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## Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics

Ian Vandewalker

*Brennan Center for Justice at New York University School of Law*

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ABORTION AND INFORMED CONSENT:  
HOW BIASED COUNSELING LAWS MANDATE  
VIOLATIONS OF MEDICAL ETHICS

*Ian Vandewalker\**

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\* Counsel, Brennan Center for Justice at New York University School of Law (employer provided for identification purposes only). I would like to thank my former colleagues at the Center for Reproductive Rights for everything they have done to make this Article possible, and especially Erez Aloni, Janet Crepps, Diana Hortsch, Michelle Movahed, Suzanne Novak, Elizabeth Sepper, and Stephanie Toti for comments on an earlier version.

## INTRODUCTION

Imagine a doctor who has a moral objection to the use of birth control pills. A patient comes to him seeking a prescription for the pill, but he tries to discourage her. He exaggerates its risks to her health, and he tells her that she may experience various side effects even where there is no scientific evidence of such effects. During their conversation, he tells her graphic details about another form of birth control, tubal ligation surgery, and shows her photographs of such a surgery being performed—even though the patient expressed no interest in tubal ligation and in fact said she did not want to hear about the surgery once the doctor brought it up. Finally, he tells her that birth control is morally wrong. At the end of this conversation, the patient tells the doctor that she has considered her options and the information the doctor gave her and is ready to proceed with the pill. However, the doctor sends the patient home to think it over, telling her she must wait at least one day. Because of the patient's work and child care obligations, she is not able to return to the doctor's office for her prescription until the following week.

This doctor's actions would strike many people as morally wrong. He has used deception, frightening and medically irrelevant information, and the practical obstacle of delay to try to prevent his patient from obtaining a medication—all as ways of imposing his moral view on the patient. In fact, there is an ethical doctrine that regulates the practice of medicine that can be used to evaluate the moral character of the doctor's actions: that of *informed consent*. At its heart, the doctrine requires that health care professionals provide their patients with sufficient information to allow them to make an intelligent decision as to whether to undergo a medical intervention, and that the patient's decision determines whether the patient undergoes the intervention.

If we slightly change the facts of the story about the discouraging doctor, it becomes a story that happens every day. Abortion patients face attempts to discourage them from terminating their pregnancies like those the imaginary doctor used, as well as others—and state laws mandate these attempts. While the law of every state requires health care professionals to secure the informed consent of the patient before any medical intervention, over half of the states place additional requirements on legally effective informed consent for abortion. These laws sometimes include features that have ethical problems, such as giving patients deceptive information.

Such laws are part of anti-abortion activists' strategy to chip away at the legal availability of abortion in the United States by heavily regulating

the practice of providing abortions. These laws are examples of abortion exceptionalism, in which abortion is singled out for more restrictive government regulation as compared to other, similar procedures.<sup>1</sup> Various justifications are offered for abortion-specific regulations, but at heart they are driven by moral opposition to abortion and legislators' desire to come as close as possible to banning it without enacting a law that will be struck down as unconstitutional.

Unique informed consent requirements for abortion are depicted by their supporters as necessary for fully informed and voluntary consent to abortion. They are purported to protect health by regulating the practice of medicine. But their worst features are detrimental both to the goals of the doctrine of informed consent and to women's health. I refer to these laws as "biased counseling laws" because they are not intended to ensure that patients give their informed consent to abortion, but rather are intended to make women less likely to terminate their pregnancy. I employ a broad definition of biased counseling laws; for my purposes, any law that is intended to discourage women from deciding to obtain abortions is a biased counseling law. However, not all abortion-specific consent laws are equally ethically problematic. Thus, my argument will focus on certain features of biased counseling laws.

This Article contributes to the literature by examining in detail the most problematic features of biased counseling laws, collecting and explaining some of the most influential ethical accounts of informed consent, and demonstrating the deep ethical problems with biased counseling laws. Legal scholars have previously argued that biased counseling laws are unconstitutional because they impose an undue burden on the right to terminate a pregnancy,<sup>2</sup> they violate the First Amendment,<sup>3</sup> and

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1. As one court explained, "first trimester abortions are less likely to result in complications than many other surgical procedures that are routinely performed in doctor's offices. Loop electrical excision procedures, regular diagnostic D & C's, hysteroscopy, diagnostic laparoscopy, genetic amniocentesis and laser procedures all pose risks to women equal to or greater than first trimester abortions." *Tenn. Dep't of Health v. Boyle*, No. M2001-01738-COA-R3-CV, 2002 WL 31840685, at \*7 (Tenn. Ct. App. Dec. 19, 2002) (invalidating statute requiring providers of a "substantial number" of abortions to acquire a license).
  2. See, e.g., Sarah E. Weber, Comment, *An Attempt to Legislate Morality: Forced Ultrasounds as the Newest Tactic in Anti-Abortion Legislation*, 45 *TULSA L. REV.* 359, 366-72 (2009) (arguing that an Oklahoma bill requiring an ultrasound before an abortion violates women's due process right to obtain abortions).
  3. See, e.g., Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 *U. ILL. L. REV.* 939 (2007); Sarah Runels, Note, *Informed Consent Laws and the Constitution: Balancing State Interests with a Physician's First Amendment Rights and a Woman's Due Process Rights*, 26 *J. CONTEMP. HEALTH L. & POL'Y* 185, 194-98 (2009) (arguing that biased counseling laws constitute

they constitute sex discrimination.<sup>4</sup> This Article shows that, in addition to their shortcomings when judged by the standards of the Constitution, biased counseling laws have serious problems when judged by the standards of medical ethics. The Article provides an innovative, interdisciplinary analysis of statutory provisions in an area in which legislatures have been highly active in recent years and will likely continue to be.

Part I sketches the legal doctrine of informed consent, which constitutes useful background for understanding the related ethical doctrine and illustrates the baseline of general informed consent requirements that abortion-specific laws go beyond. The ways in which biased counseling laws exceed general informed consent requirements are an example of abortion exceptionalism, the strategy of regulating abortion more stringently than similar medical procedures in order to decrease patients' access to the procedure. Part I also draws attention to Supreme Court decisions discussing informed consent to abortion that contain the troubling beliefs held by supporters of biased counseling laws. Part II describes several biased counseling laws, pointing out specific features that have medical ethical significance. Part III surveys several well-developed, influential accounts of informed consent from the field of medical ethics, as well as the positions of two medical professional associations. I apply each of them to the features of biased counseling laws that are discussed in Part I and argue that none of them provides a justification for the problematic features of biased counseling laws. In fact, those features of biased counseling laws are deeply flawed according to all the ethics authorities this Article examines.

