g., *Largey v. Rothman*, 110 N.J. 204, 209–12 (1988) (discussing both standards and electing to follow the reasonable patient rule).

⁷⁷ See Post, *supra* note 51, at 954. However, some research suggests that many common presumptions about patient health literacy (including what information is known or "obvious" to patients) are incorrect. See generally Brietta Clark, *Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, and Cost* (unpublished draft on file with author).

⁷⁸ The choice between the reasonable patient standard and the reasonable physician standard also clearly implicates social values.

would deem material; it will depend both on the patient herself and the attitudes of the community regarding the nature and probability of various risks.⁷⁹ Consider, for example, a medical intervention for glaucoma that, if effective, poses a twenty-five percent chance of causing complete blindness, and a twenty-five percent chance of causing a change in the person's eye color, however improbable. Would either or both of these risks be material to the average patient? Although a patient would presumably want to know of the possibility of a change in eye color, it is unlikely that the average patient would consider this information material enough to cause him to rethink his decision.⁸⁰ Faced with the choice of glaucoma or a successful treatment that causes a change in eye color, it is difficult to imagine a reasonable patient opting against treatment. Imagine instead that this decision were taking place in a discriminatory society with a caste system based on eye color, where people with blue eyes are routinely discriminated against. In such a context, surely the risk of a change in eye color would be relevant to a reasonable person's decision. This example demonstrates that societal values are necessarily tied to the determination of what information must be disclosed during the informed consent process.

For a more realistic example, consider whether a physician or researcher has a legal or ethical obligation to disclose a financial conflict of interest to his patients or research subjects.⁸¹ While at least one court has found that a patient may have a cause of action against a physician who fails to disclose any financial interest she may have in the procedure she is performing on the patient,⁸² there is no clear legal or ethical consensus on the scope of required disclosures.⁸³ Similarly, it is unclear whether a physician's personal characteristics—HIV status, religion, gender, drug use—are or should be material to patients when making medical deci-

⁷⁹ See, e.g., Schuck, *supra* note 73, at 912. Schuck describes assumption of risk in the informed consent context as a factual question for the jury, "shaped by evolving social norms." Implied assumption of risk, "notwithstanding its ostensible and legally institutionalized character as "fact," is in reality a culturally constructed and highly normative doctrine[.]" *Id.*

⁸⁰ For a patient to prevail in an informed consent suit, she must show that the failure of informed consent caused her injury—in other words, that a reasonable patient would have chosen not to undergo the procedure had she been informed of the relevant facts. See *infra* note 85.

⁸¹ See, e.g., *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990); see also Robin Fretwell Wilson, *Estate of Gelsinger v. Trustees of the University of Pennsylvania: Money, Prestige, and Conflicts of Interest in Human Subjects Research*, in *HEALTH LAW AND BIOETHICS: CASES IN CONTEXT* (Sandra Johnson et al. eds., 2009).

⁸² See *Moore*, 793 P.2d at 483.

⁸³ See e.g., Jerome P. Kassirer, *Financial Conflict of Interest: An Unresolved Ethical Frontier*, 27 *AM. J.L. & MED.* 149, 158–59 (2001); see also BARRY FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 1607 (2d ed. 2004) (discussing varying federal thresholds for conflict of interest disclosures in research).

sions.⁸⁴ Whether a physician chooses to disclose this information will ultimately depend on both her own understanding of her ethical obligations and on the legal precedent in her jurisdiction. Likewise, when it comes to ultrasound images, descriptions of fetal development, standardized language, and information about social support systems for women seeking abortions, the legal and ethical requirements under the doctrine of informed consent will also depend on social norms and patient expectations.⁸⁵

Beyond the value judgments inherent in the decision of what information must be disclosed, there is a secondary question of whether physicians may legitimately communicate ideological or value-based information to their patients during the course of the informed consent process. Perhaps surprisingly, even some of the same scholars who challenge abortion disclosure laws recognize that such value-laden information may be a legitimate part of the informed consent process. Howard Minkoff and Mary Faith Marshall, for example, note that simply because a physician's disclosure script is "value-laden," it "is not necessarily incompatible with the ethics of counseling."⁸⁶ Rather, they clarify that only certain kinds of values—those relevant to the physician or to the patient—are appropriate during the informed consent communication.⁸⁷ Indeed, in another hotly disputed bioethical context, that of physicians with conscientious objections to certain medical procedures, some commentators recommend that physicians explain their medical decisions by reference to their own moral obligations.⁸⁸ Moreover, PPACA, which funds programs to improve shared decision-making,⁸⁹ recognizes that some medical decisions cannot be resolved on the basis of facts alone. "Preference sensitive care," for example, is defined by PPACA as "medical care for which the clinical evidence does not clearly support one

⁸⁴ See generally Laurel R. Hanson, *Informed Consent and the Scope of a Physician's Duty to Disclose*, 77 N.D. L. REV. 71 (2001) (discussing the lack of clear standards regarding what personal information a physician must disclose to patients).

⁸⁵ Tort law, of course, addresses this area of uncertainty by relying on the reasonable person standard. Rather than enumerate exactly what information physicians are required to disclose during the informed consent process, American tort law relies on a model of reasonableness and injury. In order for a plaintiff to recover in an informed consent claim, he must demonstrate, first, that the physician's disclosure fell short of the standard of reasonableness, and second, that the physician's breach actually caused the injury. In other words, the plaintiff would have chosen another option had he been provided with the missing information. By requiring proof of both reasonableness and injury, tort law ensures that recovery is based on individual harm while at the same time taking into account norms of medical decision-making.

⁸⁶ Minkoff & Marshall, *supra* note 3, at 22.

⁸⁷ See *id.*

⁸⁸ See, e.g., Law, *supra* note 28 at 304 (quoting Billy E. Moore, an attorney who represents physicians who are Jehovah's Witnesses, as saying "Of course the doctor needs to explain his beliefs to [his] patients.").

⁸⁹ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3506, 124 Stat. 119, 527 (2010).

treatment option such that the appropriate course of treatment depends on the values of the patient.”⁹⁰

Thus, the argument that value judgments have no place whatsoever in informed consent cannot stand. A better approach is the one Minkoff and Marshall take, suggesting that that only patient and physician value judgments—not those of the state—are relevant to informed consent. As further discussed in Section III.C,⁹¹ the principle of medical materiality supports the argument that the value judgments expressed during the informed consent encounter ought to be limited to those of the patient, and, if necessary, the physician. Conversely, non-medical facts and values that may be deemed relevant by the state have no place in the informed consent discussion.

B. *How is the Information Disclosed?*

Even if there were a value-neutral way of determining what categories of information physicians are ethically and legally obligated to disclose, the process of disclosure itself is far from objective. And unfortunately, neither the ethical nor the legal doctrines of informed consent offer much guidance in this regard.

Psychology and communications research consistently demonstrate that the language used to disclose information affects people’s understanding, retention, and decision-making. Framing effects, in particular, have a significant impact on patient choices.⁹² Changes in levels of medical risk can be framed in either absolute or relative terms,⁹³ and a pa-

⁹⁰ *Id.* at § 3506(b)(2), 124 Stat. at 527. In fact, the Act specifically precludes the research from these programs to affect coverage or reimbursement decisions “with the intent to discourage an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.” *Id.* at § 1182(d)(1), 124 Stat. at 740. See also Annette O’Connor et al., *Modifying Unwarranted Variations in Health Care: Shared Decision Making Using Patient Decision Aids*, HEALTH AFFAIRS var-63, Oct. 7, 2004, <http://content.healthaffairs.org/content/early/2004/10/07/hlthaff.var.63> (identifying “preference-sensitive” care as care where “the best choice depends on patients’ values or preferences for the benefits, harms, and scientific uncertainties of each option.”).

⁹¹ See *infra* Section III.C (arguing that non-medical information, such as statements of moral values, that are deemed relevant by the state ought to be communicated directly by the state, rather than by the physician); Section III.D (suggesting that while patients do make decisions based on emotional judgments, it may not be appropriate for third parties to take advantage of these emotions).

⁹² See, e.g., Adrian Edwards et al., *Presenting Risk Information: A Review of the Effects of “Framing” and Other Manipulations on Patient Outcomes*, 6 J. HEALTH COMM.: INT’L PERSP. 61 (2001) [hereinafter: *Presenting Risk Information*]; A. Edwards & G. Elwyn, *Understanding Risk and Lessons for Clinical Risk Communication About Treatment Preferences*, 10 QUAL. HEALTH CARE i9, i11 (2001).

⁹³ Reducing a risk from 20% to 15% is a 5% absolute reduction in risk. In contrast, reducing a risk from 20% to 15% means that the risk is 20% less likely to occur in relative terms. Most proponents of health literacy recommend the disclosure of risks in absolute,

tient's judgment may change based on which terms are used. Similarly, presenting a patient with an 85% chance of survival may cause the patient to make a different decision than presenting him with a 15% chance of death.

Scholars who challenge the validity of theoretical models of informed consent often note that there is little evidence to support the idea that these models actually are effective in communicating information.⁹⁴ Much discussion in modern medical practice has been devoted to the question of how information can be communicated to patients most effectively,⁹⁵ but the ethical theory of informed consent neither defines effectiveness nor offers suggestions as to how to achieve it. To the extent that researchers do study the effectiveness of informed consent, they typically gauge it by the patient's ability to recall, understand, and "teach back" what the physician has explained.⁹⁶ These studies only test patients' ability to recall the information that medical providers have told them; they do not test the accuracy or validity of the underlying information itself.

For an example of disclosure variations in the abortion context, consider the Texas Department of Health's informational pamphlet, *A Woman's Right to Know*, which Texas physicians are required by law to make available to women seeking abortion.⁹⁷ This brochure is purportedly neutral in that it describes the risks associated with abortion as well as the risks associated with pregnancy. However, a review of the language used in the document clearly reveals the state's preference. Under the heading "Abortion Risks," patients are informed that:

rather than relative terms, as patients are less likely to misunderstand absolute values. See *Presenting Risk Information*, *supra* note 92, at 74.

⁹⁴ See generally Schuck, *supra* note 73.

⁹⁵ The Patient Protection and Affordable Care Act, for example, addresses this question by promoting the use of patient decision aids, defined as "educational tool[s] that help[] patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences." Pub. L. No. 111-148 § 3506(b)(1), 124 Stat. 119, 527 (2010). See also Isaac M. Lipkus, *Numeric, Verbal, and Visual Formats of Conveying Health Risks: Suggested Best Practices and Future Recommendations*, 27 MED. DECISION MAKING 696 (2007).

⁹⁶ HELEN W. WU ET AL., NAT'L QUALITY FORUM, IMPROVING PATIENT SAFETY THROUGH INFORMED CONSENT FOR PATIENTS WITH LIMITED HEALTH LITERACY: AN IMPLEMENTATION REPORT 3 (2005), <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=ID&ItemID=22090>. Thanks to LLM student Jayne Westendorp Holland for connecting me with this research.

⁹⁷ PROTECT TEXAS, A WOMAN'S RIGHT TO KNOW 10 (Texas Dep't of Health ed., 2003), <http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf>.

The risks are fewer when an abortion is done in the early weeks of pregnancy. The further along in the pregnancy, the greater chance of serious complications and the greater the risk of dying from the abortion procedure. For example:

- *One death per every 530,000 abortions if you are at eight weeks or less.*
- *One death per every 17,000 abortions for pregnancies 16-20 weeks.*
- *One death per 6,000 abortions at 21 weeks or more.*⁹⁸

The brochure also lists a number of factors that “affect the possibility of complications,” including the physician’s skill, the type of anesthesia, the patient’s health, and the type of abortion procedure used.⁹⁹

Compare this with the language used under the heading “Pregnancy and Childbirth”:¹⁰⁰

Pregnancy and childbirth is usually a safe, natural process although complications can occur. The most common complications of pregnancy include:

- *Ectopic pregnancy*
- *High blood pressure*
- *Complicated delivery*
- *Premature labor*
- *Depression*
- *Infection*
- *Diabetes*
- *Hemorrhage (heavy bleeding)*
- *One out of 8,475 women dies from pregnancy complications.*¹⁰¹

Pregnancy, although carrying a 1 in 8,475 risk of death,¹⁰² is described as “usually a safe, natural process.” In contrast, abortion, which

⁹⁸ *Id.* Note that the information provided in the Texas brochure identifies significantly higher levels of risk than the information collected by the Guttmacher Institute, which collects reliable and nonpartisan research relating to sexual activity and reproductive health. See *Frequently Asked Questions*, GUTTMACHER INST., <http://www.guttmacher.org/about/faq.html> (last visited Aug. 27, 2011). The Guttmacher Institute reports that the risk of death is approximately 1 in one million before eight weeks, 1/29,000 at 16–20 weeks, and 1/11,000 at 21 weeks or later. GUTTMACHER INST., *Facts on Induced Abortion in the United States* (Jan. 2011), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html [hereinafter *Facts on Induced Abortion*].