## I. THE LEGAL CONTEXT

### *A. The Legal Doctrine of Informed Consent*

The tort doctrine of informed consent in the United States was developed in the common law in the early twentieth century, although it

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compelled speech in violation of the First Amendment); *see also* Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. REV. 939, 1007–11 (2009) (arguing that some biased counseling laws violate an as-yet unrecognized right against compelled listening).

4. *See* Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991 (2007) (arguing that the woman-protective justifications offered for a South Dakota abortion ban and biased counseling law are based on unconstitutional gender stereotypes).

has since been codified in many states.<sup>5</sup> The doctrine has shifted in its legal consequences; initially, a doctor's failure to obtain informed consent created a cause of action sounding in battery, protecting the patient's bodily integrity,<sup>6</sup> but the cause of action later generally came to be thought of as sounding in negligence.<sup>7</sup>

The key element of informed consent is that the doctor must disclose material risks to the patient. About half the states define "material risks" as those that a reasonable person would likely find significant "in deciding whether or not to forego the proposed therapy,"<sup>8</sup> while the other half defines the term by reference to professional practice and what a reasonable physician would disclose.<sup>9</sup> Under the doctrine, the decision belongs to the patient: patients have the right to refuse medical interventions.<sup>10</sup> Thus, informed consent is "the legal recognition of the medical patient's protectable interest in autonomous decisionmaking."<sup>11</sup> The fundamental value undergirding the doctrine is generally considered to be patient autonomy.<sup>12</sup> There are four widely-recognized exceptions to the requirement that a physician obtain informed consent to a medical intervention: emergencies; patient incompetence; patient waiver; and therapeutic privilege, a doctrine that allows doctors to refrain from making a disclosure where it will seriously harm the patient.<sup>13</sup>

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5. See RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 139–40 (1986) (discussing the development of statutory law of informed consent).
  6. See, e.g., *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905).
  7. See, e.g., *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).
  8. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).
  9. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 122–23 (6th ed. 2009); JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 46–51 (2d ed. 2001).
  10. See, e.g., *Natanson*, 350 P.2d at 1104 ("Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment.").
  11. *Arato v. Avedon*, 858 P.2d 598, 605 (Cal. 1993); see also Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 420 (1979) (arguing that "[t]he purpose of requiring the patient's consent to treatment is to protect his physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous, self-determining human being").
  12. The value of individual autonomy also grounds the right to privacy under the United States Constitution, which protects "a person's most basic decisions about family and parenthood," *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 849 (1992), as well as the "constitutionally protected liberty interest in refusing unwanted medical treatment," *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).
  13. See Meisel, *supra* note 11, at 433. *Canterbury* includes an early articulation of the therapeutic privilege. 464 F.2d at 788–89.

Other sources of law buttress the tort doctrine requiring informed consent for medical treatment. Although the two are distinct, “there is quite a bit of convergence between the principles underlying the tort law doctrine of informed consent and the constitutional right of privacy.”<sup>14</sup> Both doctrines are undergirded by the value of individual autonomy. In addition, the right not to be subjected to medical treatment without one’s informed consent is a human right that is guaranteed to individuals in the United States by the International Covenant on Civil and Political Rights (“ICCPR”).<sup>15</sup> The ICCPR requires states parties to ensure that patients give “full and informed consent” to medical procedures.<sup>16</sup>

The legal doctrine of informed consent and the ethical doctrine of informed consent are analytically distinct, although they have been intertwined in their historical development. It is conceptually possible for the legal doctrine to place an obligation on doctors that the ethical doctrine is silent upon or even prohibits.<sup>17</sup> Since this Article argues that biased counseling laws violate the ethical doctrine, I will not analyze the legal doctrine in any detail.

### *B. Abortion Exceptionalism*

Since every state has generally-applicable informed consent laws, statutes that require more involved consent protocols are an example of abortion exceptionalism.<sup>18</sup> This is the anti-abortion legislator’s strategy to decrease the number of abortions by placing onerous regulations on abortion where similar procedures are unregulated, making abortions more difficult and more expensive to provide.<sup>19</sup> Abortion providers often

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14. Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 262–63 (2009).

15. International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171.

16. See U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: Slovakia* ¶ 12 CCPR/CO/78/SVK (Aug. 22, 2003).

17. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OP. NO. 439, INFORMED CONSENT 2 (2009) [hereinafter INFORMED CONSENT], available at [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Ethics/Informed\\_Consent](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/Informed_Consent) (noting the distinction between legal and ethical informed consent requirements).

18. Although I am sure I did not invent this term, I am not aware of any prior use of it in the legal literature.

19. See Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997, 1062–63 (2010). In *Planned Parenthood of the Heartland v. Heineman*, 724 F. Supp. 2d 1025 (D. Neb. 2010), the court held that a Nebraska statute’s requirements on abor-

face more stringent regulations than other health care providers—such as physician’s offices or outpatient surgery facilities—that have similar risk profiles. Abortion providers are often required to obtain licenses, be subject to inspections, maintain certain written policies, and meet physical plant requirements—even where other health care providers are not.<sup>20</sup> While most regulation of the medical profession is enforced only by professional sanctions such as disciplinary action by a licensing body, abortion regulations are often backed by the threat of criminal penalties, including prison sentences.<sup>21</sup> Provisions like the federal Hyde Amendment<sup>22</sup> and similar state laws<sup>23</sup> prohibit public funds from being used to pay for abortions, on the basis that taxpayers who oppose abortion should not have to pay for it.<sup>24</sup> However, there are no similar provisions prohibiting taxpayer money from funding other activities that are morally offensive to large numbers of Americans, such as the production of highly destructive military weaponry.

The popularity of laws that create unique requirements for legally effective informed consent to abortion stands in contrast to the rarity of informed consent laws specific to other procedures. Some states have

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tion providers, including putative informed consent requirements, were so onerous that the only interpretation of the statute was that it was “intended to place a substantial, if not insurmountable, obstacle in the path of any woman seeking an abortion[.]” *Id.* at 1046. The court also noted the exceptionalism of the abortion law, pointing out that “[n]o such 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 pose an equal or greater threat to the physical, mental, and emotional health of the patient.” *Id.* at 1044.