⁹⁹ PROTECT TEXAS, *supra* note 97, at 12.

¹⁰⁰ *Id.* at 19.

¹⁰¹ *Id.*

¹⁰² Note that the Texas brochure provides a much more precise figure for pregnancy risk

poses significantly less risk of death in 98.5% of cases,¹⁰³ is described primarily in terms of its risks of death and potential complications. This approach communicates information in a very different way than if the risks of death had simply been listed and compared between abortion and pregnancy.

Of course, this is not to say that simply listing comparative risk statistics is the better approach. Indeed, some practitioners and policy-makers suggest that using qualitative terms such as “often” and “rarely” may in some cases be more effective in communicating risk than focusing on quantitative data.¹⁰⁴ In practice, physicians are constantly striving to improve methods of communication and retention. The conclusions here are merely that it is difficult, without empirical evidence, to conclude that one way of communicating information is more correct or more accurate than another, and that the theory of informed consent gives physicians little guidance about which approach to take.¹⁰⁵

C. *What are the Motives of the Discloser?*

While critics of abortion disclosure statutes tend to view the ideal informed consent process as neutral and unbiased, it is not clear that the doctrine of informed consent always demands neutrality. Even the most stringent defenders of informed consent will acknowledge that physicians are permitted not only to make recommendations to patients, but also to influence patients to follow their recommendations. While the boundaries of such influence are not clear, one obvious limitation is that the physician’s influence may not extend so far as to negate the voluntariness of the patient’s decision.¹⁰⁶

Tom Beauchamp and James Childress, leading theorists in medical ethics, distinguish between two categories of influence that are relevant

(1 in 8,475), as compared to the figures for abortion risk (which are all rounded to the nearest thousand). This difference in representation of the facts may also contribute to a reader’s conclusion that the risks of abortion are greater.

¹⁰³ Only approximately 1.5% of abortions take place at twenty-one weeks or later, the period during which, according to the Texas brochure, abortion poses a slightly greater risk of death than childbirth. *Facts on Induced Abortion*, *supra* note 98.

¹⁰⁴ See, e.g., Adrian Edwards et al., *General Practice Registrar Responses to the Use of Different Risk Communication Tools in Simulated Consultations: A Focus Group Study*, 319 BRIT. MEDICAL J. 749 (1999). See also European Commission Pharmaceutical Committee, *A Guideline on the Readability of the Label and Package Leaflet of Medicinal Products for Human Use*, (1998) 22 an.1b, available at http://www.alims.gov.rs/download_eng/regulativa/gl981002.pdf (recommending that frequency of drugs side-effects be described with one of five qualitative descriptions—very rare, rare, uncommon, common, very common).

¹⁰⁵ For example, describing a four-week-old fetus as a “human being” or a “cluster of cells” may be equally accurate; informed consent doctrine offers no guidance between the two options.

¹⁰⁶ For a legal parallel, consider the *Casey* undue burden standard for limiting state regulations of abortion. See *infra* note 129.

in this context: persuasion and manipulation.¹⁰⁷ They conclude that persuasion, whereby a physician appeals to reason in an effort to encourage a patient to reach a particular conclusion, is acceptable as long as the physician does not make emotional appeals intended to provoke potentially overwhelming emotional responses.¹⁰⁸ In many clinical situations, particularly those where lack of treatment is likely to result in serious harm, medical ethicists note that physicians would be “morally blameworthy if they did not attempt to persuade their patients” to reach a particular decision or consent to a particular intervention.¹⁰⁹

Manipulation, on the other hand, is defined as “any intentional and successful influence of a person by non-coercively altering the actual choices available to the person or by non-persuasively altering the other’s perception of these choices.”¹¹⁰ It can include information manipulation—by managing information in a way that non-persuasively alters a patient’s understanding and motivates the patient to do what the physician intends¹¹¹—manipulation of options, and psychological manipulation.¹¹² According to Ruth Faden and Tom Beauchamp, the extent to which manipulation is permissible as part of the informed consent process depends on the degree to which it is compatible with patient autonomy and “substantial understanding.”¹¹³ In other words, manipulation, particularly minor manipulation, occasionally may be justified.¹¹⁴ Moreover, as a matter of routine medical practice, persuasion and manipulation are quite common.¹¹⁵

¹⁰⁷ BEAUCHAMP & CHILDRESS, *supra* note 644, at 133–35. They also distinguish these from coercion, which involves the threat of force and is usually impermissible.

¹⁰⁸ *Id.* at 133. See also FADEN & BEAUCHAMP, *supra* note 644, at 346–52.

¹⁰⁹ FADEN & BEAUCHAMP, *supra* note 644, at 347. See also BEAUCHAMP & CHILDRESS, *supra* note 644, at 308 (citing the AMA Council on Ethical and Judicial Affairs’ policy with respect to HIV-positive patients who are reluctant to disclose their status to a partner, which recommends that the physician in such a case “attempt to persuade the infected patient to cease endangering the third party”); Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J. L., MED. & ETHICS 85, 89 (2010) (noting that patients making treatment decisions seek and need the “advice of their treating physician”).

¹¹⁰ FADEN & BEAUCHAMP, *supra* note 644, at 354.

¹¹¹ *Id.* at 355. Information manipulation can include lying, withholding information, exaggerating, or framing information in a negative or positive way.