20. See generally Center for Reproductive Rights, *Targeted Regulation of Abortion Providers: Avoiding the “TRAP”*, 2–4 (2003), [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub\\_bp\\_avoidingthetrap.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_avoidingthetrap.pdf) (describing regulations specific to abortion providers in various states).
21. See, e.g., N.D. CENT. CODE §§ 12.1-32-01(5) (2011), 14-02.1-04(4), (5) (2011) (providing that a physician’s failure to ensure that an abortion patient is offered the opportunity to view an ultrasound is a misdemeanor punishable by one year in prison or a \$2,000 fine, or both).
22. Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434. Congress has passed a version of this appropriations rider prohibiting the use of federal funds to pay for abortions every year since 1976.
23. For example, Arizona law prohibits state money from being used to pay for abortions. ARIZ. REV. STAT. § 35-196.02(A) (2011). In 2011, the legislature expanded this ban to prohibit public funds going to “any person or entity who provides, pays for, promotes, provides coverage of or provides referrals for abortions.” H.R. 2384, 50th Leg., 1st Reg. Sess. (Ariz. 2011).
24. See, e.g., 139 Cong. Rec. 22,629 (1993) (discussing the Hyde Amendment and stating: “Forcing . . . millions of pro-life Americans to pay for abortion on demand with their tax dollars would be a gross violation of their freedom of conscience.”)



informed consent statutes specific to sterilization.<sup>25</sup> Some states have laws specific to breast cancer treatment, and some show special concern for psychological treatments like electroconvulsive therapy and psychotropic drugs.<sup>26</sup> Other statutes provide specific disclosure requirements for telemedicine,<sup>27</sup> which is the provision of medicine remotely through the use of telecommunications, or for umbilical cord blood banking.<sup>28</sup> Interestingly, unique application to women or reproduction is a feature of most of these areas of special regulation of consent. Sterilization is one area where the state shows its desire to regulate reproduction and specifically to protect childbearing capacity, just as it does in the abortion context. Two others involve medical circumstances faced only or primarily by women, breast cancer and umbilical cord blood banking. This gender distinction fits with the notion that women need special protection in their medical decision making, which is an important aspect of anti-abortion policy making, as I discuss in the next section.

### *C. The Constitutional Right to Abortion and Views of Women's Decision Making*

The United States Constitution protects the right to terminate a pregnancy.<sup>29</sup> The constitutionality of laws that impact the right to abortion is judged by the "undue burden" standard articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>30</sup> The Supreme Court's abortion jurisprudence in *Casey* and since touches on informed consent principles and women's autonomy. Apparent in these decisions is a troubling strain of paternalism and distrust of women's decision-making ability. The Court's use of these ideas in decisions regarding which forms of abortion regulation are constitutionally permissible helps illustrate how such regulation in the form of biased counseling laws conflicts with the doctrine of informed consent.

*Casey* departed from prior Supreme Court decisions by enhancing the government's "interest in promoting the life or potential life of the unborn."<sup>31</sup> The plurality reasoned that, while the government may constitutionally act to further an interest in potential life by persuading women to choose childbirth over abortion, the means it uses "must be

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25. See, e.g., DEL. CODE ANN. tit. 16, § 5701 (2011); OR. REV. STAT. § 436.225 (2011).

26. FADEN & BEAUCHAMP, *supra* note 5, at 140.

27. See, e.g., OKLA. STAT. tit. 36, § 6804 (2011).

28. See, e.g., OKLA. STAT. tit. 63, § 2175 (2011).

29. See *Roe v. Wade*, 410 U.S. 113 (1973).

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

31. *Casey*, 505 U.S. at 870 (plurality opinion).

calculated to inform the woman's free choice, not hinder it."<sup>32</sup> One of the many restrictions in the Pennsylvania abortion law that was upheld in *Casey* was a biased counseling provision.<sup>33</sup> The statute requires that, twenty-four hours before an abortion, a woman must be "orally informed" of the gestational age of the embryo or fetus and of the nature and risks of the procedure and alternatives,<sup>34</sup> and must be offered state-produced materials that "describe the unborn child and list agencies which offer alternatives to abortion,"<sup>35</sup> among other disclosures.

The *Casey* plurality had no trouble upholding the risk disclosure, approving the requirement to give "truthful, nonmisleading information" about the procedure and its risks. But the following language, which appears in the portion of the plurality opinion upholding disclosures about gestational age and fetal development, reveals the plurality's view of women's capacity to decide whether to terminate their pregnancies:

[It cannot] be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.<sup>36</sup>

The plurality's statement contains wholly unsupported empirical claims about what women think. In addition, the plurality writes as if the law requires disclosure of the consequences of an abortion to the embryo or fetus,<sup>37</sup> when it is common knowledge that an abortion results in its destruction. The disclosure at issue is not about what the consequences are, but what the embryo or fetus *looks like*, information which is not clearly

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32. *Casey*, 505 U.S. at 877. The protection of the health of pregnant women is also a permissible purpose for abortion regulations. *Id.* at 846 (plurality opinion).

33. 18 PA. CONS. STAT. § 3205 (1989).

34. *Id.* at § 3205(a)(1).

35. *Id.* at § 3205(a)(2)(i).

36. *Casey*, 505 U.S. at 882.

37. Although the term "fetus" is typically used in discussions of abortion to the exclusion of "embryo," the vast majority of abortions in the United States occur at stages of pregnancy when the former term is inappropriate. The fetal period begins at the end of the tenth week of pregnancy, and approximately 80% of abortions are performed at earlier gestational ages. See GUTTMACHER INST., FACTS ON INDUCED ABORTION IN THE UNITED STATES (2011), available at [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.pdf](http://www.guttmacher.org/pubs/fb_induced_abortion.pdf).

relevant to patients' decisions.<sup>38</sup> Finally and most importantly, the plurality betrays its skepticism about women's decision-making ability and autonomy by assuming that it is appropriate for the state to protect women from their putative inability to think through their own decisions and then face the consequences of those decisions.<sup>39</sup>

Turning to the Pennsylvania law's waiting period, the *Casey* plurality said: "The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision."<sup>40</sup> We should ask, what is the problem the state is addressing here? Why do policy-makers believe that women are unable to take sufficient time to make the decision on their own and need to be forced to sleep on it?<sup>41</sup> What is more, informed consent is a doctrine designed to help patients make decisions when they need medical information to decide among treatment options, but the decision of whether to bear a child goes far beyond that. Yet *Casey* treats the state's disapproval of abortion as if it were as relevant as the medical risks. Even if the state has a legitimate interest in discouraging abortion, that does not entail that it is appropriate to use the informed consent process to express that interest or intrude upon the relationship between doctor and patient.<sup>42</sup>

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38. This point shows the *Casey* plurality's analogy to the kidney transplant beneficiary who wants to know what the risks are to the donor, *see Casey*, 505 U.S. at 883, to be a complete non sequitur. No one who is mentally capable of consenting to an abortion is unaware that abortion results in the termination of a pregnancy. Of course, some women may think that the means by which the embryo or fetus is destroyed and removed is relevant to their decision. Under the general doctrine of informed consent, those women are free to ask for that information and health care professionals are obliged to disclose it. But some biased counseling laws require all patients to receive the same information, regardless of their wishes.

39. This strain of thought runs counter to the Court's sex discrimination jurisprudence. *See United States v. Virginia*, 518 U.S. 515, 533 (1996) (stating that the justification for a law "must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females"); *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 725 (1982) ("[I]f the statutory objective is to exclude or 'protect' members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior, the objective itself is illegitimate.").

40. *Casey*, 505 U.S. at 885.

41. *Cf. Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 23 (Tenn. 2000) (quoting trial court's statement that "[t]he majority of the expert testimony seemed to acquiesce in the fact that most women have seriously contemplated their decision before making their appointment").

42. *See Manian*, *supra* note 14, at 251 (arguing that allowing the state to "pressure women to choose childbirth over abortion" contradicts the purposes of informed consent).

In its most recent abortion decision, *Gonzales v. Carhart*, the Supreme Court upheld the so-called Partial-Birth Abortion Ban Act of 2003 against constitutional challenge.<sup>43</sup> This federal statute places a criminal prohibition on some methods of abortion.<sup>44</sup> The physicians challenging the act argued, *inter alia*, that it placed an unconstitutional undue burden on the right to abortion by imposing a substantial obstacle in the path of women seeking abortions. *Carhart* cited *Casey* for the proposition that the state does not impose an undue burden on the abortion right with “[r]egulations which do no more than create a structural mechanism by which the State . . . may express profound respect for the life of the unborn . . . , if they are not a substantial obstacle to the woman’s exercise of the right to choose.”<sup>45</sup> The Court found that the statute’s prohibition on abortion methods that involve the partial removal of a fetus from the uterus before fetal demise was justified by the government’s interest in showing its “profound respect for the life within the woman.”<sup>46</sup> The Court accepted congressional findings that procedures that are similar to infanticide should be prohibited in order to maintain a bright line between abortion and infanticide.<sup>47</sup>

In addition to the government’s interest in protecting the dignity of human life by proscribing certain methods of terminating pregnancies, the Court found that the government’s interest in protecting women from the consequences of their own actions was a purpose that helped keep the statute from imposing a substantial obstacle. Like *Casey*, *Carhart* made bold assertions without statistical support and even acknowledged doing so: “While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.”<sup>48</sup> It is alarming that the mere possibility that some individuals might regret an act can be part of the government’s justification for criminalizing it. It is “unexceptionable” to conclude that some people regret getting married or divorced, but no one would argue that this is a reason for either to be criminalized, both because the proportion of regretful people is presumably small and because people have a fundamental right to control their

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43. *Gonzales v. Carhart*, 550 U.S. 124, 168 (2007).

44. 18 U.S.C. § 1531 (2003).

45. *Carhart*, 550 U.S. at 146 (quoting *Casey*, 505 U.S. at 877).

46. *Carhart*, 550 U.S. at 157.

47. *Carhart*, 550 U.S. at 158.

48. *Carhart*, 550 U.S. at 159 (internal citation omitted) (citing Brief for Sandra Cano et al. as Amici Curiae in No. 05–380, pp. 22–24 (quoting women who attributed emotional problems to having had abortions)).

family lives,<sup>49</sup> even where they may come to regret their decisions. Both reasons apply equally well to abortion.<sup>50</sup>

Even more alarming—and germane to informed consent—the Court found another justification for the ban in the following string of possibilities: doctors might not describe the details of the procedure in question to their patients, some patients might later learn of those details, and some of those patients might experience serious grief and sorrow. The last step in this imagined scenario, that a woman who regrets her abortion “must” face deeper grief and sorrow once she discovers the details of the procedure, was characterized as “self-evident” by the Court,<sup>51</sup> even though it is an empirical proposition that demands supporting evidence like any other claim about human psychology. Bafflingly, the *Carhart* Court used an informed consent justification to uphold not a requirement of robust disclosures, but a criminal ban on a safe procedure. This ban restricts patients’ autonomy, rather than protecting it.<sup>52</sup> As Justice Ginsburg put it in her dissent: “Eliminating or reducing women’s reproductive choices is manifestly not a means of protecting them.”<sup>53</sup> The Court’s mistaken argument is a particularly transparent example of the anti-abortion strategy of using the idea of informed consent to justify regulation that does nothing to protect the values that informed consent serves: the provision of information and the enabling of autonomous choice. Rather, the anti-abortion strategy uses informed consent as an obstacle to abortion access.<sup>54</sup>

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49. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 384 (1978) (“[T]he right to marry is of fundamental importance for all individuals.”); *Boddie v. Connecticut*, 401 U.S. 371, 382 (1971) (describing marriage as one of the basic values of society); *Griswold v. Connecticut*, 381 U.S. 479, 495 (1965) (Goldberg, J., concurring) (“[T]he rights to marital privacy and to marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected.”).

50. See *Roe v. Wade*, 410 U.S. 113, 152–53 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion) (affirming the central holding of *Roe*). See also BRENDA MAJOR ET AL., AM. PSYCHOLOGICAL ASS’N., REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 81 (2008) [hereinafter APA TASK FORCE REPORT] available at <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> (reporting findings that most women are satisfied with their decision to have an abortion).

51. *Carhart*, 550 U.S. at 159–60 (“It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.”)

52. See Manian, *supra* note 14, at 257 (“The Court’s concern for informed decision-making hardly seems genuine when its solution denies decision-making altogether.”).

53. *Carhart*, 550 U.S. at 184 n.9 (Ginsburg, J., dissenting).