¹¹² *Id.* at 355. See generally Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159 (2003).

¹¹³ FADEN & BEAUCHAMP, *supra* note 64, at 362.

¹¹⁴ *Id.*

¹¹⁵ See *supra* accompanying text at note 258–59, 354. See also Janet Smith, *Guided Autonomy and Good Friend Physicians*, in *BIOETHICS WITH LIBERTY AND JUSTICE: THEMES IN THE WORK OF JOSEPH M. BOYLE*, 166 (Christopher Tollefsen, ed., 2011) (“[N]early every health care professional, no matter how relativistic in his/her philosophical commitments, routinely utilizes a bag of tricks for persuasion, manipulation and coercion, not unlike those of a parent dealing with a willful child[.]”); John F. Peppin, *Physician Neutrality and Patient Autonomy in Advance Directive Decisions*, 11 ISSUES L. & MED. 13, at 15–16 (1995) (describing

As a legal matter, neutrality has not been a required part of the informed consent process since the Supreme Court's 1992 decision in *Casey* overruled *Thornburg* and *Akron* to the extent they prohibited state attempts to influence a woman's abortion choice.¹¹⁶ In *Casey*, the Supreme Court held that state laws may legitimately reflect a preference for life over abortion.¹¹⁷ In other contexts as well—most notably, end-of-life and public health contexts—American law also permits the state to interject its own value judgments into the sphere of medical decision-making, though these interventions have faced similar constitutional challenges.¹¹⁸

Moreover, even a physician who strenuously avoids manipulation and persuasion may have motivations or expectations that impact patient care. Consider, for example, a patient who repeatedly declines a clinically-recommended treatment without offering a reason for his decision. It would be unusual for a physician to accept this decision at first glance. More likely, the physician will call for a psychiatric consult to evaluate the person's competence. Obviously, there is nothing inherently wrong with determining a patient's psychiatric status before allowing the patient to give informed consent—after all, competence and voluntariness are essential to the consent process. But the fact that physicians routinely call for psychiatric consults only when they disagree with a patient's decision indicates that the values and motivations of medical professionals are clearly at play in the informed consent process.

Finally, even a physician who strives for neutrality and objectivity in disclosure may find this attitude difficult to maintain. The way a physician frames or presents information that affects patient decision-making is necessarily dependent on the physician's own attitude. As Minkoff and Marshall note, “[p]otential for undue bias exists even when physicians frame their counseling carefully, since their choice of words, of

“manipulation of the consent process” aimed at persuading patients to accept treatment as a daily occurrence); Edmund Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 55 (1994) (“As any clinician knows, she can get almost any decision she wants from most patients.”); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 63–68 (1982) (noting how easy physicians believe it is to “package and present the facts in a way that leaves the patient with no real choice”).

¹¹⁶ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 870 (1992).

¹¹⁷ *Id.*

¹¹⁸ See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (upholding as constitutional, on the basis of a permissible state preference for life over death, a Missouri law requiring a party petitioning for withdrawal of life-sustaining treatment to demonstrate the patient's wishes by clear and convincing evidence).

emphasis, and even of body language unwittingly transmits bias.”¹¹⁹ This is a problem of practical application rather than theory, but it calls into question the feasibility of a doctrine of informed consent that aspires to complete neutrality.¹²⁰ While the aspirational goal of defining the scope and manner of informed consent disclosures using neutral and unbiased medical information is laudable, it is questionable whether even the most stringent procedures for assuring such neutrality can effectively be shielded from political and personal agendas.¹²¹

III. A FEW MODEST RECOMMENDATIONS

Many opponents of abortion disclosure laws paint the doctrine of informed consent as grounded in neutrality. They argue that the content of disclosure should not be influenced by special interests, that physicians ought to refrain from persuading patients to reach a favored decision, that appeals to emotion are inappropriate, and that disclosures ought to be limited to medically relevant facts. And yet Section II demonstrates that this view of informed consent may be overly simplistic. As a matter of ethics, informed consent regards broad disclosure as necessary for the exercise of patient autonomy, encourages disclosure of patient-specific information, and permits the use of rational persuasion and information manipulation. As a matter of positive law, informed consent requirements inevitably incorporate value judgments about the primacy of patient, as opposed to physician, interests and the reasonableness of

¹¹⁹ Minkoff & Marshall, *supra* note 3, at 22. See also Pellegrino, *Patient and Physician Autonomy*, *supra* note 113 at 55 (1994) (“Which facts the physician chooses, which she emphasizes, and which she represses are often subtly or frankly conditioned by her judgment of what she thinks is in the patient’s best interests.”).

¹²⁰ At least one commentator, who has described the belief that “physicians work from a morally neutral position” as “naïve,” responds to this dilemma by suggesting that physicians instead honestly divulge their values when communicating with patients. Peppin, *supra* note 1155, at 14.

¹²¹ Consider, for example, PPACAs prioritization of funding for shared decision-making using patient decision aids, particularly in the context of preference-sensitive care. Pub. L. No. 111-148, § 931(c)(2)(C), 124 Stat. 119, 381–384. PPACA directs the Secretary of Health and Human Services to contract with an entity comprised of “experts and key stakeholders” to craft “consensus-based” standards for evaluating patient decision aids. *Id.* at § 936, 124 Stat. at 527–30. This language was obviously crafted to ensure the scientific accuracy and defensibility of the resulting decision aids. However, one need look no further than the heated opposition of many established physicians to implementation of shared decision-making, patient decision aids, and even clinical pathways based on evidence-based medicine to recognize how difficult it will be for even a group of experts to reach consensus about the nature of the information to be communicated to patients via decision aids. Many thanks to the participants in the Salzburg Global Seminar, Session 477, “The Greatest Untapped Resource in Healthcare? Informing and Involving Patients in Decisions about their Medical Care,” particularly Ben Moulton of the Foundation for Informed Medical Decision Making, for their feedback and reflection on this and related issues.

patient decision-making. Moreover, practically, it is simply impossible to attain the sort of neutrality many commentators desire.