54. See, e.g., *supra* note 19 (discussing Nebraska law).

These examples show the Court's willingness to accept the notion that women's decision-making abilities are deficient, which is supposed to justify forcing women to receive certain information, to endure mandatory waiting periods, and to have some options taken away from them altogether. Unsupported assumptions about future regret become reasons to restrict women's actions, despite the fact that various life choices people make may become a source of regret. The power of self-determination that principles of liberty grant to individuals entails a requirement that individuals face the consequences of their actions. Informed consent, a doctrine designed to facilitate self-determination through the provision of the information needed to make a decision, is manipulated in the service of the political goal of restricting abortion. That this is the political goal of biased counseling statutes will become clear as Part II describes these statutes and explains the ways they are intended to discourage abortions. Legislatures have been encouraged by the fact that the Supreme Court upheld Pennsylvania's biased counseling in *Casey*, as well as the mistrust of women apparent in the Court's decisions, to enact biased counseling laws that go far beyond the Pennsylvania statute that was before the Court in 1992.

## II. BIASED COUNSELING LAWS

Over half of the states have laws that specifically regulate the informed consent process for abortion, placing requirements on providers and patients that are more demanding than for any other medical procedure.<sup>55</sup> These laws are intended to discourage women from choosing to terminate their pregnancies. Part II discusses examples of the most troubling features of these laws: they intend to discourage abortions, reveal disdain for women's decision making, and are based on false views of the medical facts. Part III will argue that these characteristics of biased counseling laws violate medical ethics.

### *A. False or Misleading Statements About Risks*

Several states' biased counseling laws require that health care providers make statements to patients about specific risks, such as infertility

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55. See Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL'Y REV., Fall 2007, at 6, 7–9, available at <http://www.guttmacher.org/pubs/gpr/10/4/gpr100406>. In addition to the twenty-three states listed by Gold and Nash in 2007, at least four states have since enacted biased counseling laws: Arizona, Florida, Indiana, and Missouri.

or psychological problems, in order to properly “inform” the patients’ consent. Some of these risk statements are exaggerated, misleading, or simply false.

### 1. Infertility

Statutes in several states require abortion patients to be told of a risk of infertility when medically accurate.<sup>56</sup> However, some states do not include qualifications about medical accuracy or specificity regarding the patient’s procedure. The Texas counseling booklet for patients states that complications of abortion “may make it difficult or impossible to become pregnant in the future or carry a pregnancy to term.”<sup>57</sup> State-produced materials that must be offered to patients in South Dakota state that infertility is a risk of abortion, without any qualification.<sup>58</sup>

However, studies have found that there is no association between induced abortion and later infertility.<sup>59</sup> The most common first-trimester abortion method, vacuum aspiration, “poses virtually no long-term risk of infertility, ectopic pregnancy, spontaneous abortion or congenital malformation.”<sup>60</sup> Some complications of abortion may implicate future reproduction, but complications are rare.<sup>61</sup>

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56. See, e.g., NEB. REV. STAT. § 28-327(1)(a) (2011) (preliminarily enjoined in part by *Planned Parenthood of the Heartland v. Heineman*, 724 F. Supp. 2d 1025 (D. Neb. 2010)); N.D. CENT. CODE § 14-02.1-02(8)(a)(3) (2011); W. VA. CODE § 16-21-2(a)(1) (2011); WIS. STAT. § 253.10(3)(c)(1)(f) (2011) (listing infertility as a risk that patients must be informed of). Pennsylvania requires mention of infertility by regulation. 28 PA. CODE § 29.37(b)(1)(iii) (2011).

57. TEX. DEP’T OF HEALTH, A WOMAN’S RIGHT TO KNOW 17 (2003), available at <http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf>.

58. S.D. Dep’t of Health, *Induced Abortion Methods and Risks*, <http://doh.sd.gov/abortion/risks/> (last visited Mar. 18, 2012); see also Gold & Nash, *supra* note 55, at 6, 11.

59. See Hani K. Atrash & Carol J. Rowland Hogue, *The Effect of Pregnancy Termination on Future Reproduction*, 4 BALLIÈRE’S CLINICAL OBSTETRICS & GYNECOLOGY 391 (1990).

60. Gold & Nash, *supra* note 55, at 6, 11.

61. S.K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in A CLINICIAN’S GUIDE TO MEDICAL AND SURGICAL ABORTION 11 (Paul M et al. eds., 1999); see also David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140 ANNALS OF INTERNAL MED. 620, 620 (2004) (finding that induced abortion does not lead to medical problems in the long term).

## 2. Psychological Consequences

Many states' laws require health care providers to tell patients about the emotional or psychological consequences of having an abortion.<sup>62</sup> Several states' biased counseling materials note that women who obtain abortions may feel a range of emotions, from sadness to relief,<sup>63</sup> a statement that is of course trivially true of many significant life events. These laws require doctors to tell all of their patients, vastly most of whom are competent adults, that there may be emotional consequences to the decision to terminate their pregnancies. Anti-abortion legislators believe that women need to be told this because they likely espouse an unjustifiable skepticism about women's moral reasoning and decision-making abilities.

Some states' biased counseling laws and materials claim that abortion can result in specific negative emotions and serious psychological problems.<sup>64</sup> In Michigan, the counseling materials that must be given to every patient<sup>65</sup> are required by statute to "[s]tate that as the result of an abortion, some women may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger."<sup>66</sup> In West Virginia, counseling materials that must be offered to abortion patients<sup>67</sup> state that "[m]any women suffer from Post-Traumatic Stress Disorder Syndrome following abortion. PTSD is a psychological dysfunction resulting from a traumatic experience."<sup>68</sup> The materials provide a long list of symptoms that includes depression, drug abuse, eating disorders, "chronic relationship problems," and "suicidal thoughts or acts," among

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62. For example, Nevada's biased counseling statute requires that a health care professional "[e]xplain the physical and emotional implications of having the abortion." NEV. REV. STAT. § 442.253(1)(c) (2011); *see also* MO. REV. STAT. § 188.027(1)(1)(b)(b) (2011) (requiring providers to inform patients, in person, of "possible adverse psychological effects associated with the abortion"). In 2011, North Dakota added a statutory requirement that its counseling materials discuss "the possible adverse psychological effects associated with an abortion." N.D. CENT. CODE § 14-02.1-02.1(1)(d) (2011). The law apparently requires that these materials be given to abortion patients. N.D. CENT. CODE § 14-02.1-02(8)(b)(2) (2011).

63. Gold & Nash, *supra* note 55, at 6, 11.

64. *Id.* (listing South Dakota, Texas, Utah, and West Virginia).

65. MICH. COMP. LAWS § 333.17015(3) (2011).

66. MICH. COMP. LAWS § 333.17015(11)(b)(iii) (2011).

67. W. VA. CODE § 16-21-2(a), (b)(4) (2011).

68. W. VA. DEP'T OF HEALTH & HUMAN RES., INFORMATION ON FETAL DEVELOPMENT, ABORTION AND ADOPTION 15, *available at* <http://www.wvdhhr.org/wrtk/wrtkbooklet.pdf>.



other things.<sup>69</sup> South Dakota's biased counseling statute required that abortion patients be told about the "known medical risks" of abortion, including an "[i]ncreased risk of suicide ideation and suicide,"<sup>70</sup> but that requirement has been struck down because they are not "known" risks of abortion.<sup>71</sup> In addition, some states' counseling materials mention psychological risks, even when they are not required to by statute.<sup>72</sup>

The best scientific evidence shows that there is no causal relationship between abortion and psychological problems.<sup>73</sup> Many studies to the contrary have been found to have methodological problems.<sup>74</sup> There is an *association* between abortion and mental health problems, but studies show that the association is due to common causal factors.<sup>75</sup> That is, factors that place women at higher risk of mental problems also increase the risk that they will experience unwanted pregnancies and obtain

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69. *Id.* The statute governing the production of these counseling materials requires that the materials "contain objective information describing . . . the possible detrimental psychological effects of abortion." W. VA. CODE § 16-21-3(a)(2) (2011).

70. S.D. CODIFIED LAWS §§ 34-23A-10.1, 34-23A-10.3 (2011).

71. *Planned Parenthood Minn. v. Rounds*, 653 F.3d 662, 673 (8th Cir. 2011) (finding warning of suicide and suicidal ideation violated patients' due process rights and doctors' First Amendment rights "[b]y compelling untruthful and misleading speech"), *vacated in part pending reh'g en banc* by 662 F.3d 1072 (8th Cir. 2011).

72. *See, e.g., TEX. DEP'T OF HEALTH*, *supra* note 57, at 16. The booklet goes on to recommend that women receive counseling at one of the crisis pregnancy centers listed in another state-produced booklet that must be offered to abortion patients. *Id.* Crisis pregnancy centers are dedicated to discouraging pregnant women from getting abortions. *See generally* MINORITY STAFF OF H. COMM. ON GOV'T REFORM, 109TH CONG., FALSE AND MISLEADING HEALTH INFORMATION PROVIDED BY FEDERALLY FUNDED PREGNANCY RESOURCE CENTERS (2006), *available at* [http://waxman.house.gov/UploadedFiles/FALSE\\_AND\\_MISLEADING\\_HEALTH\\_INFORMATION.pdf](http://waxman.house.gov/UploadedFiles/FALSE_AND_MISLEADING_HEALTH_INFORMATION.pdf).

73. Trine Munk-Olsen et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 *NEW ENG. J. MED.* 332, 332 (2011) (finding no increase in likelihood of contact with psychiatric services for mental disorder after induced abortion but finding a slight increase after childbirth); Brenda Major et al., *Abortion and Mental Health*, 64 *AM. PSYCHOLOGIST* 863, 885 (2009) ("[T]he relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy for nontherapeutic reasons is no greater than the risk among women who deliver an unwanted pregnancy."); Post, *supra* note 3, at 962-66 (collecting authorities refuting the existence of "Post-Abortion Syndrome," a spurious emotional condition supposedly caused by abortion); Siegel, *supra* note 4, 1011 n.92 (collecting studies).

74. APA TASK FORCE REPORT, *supra* note 50, at 15-20.

75. *See, e.g.,* Julia R. Steinberg & Lawrence B. Finer, *Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model*, 72 *SOC. SCI. & MED.* 72 (2010) (concluding that the common-risk-factor explanation of the association between abortion and mental disorder is supported by the evidence, and the abortion-as-trauma explanation is not).

abortions. This association is not evidence that having an abortion causes later psychological problems,<sup>76</sup> but rather that both are caused by previously-existing factors. In sum, “the most powerful predictor of a woman’s mental state after an abortion is her mental state before the abortion.”<sup>77</sup> In addition, women who seek abortions are by definition experiencing an unwanted pregnancy, which is itself a stressful circumstance that may exacerbate psychological problems.<sup>78</sup>

What is more, the warnings in biased counseling statutes are not accompanied by similar warnings about the mental health consequences of childbirth, such as post-partum depression, which poses a significant risk.<sup>79</sup> Studies show that becoming a parent can increase the risk of depression and other mental-health problems.<sup>80</sup>

While it is true that some women experience negative emotional responses to their abortions, this is also true of many medical interventions and other types of life events.<sup>81</sup> However, the laws surveyed above exaggerate the likelihood and severity of the risks. The putative patient-protective benefit of these laws is premised on the idea that women cannot predict their feelings after abortion and need to be informed that they may suffer negative emotional consequences. By

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76. Major et al., *supra* note 73, at 885 (“[T]he claim that observed associations between abortion history and a mental health problem are *caused by* the abortion per se, as opposed to other factors, is not supported by the existing evidence.”).
77. *Understanding Postpartum Depression: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 108th Cong. 21 (2004) (statement of Dr. Nada Stotland) (“The psychological outcome of abortion is optimized when women are able to make decisions on the basis of their own values, beliefs and circumstances, free from pressure or coercion, and to have those decisions supported by their families, friends and society in general.”).
78. A recent review of the literature suggested: “An unwanted pregnancy was associated with an increased risk of mental health problems.” *ACAD. OF MED. ROYAL COLLS., INDUCED ABORTION AND MENTAL HEALTH* 8 (2011); *see also id.* at 125 (“When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth.”).
79. *See, e.g.*, B.N. GAYNES, ET AL., DEP’T OF HEALTH & HUMAN SERVS., *PERINATAL DEPRESSION: PREVALENCE, SCREENING ACCURACY, AND SCREENING OUTCOMES* (2005).
80. Bonnie Rochman, *Having an Abortion Doesn’t Lead to Depression*, *TIME*, Jan. 28, 2011, <http://healthland.time.com/2011/01/28/having-an-abortion-doesnt-lead-to-depression>.
81. *See* Major et al., *supra* note 73, at 885 (“Some women feel confident they made the right choice and feel no regret; others experience sadness, grief, guilt, and feelings of loss following the elective termination of a pregnancy. Some women experience clinically significant outcomes, such as depression or anxiety.”); *see also* Gonzales v. Carhart, 550 U.S. 124, 183 n.7 (2007) (Ginsburg, J., dissenting) (stating that, “for most women, abortion is a painfully difficult decision” but citing evidence that having an abortion is not more harmful to long-term psychological health than having an unintended child).

focusing on negative psychological risks, these laws attempt to use fear to discourage women from terminating their pregnancies.