Recognizing the nuance and flexibility inherent in informed consent doctrine makes it much more difficult to accept the argument that modern abortion disclosure laws are inherently incompatible with informed consent. This is not to say that the argument from informed consent lacks merit and should be abandoned in its entirety. Viewing the doctrine of informed consent in its true light still permits legitimate, albeit more modest, criticism of abortion disclosure laws. This Section attempts to identify, where possible, which elements of abortion disclosure laws are problematic, even in light of the more complex view of informed consent this Article espouses.

A. *Bias*

First, consider the argument that abortion disclosure laws are biased and non-neutral, aimed primarily at persuading patients to continue with their pregnancy rather than encouraging independent choice. Examples of such bias include presenting selective information—by disclosing the risks associated with abortion but not childbirth, for example; framing information in a manner that paints abortion in a negative light; highlighting visual information that is likely to trigger fear or negative emotional responses in patients; and presenting evidence against abortion that the scientific community disputes. As shown in Section II, it is impossible to dissociate the theory of informed consent from underlying social values and biases about reasonable patient decision-making. The doctrine of informed consent offers little guidance as to how to disclose relevant information, and it recognizes, as both an ethical and legal matter, that the use of persuasion in medical practice is permissible and sometimes necessary.

Is it possible to reach any firm conclusions about the legitimacy of non-neutral disclosure requirements? Perhaps not. While neutrality and objectivity in the informed consent process should be the ultimate goal, it is not clear that state laws supporting biased disclosures are per se impermissible. In some cases, as where a patient's requested treatment conflicts with the physician's ethical obligations, such as a physician's opposition to abortion on religious grounds, encouraging the patient to pursue a different option may be permissible ethically, provided that the physician's persuasive influence does not negate the patient's ability to make an autonomous choice. Similarly, where a state has determined that existing disclosures are biased in favor of abortion, and if as many pro-life advocates claim,¹²² abortion providers intentionally avoid dis-

¹²² See, e.g., Avila, *supra* note 37 at 513.

cussing fetal characteristics with the patient, it may be permissible for a state to remedy this bias by balancing the information that is made available to patients. All such decisions need to be made on a case-by-case and law-by-law basis. Moreover, even if we conclude that obtaining a patient's truly informed consent requires disclosing information with which the patient disagrees, there may be other legal limitations on the state's right to legislate such issues.¹²³

B. *Factual Accuracy*

The doctrine of informed consent requires that factual information disclosed to patients be accurate.¹²⁴ This much is clear. But neither informed consent theory nor any other ethical or legal theory provides guidance on how to disclose information where there is no clear consensus in the scientific community.¹²⁵ Proponents of breast cancer and fetal pain disclosures argue that because there are published studies supporting their position, patients ought to be provided with this information. Critics of such disclosures argue that the existence of one or two studies supporting a correlation does not mean that there is legitimate scientific dispute on an issue.

When there is a lack of consensus on a scientific issue or when there is no agreement as to the fact of consensus, what conclusions, if any, can be reached about the legitimacy of disclosure requirements? One solution would be to require a disclosure that alerts patients to the conflict. For example, “[w]hile the majority of the scientific community believes there is no reliable evidence of a link between abortion and future infertility, some researchers have argued that there is.” The problem with this approach is that it suggests to patients that there is a legitimate scientific dispute about an issue that most scientists believe is not in question. Arguably, disclosing such information would permit patients, many of whom lack the education and training to understand medical and public health research, to reach their own conclusions about an issue that the scientific peer review process has essentially settled. While a populist trend to this effect seems to have been developing in recent years,¹²⁶ it does not seem unreasonable to require legislatures and courts to defer to the opinion of a majority of the scientific community when setting dis-

¹²³ See *infra* Section IV.

¹²⁴ As does the “truthful and not misleading” doctrine set forth by the Supreme Court in *Casey*.

¹²⁵ See Post, *supra* note 51, at 988.

¹²⁶ Similar arguments have been raised in the context of global warming and climate change: although some researchers offer evidence to suggest that there is no such phenomenon as man-made global warming, the majority of the scientific community disagrees with this view. The alleged link between vaccination and autism, which has since been discredited, is another example.

closure requirements, where there is consensus on factual issues relating to the risks of abortion.¹²⁷ Given that states have discretion as to whether to require specific risk disclosures, state legislators who disagree with the conclusions drawn by the scientific community about an issue like fetal pain, either as a matter of evidence or of policy, are free to simply avoid legislating disclosure of factual information relating to this issue. In light of the fact that states are taking the initiative to require factual disclosures, the burden should be on the legislators to demonstrate that their disclosures are factually correct as judged by the scientific and medical communities as a whole.¹²⁸

C. *Materiality and Misunderstanding*

With respect to the issues of materiality and inclusion of potentially misleading value-based judgments, informed consent doctrine is surprisingly unhelpful. As an ethical matter, informed consent requires disclosure of information that would assist the individual patient in her decision; legally, informed consent requires disclosure of information based on a reasonable patient or reasonable physician standard. Thus, whether a piece of information is material is largely dependent on social norms and context.

If required disclosures ought to be limited to information that is medically material, the reason for that limitation cannot be because non-medical information is irrelevant to patients.¹²⁹ Presumably, the reason we impose a medical materiality restriction on medical disclosures is because the physician who initiates the informed consent conversation is less qualified to speak on non-medical issues. As noted in Section II, physicians are trained as medical practitioners and may not be well-versed in issues like the financial resources states make available to women with children, the religious or moral perspectives on fetal development, the availability of adoption services, or the effect of the abortion

¹²⁷ See, e.g., Tobin, *supra* note 14, at 114 (arguing that disclosures of “specific factual claims” should be “subject to non-deferential judicial review of their accuracy and fairness.”); Borgmann, *supra* note 59 (arguing that courts neglect their responsibility for justice and truth when they defer to biased and unreliable legislative fact-finding on abortion). See also *Planned Parenthood v. Rounds*, --- F.3d ---, 2011 WL 3862585, at *8 (8th Cir. 2011) (“A compelled medical statement that contradicts in unequivocal terms the leading associations of experts in relevant fields does not serve [the end of facilitating informed decisions].”).