### 3. Breast Cancer

In a handful of states, statutes require that patients be told that having an abortion increases their risk of breast cancer when it is medically accurate.<sup>82</sup> In Alaska,<sup>83</sup> Oklahoma,<sup>84</sup> and Texas,<sup>85</sup> state-produced materials that must be either given or offered to abortion patients claim that there is a possible link between abortion and breast cancer.<sup>86</sup> In 2011, North Dakota added a statutory requirement that its counseling materials discuss “the possible increased risk of breast cancer.”<sup>87</sup>

While scientific studies have produced inconsistent results as to whether abortion increases the risk of breast cancer, the methodology of many of the studies that apparently show a link has been criticized. These

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82. MINN. STAT. §§ 145.4242, 145.4243 (2011); MISS. CODE ANN. § 41-41-33(1)(a)(ii) (2011); MONT. CODE ANN. §§ 50-20-104(5), -106 (2011); TEX. HEALTH & SAFETY CODE ANN. §§ 171.011, 171.012 (West 2011).

83. See Alaska Dep't of Health and Soc. Servs., *Making a Decision About Your Pregnancy*, <http://www.hss.state.ak.us/dph/wcfh/informedconsent/abortion/risks.htm> (last visited Apr. 3, 2012) (noting a statement from the American College of Obstetricians and Gynecologists that there is no increased risk, as well as the position of the American Association of Pro-Life Obstetricians and Gynecologists that there is a causal relationship).

84. OKLA. BD. OF MED. LICENSURE AND SUPERVISION, *A WOMAN'S RIGHT TO KNOW 14* (2006), available at [http://www.awomansright.org/pdf/AWRK\\_Booklet-English-sm.pdf](http://www.awomansright.org/pdf/AWRK_Booklet-English-sm.pdf) (stating that some “studies indicate that there might be an increased risk” and recommending that some patients seek the advice of their physician).

85. The Texas booklet states: “While there are studies that have found an increased risk of developing breast cancer after an induced abortion, some studies have found no overall risk. There is agreement that this issue needs further study.” TEX. DEP'T OF HEALTH, *supra* note 57, at 17. Abortion patients must be told that they have the right to review this booklet. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(2)(D) (West 2011).

86. See generally GUTTMACHER INST., *STATE POLICIES IN BRIEF: COUNSELING AND WAITING PERIODS FOR ABORTION* (2012) [hereinafter *COUNSELING AND WAITING PERIODS FOR ABORTION*], available at [www.guttmacher.org/statecenter/spibs/spib\\_MWPA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf); Gold & Nash, *supra* note 55, at 6, 8–9. Minnesota's state-produced booklet, which abortion patients must be offered, accurately notes that earlier studies suggested an increased risk, but the National Cancer Institute has reported that there is no link. MINNESOTA DEP'T OF HEALTH, *IF YOU ARE PREGNANT: INFORMATION ON FETAL DEVELOPMENT, ABORTION, AND ALTERNATIVES 22* (2009), available at <http://www.health.state.mn.us/wrtk/wrtk-handbook.pdf>.

87. N.D. CENT. CODE § 14-02.1-02.1(1)(d) (2011). The law apparently requires that these materials be given to abortion patients. N.D. CENT. CODE § 14-02.1-02(8)(b)(2) (2011).

studies used small sample sizes, collected data from subjects after breast cancer had been diagnosed, and relied on self-reporting of abortions.<sup>88</sup> Better-designed studies and meta-analyses have collected data on tens of thousands of subjects and relied on medical records rather than potentially unreliable disclosures by patients about their abortion history.<sup>89</sup> In recent years, study after study has established that there is no link.<sup>90</sup>

The laws mentioned above allow providers to refrain from making a statement to the effect that abortion increases the risk for breast cancer because that statement is not medically accurate. However, the inclusion of inaccurate statements in state-produced counseling materials that providers are required to give or offer to patients is concerning, as some patients may understand the statement to be endorsed by the health care provider who actually gives them the materials.

### *B. Irrelevant or Immaterial Information*

Several states require that women be given state-published counseling materials prior to an abortion—materials that contain information that is irrelevant or immaterial to the decisions before the abortion patient. For example, Idaho's statute requires women be given materials that describe and display photographs of the characteristics of the embryo or fetus at two-week intervals from the fourth to the twenty-fourth week of gestation, as well as descriptions of "the abortion procedures used in current

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88. See Nat'l Cancer Inst., Nat'l Inst. of Health, *Fact Sheet: Abortion, Miscarriage, and Breast Cancer Risk*, <http://www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage> (last visited Apr. 3, 2012).

89. See, e.g., Valerie Beral et al., *Breast Cancer and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83,000 Women with Breast Cancer from 16 Countries*, 363 LANCET 1007, 1007 (2004) This meta-study finds that abortion does not increase risk of breast cancer. *Id.* Studies that ask women to report abortions after they are diagnosed with breast cancer indicate a higher risk than studies in which women record abortions before the cancer diagnosis. *Id.* This suggests the result is driven by a difference in women's likelihood of disclosure.

90. See, e.g., Katherine DeLellis Henderson et al., *Incomplete Pregnancy is not Associated with Breast Cancer Risk: The California Teachers Study*, 77 CONTRACEPTION 391 (2008) (study of thousands of women finding no statistically significant association between incomplete pregnancy, including induced abortion, and breast cancer risk); Karin B. Michels et al., *Induced and Spontaneous Abortion and Incidence of Breast Cancer Among Young Women: A Prospective Cohort Study*, 167 ARCHIVES OF INTERNAL MED. 814 (2007); Gunnar Erlandsson et al., *Abortions and Breast Cancer: Record-Based Case-Control Study*, 103 INT'L J. CANCER 676 (2003); Nat'l Cancer Inst., Nat'l Inst. of Health, *Summary Report: Early Reproductive Events and Breast Cancer*, <http://www.cancer.gov/cancertopics/causes/ere/workshop-report> (last visited Apr. 3, 2012) ("Induced abortion is not associated with an increase in breast cancer risk.")

medical practices at the various stages of growth of the fetus and any reasonable foreseeable complications and risks to the mother.”<sup>91</sup> Thus, for example, a patient who at seven weeks seeks a medication abortion, which involves no surgery, must be given information about the characteristics of fetuses at much later stages of development. In addition, she is given information about surgical abortion procedures used only at later stages of pregnancy—information that bears no relevance to her medical situation.