¹²⁸ For example, PPACA, which promotes the use of patient decision aids to facilitate shared decision-making, requires that such decision aids be “evidence-based” and present “up-to-date clinical evidence about the risks and benefits of treatment options.” Pub. L. No. 111-148, § 3506(d), 124 Stat. 119, 527. PPACA also requires that such patient decision aids be evaluated and certified by a diverse group of experts and stakeholders; this is likely to ensure some degree of consensus about the accuracy of disclosed information. *Id.* at § 3506(c)(2)(a). *But see supra* note 103 and accompanying text (questioning whether such unbiased consensus can ever be reached).

¹²⁹ See *supra* notes 47–48 and accompanying text.

decision on third parties or society as a whole. Consequently, while the Supreme Court has found no constitutional prohibition against requiring physicians to disclose such information,¹³⁰ requiring these types of disclosures seems inconsistent with the principle of informed consent. The fact that informed consent takes place within the physician-patient relationship strongly suggests that the information conveyed ought to be medical in nature.¹³¹

That said, it is important to note that some of the information currently required by abortion disclosure statutes need not be conveyed by the physician directly but may instead be communicated (as often occurs) in the form of a state pamphlet. To the extent that abortion disclosure laws require conveyance of non-medical information, such laws would be more consistent with informed consent doctrine if the state, rather than the physician, were to make the disclosures. As a matter of convenience and practicality, it is understandable that a state wishing to convey non-medical information to women seeking abortions would find a home for this communication at the time of the physician-patient encounter. But it must be emphasized that introducing the state's communicative message at this particular time and place can only be defended as a matter of convenience—and not because state speech is relevant to, analogous to, or part of the informed consent dialogue between physician and patient. For this reason, any brochures or pamphlets provided by the state ought to be clearly identified as coming from the state, so as not to mislead patients into thinking that these communications are medical in nature or endorsed by the physician.¹³² Ideally, these state communications would be made outside the context of medical care.

¹³⁰ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882–83 (1992) (“We would think it constitutional for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself.”).

¹³¹ In a somewhat related context, an earlier version of the 2008 Prenatally and Postnatally Diagnosed Conditions Awareness Act would have required physicians to disclose to parents receiving a prenatal diagnosis of Downs syndrome or other disabling conditions information about families living with disabilities in an effort to better inform their choices. See S. 1810, 110th Cong. § 3(d) (as introduced in Senate, Jul. 18, 2007). This language was eliminated in the final version of the Act. See Elizabeth F. Emens, *Framing Disability* (unpublished manuscript) (on file with author). In her Article, Emens proposes that families of disabled children (or fetuses) be provided with information about the quality of life of disabled individuals and their families, whether through conversation with a medical practitioner, written brochures, or videos. Emens presents a thoughtful challenge to reliance on medical materiality in defining the bounds of physician disclosure; she argues that emphasizing medical risk is in itself a social and value-laden decision, as recognized by the disability studies movement.

¹³² However, even a clear indication that an abortion-related communication is coming from the state may be problematic if is incorporated as part of informed consent process. Consider for example the State of Michigan, which offers an online alternative to the traditional informed consent process. That is, a patient seeking an abortion may, rather than engaging in a conversation with her physician, independently view state-sponsored abortion

D. Emotional Impact

Traditional informed consent doctrine establishes that persuasion of patients is permissible only if it relies on reason rather than emotions. Autonomous decision-making is grounded in reasoned judgment, scholars assert,¹³³ and attempts to sway a patient's opinion in non-rational ways are ethically impermissible. Based on these descriptions alone, one would be inclined to conclude that abortion disclosure requirements with a significant emotional impact—most notably, fetal images—are impermissible. However, it may be worth challenging traditional informed consent doctrine and its implications with respect to the issue of emotional impact.

As a preliminary matter, it may be unrealistic to view autonomous decision-making as necessarily grounded in rational analysis. People make decisions—in the medical context and elsewhere—based on a variety of factors, not all of which are well reasoned or rationally analyzed. For example, a patient with an irrational fear of needles may avoid getting an annual flu shot. Can we really say that his decision is non-autonomous? Likewise, decisions made by a patient while in the grip of excruciating pain may not be rational but are arguably autonomous and in that patient's interests.¹³⁴ Perhaps, then, there is a case to be made that emotional judgments may indeed be consistent with personal autonomy.

One might, of course, make the argument that while patients are free to make decisions beyond the bounds of reason and rationality, it ought to be impermissible for third parties, such as physicians, to use certain means of persuasion that prey on patients' emotions. There may indeed be something to this argument as a general matter.¹³⁵ But readers should proceed with care when considering the application of this argument in the abortion context. For example, one of the claims that critics of ultrasound requirements commonly make is that showing a woman seeking an abortion the ultrasound image of her fetus, while not objectionable as a matter of factual accuracy, transforms the fetus “from an

materials at the website of the Michigan Department of Community Health, print and sign a confirmation form, and present it to her physician at her next appointment as evidence of informed consent. MICHIGAN DEP'T OF CMTY. HEALTH, http://www.michigan.gov/mdch/0,1607,7-132-2940_4909-45202--,00.html <http://michigan.gov/mdch> (last visited Apr. 4, 2011).

¹³³ See *supra* notes 59–60 and accompanying text.

¹³⁴ For a classic example of this kind of reasoning, consider the case of Dax Cowart, who, immediately after suffering third-degree burns over the majority of his body, asked a passing farmer to shoot him and put him out of his misery. Over many years of painful treatment, Cowart continued to request assistance in suicide from friends, family, and physicians, who all denied his requests on the basis that his decision-making was an emotional response to pain, rather than a rational decision. DAX'S CASE (Unicorn Media, Inc. 1985).

¹³⁵ See *supra* Section II.C; see also Sanger *supra* note 3, at 403–04 (discussing a parallel in the context of jury deliberations).

abstraction to a baby in the eyes of the potentially aborting mother,” and thereby has an emotional impact far beyond its factual impact.¹³⁶ While this may be true, excessive reliance on such arguments in the context of abortion and reproductive decision-making runs the risk of supporting entrenched assumptions about women’s emotional vulnerability—as assumptions that critics of abortion disclosure laws expressly, and rightly, reject.¹³⁷ Consider, for example, Maya Manian’s thoughtful analysis of the Supreme Court’s decision in *Carhart*, which she criticizes, in part, on the grounds that the Court’s opinion treats women as “less trustworthy decision-makers.”¹³⁸ Manian and others note that in no other context have courts been willing to restrict the availability of a medical procedure on the basis that patients might later come to regret their choice.¹³⁹ Similarly, in arguably no other context do physicians base their decision to use medical imaging, such as X-rays, on the patient’s emotional vulnerability.

Is there a happy middle ground between acknowledging the potential dangers of excessive emotional influence and avoiding characterizations of women as particularly sensitive to emotional imagery? One solution may be found in the doctrine of patient waiver, an important but rarely used element of informed consent law and theory. According to the waiver doctrine, patients may waive their right to informed consent as an exercise in autonomy. For example, a patient who is committed to undergoing a medical procedure, regardless of the risks or costs, may waive her right to receive information from the physician and simply proceed with the treatment. Once a patient has exercised her right to waiver, it is wrong for the physician to try to share information with the patient against her will. Of course, physicians are under no moral or legal obligation to treat patients who waive their right to informed consent—one can certainly imagine a physician refusing to provide care to a patient who is unwilling to listen to basic information about a procedure and its risks. However, this is the choice of the individual physician and impacts only the availability of treatment; it does not impact the patient’s right to shield herself from information she would prefer not to know.

In this regard, any law that forces a physician to provide a woman seeking an abortion with specific information, particularly against her will—be it ultrasound images, images of fetal development, or descriptions of the fetus—is legally and ethically problematic. The challenge is finding a way to explain to a patient what information is available to her

¹³⁶ Sanger, *supra* note 3, at 378.

¹³⁷ See generally Dresser, *supra* note 3, at 1599 (“[T]he special-protection rationale imputes to women a psychological vulnerability that lacks evidentiary support.”).

¹³⁸ Manian, *supra* note 3, at 255.

¹³⁹ *Id.* at 257–58; Dresser, *supra* note 3, at 1599.

without running afoul of her right to refuse information, but this challenge is resolvable. One way of resolving this would be to begin the informed consent discussion by asking the patient what information she considers relevant and what information she would prefer not to hear—although this approach, applied in the abortion context exclusively, again runs the risk of buying into assumptions about women’s emotional vulnerability. Perhaps another alternative is to take a cue from identity and discrimination theory: to the extent we believe that women requesting abortions are expressly rejecting their maternal identity, we should reject mandated disclosures that reinforce this identity against the patient’s will.¹⁴⁰

E. Assumptions about Women

The goal of informed consent is to encourage autonomous medical decision-making. If we, as a liberal and enlightened society, believe that women are equally as capable as men in this regard, it would be inappropriate to enact abortion disclosure laws that rely on outdated and discriminatory assumptions about women’s capacity for rational thought.

Of course, few proponents of abortion disclosure laws are willing to defend these laws explicitly on the basis of backward opinions about women. Indeed, one would hope and expect that modern policymakers do not maintain such opinions or, if they do, that they recognize the inappropriateness of relying on such opinions when enacting legislation. To the extent that informed consent laws appear “unique” to the context of abortion, this Article argues that it is most likely because of the inherent controversy about the sanctity of life underlying the abortion debate,¹⁴¹

¹⁴⁰ That is, while physicians would still be required to disclose clinically-relevant information about the abortion procedure, they would be limited in their ability to make disclosures aimed at reinforcing or encouraging the maternal-fetal relationship, on the grounds that a woman seeking an abortion has already rejected the maternal identity. See, e.g., Law, *supra* note 28, at 297 (“Typically, women go to abortion clinics because they believe that they want an abortion.”).

This limitation would likely bar the use of ultrasound images that arguably transform the fetus “from an abstraction to a baby in the eyes of the potentially aborting mother[.]” See *supra* note 132 and accompanying text. For mandated disclosures about the relationship between mother and fetus, see *supra* note 23 and see accompanying text for information about social supports for women with children. Many thanks to Elizabeth Glazer for encouraging me to explore this idea in the context of identity theory.

¹⁴¹ See *Planned Parenthood of Heartland v. Heineman*, 724 F. Supp. 2d 1025, 1044 (D. Neb. 2010). In this case, the court noted,

No . . . legislative concern for the health of women, or of men, has given rise to any remotely similar informed-consent statutes applicable to other medical procedures, regardless of whether such procedures are elective or non-elective, and regardless of whether such procedures pose an equal or greater threat to the physical, mental, and emotional health of the patient. From a plain reading of the language of the bill, and the absence of any similar statutory ‘protections’ for the health of patients in other

rather than overt or even implicit sexism, as some have suggested.¹⁴² Evidence in support of this argument can be found in the trend towards increased regulation of the process of informed consent in the context of extraction, research, and treatment involving embryos and embryonic stem cells—a similarly controversial area.¹⁴³

If there is no underlying discriminatory intent behind abortion informed consent laws, might we object to them on the basis of discriminatory effect? An analogy could be drawn to the Civil Rights Act, which allows a plaintiff to make a claim for racial discrimination based upon a showing of disparate impact; the plaintiff may then recover only if the defendant is unable to identify a legitimate reason for its policy or if the plaintiff can show that the defendant has failed to adopt a reasonable alternative policy that does not have a discriminatory effect.¹⁴⁴ The undue burden standard adopted by the Supreme Court in *Casey* also recognizes that a burdensome effect can be just as problematic as a burdensome intent. In *Casey*, the Court defined “undue burden” as “shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”¹⁴⁵ Again, it is difficult to make any conclusive judgments about the legal or ethical validity of abortion disclosure laws on these grounds, and perhaps the strongest claim to be made is that each law ought to be evaluated independently for the possibility of discriminatory intent or effect.

CONCLUSION

Proponents of abortion disclosure laws endorse them as essential to the informed consent process. Critics argue that only if a woman has viewed images of the stages of fetal development, been offered the opportunity to view an ultrasound image of her fetus and hear its heartbeat, been told that her fetus is a human being, and been provided with information about available support services, can she truly make an informed decision about whether or not to abort. Opponents of the new abortion disclosure laws, on the other hand, maintain that policymakers who use the rhetoric of informed consent to support such laws are in fact limiting women’s opportunities for autonomous medical choice. They argue that

contexts, this Court infers that the objective underlying LB 594 is the protection of unborn human life.

Id.

¹⁴² See generally Siegel, *supra* note 37.

¹⁴³ See, e.g., MASS. GEN. LAWS ANN. ch. 111L § 4 (2010); Raynard S. Kington, *National Institute of Health Guidelines on Human Stem Cell Research* (2009), <http://stemcells.nih.gov/policy/2009guidelines.htm>.

¹⁴⁴ 42 U.S.C. § 2000e-2(k) (2006).

¹⁴⁵ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992).

such laws are biased, ideological, discriminatory, and therefore inconsistent with the doctrine of informed consent.

This Article has sought to demonstrate that the reality, as so often happens, falls somewhere in between. Certainly, some proponents of abortion disclosure laws seem motivated less by a desire to encourage autonomous decision-making, and more by a desire to dissuade women, by whatever means, from choosing abortion. On the other hand, some critics relying on the argument from informed consent seem to be drawing on a simplistic conception of the informed consent doctrine that fails to take into account the doctrine's inherent dependence on social values.

A nuanced view of informed consent doctrine will be helpful in resolving the heated debate surrounding abortion disclosure statutes. If ethical and legal theories of informed consent should influence state abortion policies, reliance on informed consent must be grounded in recognizable doctrine rather than ideological rhetoric and knee-jerk responses. Unfortunately for some, the more nuanced understanding of informed consent presented here does not lend itself to generalizations about the legitimacy of abortion disclosure laws as a whole. However, it is likely to benefit both proponents and critics of such laws as they tailor their arguments to more accurately reflect underlying doctrine. For example, it can be used to support more modest—and in turn more defensible—challenges to some abortion informed-consent laws, such as those requiring disclosure of factual information that is not supported by the scientific community, physician disclosure of information that is not medically material and ought more properly be distributed by the state, and disclosure of information or images against a patient's will.

Finally, readers should remember that this Article addresses only one of the arguments commonly raised against abortion disclosure laws—the argument from informed consent. Although some of these laws do in fact violate traditional doctrines of informed consent, it is by no means clear that informed consent doctrine ought to be the only principle guiding legislation in this context. The state has a variety of interests beyond promoting autonomous patient decision-making and the argument from informed consent does not explain adequately why the sphere of doctor-patient communication should be insulated from other important governmental goals. Indeed, in the public health context, courts and legislators expressly reject informed consent principles to further more pressing societal interests.¹⁴⁶ The most relevant limitations, therefore, are constitutional in nature.

¹⁴⁶ See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (holding a compulsory vaccination constitutional despite petitioner's medical objections). Admittedly, however, the very obvious public health threats posed by patients who refuse treatment during pandemics and epidemics are different in kind from the threat posed by women who choose abortions.

Some legal scholars, most notably Robert Post, have addressed this question from a First Amendment perspective,¹⁴⁷ but to date courts have not been particularly accommodating to such arguments.¹⁴⁸ Others have analyzed whether abortion disclosure laws violate women's right to reproductive privacy.¹⁴⁹ While such arguments—at least with respect to informed consent requirements—have not been particularly successful in the past,¹⁵⁰ it is worth considering whether future challenges might be strengthened by forging a more explicit connection between the constitutional undue burden test and bioethical principles regarding patient autonomy, voluntariness, and third-party persuasion.¹⁵¹

Another potentially promising approach for addressing abortion disclosure requirements is the relatively simple policy argument on the merits of mandated disclosure to address broader societal issues. For example, in a more general context, Omri Ben-Shahar and Carl Schneider have argued that lawmakers err when they adopt mandated disclosure as a solution to social problems without considering whether disclosure is likely to be an effective solution.¹⁵²

Although they are outside the scope of this Article, these constitutional and policy arguments will likely have a greater impact on future policy than the contemporary arguments grounded in informed consent. This Article lays the groundwork for a continuation of this critical debate among medical ethicists and health law scholars.

¹⁴⁷ Post, *supra* note 51. See also Robbins, *supra* note 51; Whitney D. Pile, *The Right to Remain Silent: A First Amendment Analysis of Abortion Informed Consent Laws*, 73 Mo. L. REV. 243 (2008).

¹⁴⁸ *Casey*, 505 U.S. at 884 (holding that physicians' First Amendment rights are "implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State"). See also *Planned Parenthood v. Rounds*, 530 F.3d 724, 737–38 (8th Cir. 2008) (holding that Planned Parenthood's evidence did not establish a likelihood of proving a First Amendment violation); *Eubanks v. Schmidt*, 126 F. Supp. 2d 451, 458–59 (W.D. Ky. 2000) (holding that physicians' First Amendment rights are not violated when the state compels them to pay for and distribute ideological speech with which they disagree); *but see Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (holding that revocation of physicians' DEA registration on the basis of their recommendation of medical marijuana violates physicians' First Amendment rights); *Planned Parenthood of Heartland v. Heineman*, 724 F. Supp. 2d 1025, 1048 (D. Neb. 2010) ("Plaintiffs have presented substantial evidence that disclosures mandated by LB 594, if applied literally, will require medical providers to give untruthful, misleading and irrelevant information to patients. Accordingly, the First Amendment rights of medical providers are implicated by the bill's mandates, and the Plaintiffs have demonstrated a likelihood of success of the merits of their First Amendment claim."); *Planned Parenthood v. Rounds*, --- F.3d ---, 2011 WL 3862585 (8th Cir. 2011) (holding that South Dakota's requirement that physicians disclose untruthful information about risk factors relating to abortion violates the First Amendment rights of physicians).

¹⁴⁹ See, e.g., Borgmann, *supra* note 599; Dresser, *supra* note 3, at 1621; Sanger, *supra* note 3; Siegel, *supra* note 37.

¹⁵⁰ See *Casey*, 505 U.S. 833.

¹⁵¹ See Siegel, *supra* note 37 (presenting a dignity-based analysis of *Casey* and *Carhart*).

¹⁵² Ben-Shahar & Schneider, *supra* note 433, at 22–23.