Even the portion of the materials that describes the procedure the patient will receive does not necessarily limit itself to relevant information. Not every detail of a surgical procedure is helpful to patients in their decision making. No law requires that heart surgery patients be told what will happen to their bodies in graphic detail.<sup>92</sup> The fact that the average person would be disgusted and disturbed by a detailed description of heart surgery does not warrant requiring such a description as a condition of effective consent. On the contrary, most patients would likely rather not hear the description because it would only increase their anxiety about a procedure they know they must undergo. Those patients who want a detailed description can always communicate that the information is material to their consent by asking the doctor for a description.

Similarly, even accurate pictures and descriptions of an embryo or fetus at the same stage as the patient’s pregnancy are not necessarily relevant to patients’ informed consent.<sup>93</sup> Informed consent disclosures are

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91. IDAHO CODE ANN. § 18-609(2) (2011). Including descriptions and pictures of the stages of embryonic and fetal development and the range of abortion procedures are common features of the counseling materials that are produced by about half the states. See COUNSELING AND WAITING PERIODS FOR ABORTION, *supra* note 86 (listing states); Gold & Nash, *supra* note 55, at 6, 8. However, most of those states do not require that the materials be given to abortion patients; they only require that the materials be offered to patients. See, e.g., MO. REV. STAT. § 188.027(2), (3) (2011) (requiring offer of materials that describe embryo or fetus in two-week increments “from conception to full-term” along with color photographs or images and descriptions of the “various” methods of abortion).

92. See Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1617–18 (2008) (noting that biased counseling laws deviate from informed consent doctrine by, inter alia, requiring “graphic language and vivid pictures designed to discourage patients from choosing a medical intervention”).

93. The accuracy of some of the pictures is highly questionable. The representation of a thirty-six-week-old fetus in Louisiana’s booklet—which must be given to patients, LA. REV. STAT. ANN. § 40:1299.35.6(B)(5) (2011)—is a drawing that appears to have the proportions of a child of two or three years, LA. DEP’T OF HEALTH & HOSPS., WOMEN’S RIGHT TO KNOW 10, available at <http://new.dhh.louisiana.gov/assets/docs/Abortion-MakingADecision.pdf>. Curiously, the booklet uses the same drawing, albeit

intended to convey *medical* risks and benefits. Pictures and descriptions of embryos and fetuses are included in counseling materials because they are assumed to have emotional or moral content.

### C. Statements About Fetal Pain

Recent years have seen a trend toward states including claims about fetal pain in their biased counseling requirements.<sup>94</sup> For example, in 2010, Missouri added a provision to its biased counseling law that requires doctors to provide patients whose pregnancies are at twenty-two weeks of gestational age or further with materials “that offer information on the possibility of the abortion causing pain to the unborn child.”<sup>95</sup> There is no “when medically accurate” qualifier. The following statements are required:

- “At least by twenty-two weeks of gestational age, the unborn child possesses all the anatomical structures, including pain receptors, spinal cord, nerve tracts, thalamus, and cortex, that are necessary in order to feel pain.”<sup>96</sup>
- A description of the abortion procedure to be performed and the elements that “could be painful to the unborn child.”<sup>97</sup>
- Fetuses at twenty-two weeks’ gestational age and beyond “seek to evade certain stimuli in a manner that in an

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rotated and reversed, to represent a fetus at forty weeks, despite using a different image for the intermediate gestational age of thirty-eight weeks. *Id.* at 10–11.

94. *Cf.* COUNSELING AND WAITING PERIODS FOR ABORTION, *supra* note 86 (listing states). On a tangential note, the possibility of fetal pain has also become a popular justification for total bans on abortion for certain periods prior to viability. In 2010, Nebraska enacted the “Pain-Capable Unborn Child Protection Act,” which bans abortions where the “probable postfertilization age” of the fetus is twenty or more weeks. NEB. REV. STAT. § 28-3, 106 (2011). The statute’s legislative findings recite: “It is the purpose of the State of Nebraska to assert a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain.” § 28-3, 104(5). Other states have followed suit. *See, e.g.*, OKLA. STAT. tit. 63, §§ 1-745.1-.11 (2011). The U.S. Supreme Court has not recognized fetal pain as an interest justifying abortion restrictions and has held that bans on abortion prior to viability are unconstitutional (twenty weeks is prior to viability). *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846 (1992); *cf.* Women’s Med. Profl Corp. v. Voinovich, 911 F. Supp. 1051, 1074–75 (S.D. Ohio 1995) (rejecting factual argument about fetal pain as ground for “partial birth abortion” ban).

95. MO. REV. STAT. § 188.027(1)(5) (2011).

96. *Id.* at § 188.027(1)(5)(a).

97. *Id.* at § 188.027(1)(5)(b).

infant or an adult would be interpreted as a response to pain.”<sup>98</sup>

- Anesthesia is given to fetuses at twenty-two weeks or more during prenatal surgery, and anesthesia is given to premature babies born at twenty-two weeks or later.<sup>99</sup> Anesthesia is available “in order to minimize or alleviate the pain to the unborn child.”<sup>100</sup>

In 2011, Indiana enacted a statute regulating the provision of abortion in several ways; one new requirement was that abortion providers must inform all abortion patients, orally and in writing, “[t]hat objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age.”<sup>101</sup> The law requires that this statement be made to all abortion patients, regardless of whether their pregnancy has progressed to twenty weeks or not.<sup>102</sup> The Texas counseling booklet states that at the twelfth week of gestation “[t]he fibers that carry pain to the brain are developed; however, it is unknown if the unborn child is able to experience sensations such as pain.”<sup>103</sup> South Dakota’s counseling materials state that “[f]indings from some studies suggest that the unborn fetus may feel physical pain,” without limiting the claim to a particular gestational age.<sup>104</sup>

98. *Id.* at § 188.027(1)(5)(c).

99. *Id.* at § 188.027(1)(5)(d), (e).

100. *Id.* at § 188.027(1)(5)(f), (4). As another example, Utah amended its biased counseling law in 2009 to require that women be offered fetal anesthesia or analgesic, in person, twenty-four hours before their abortion. UTAH CODE ANN. § 76-7-305(2)(a)(iv) (West 2011). Recently, Utah extended this waiting period to seventy-two hours. Act of March 20, 2012, 2012 Utah Laws H.B. 461 (West’s No. 232).

101. IND. CODE § 16-34-2-1.1(a)(1)(G) (2011).

102. The requirement to make a fetal-pain statement has been enjoined as applied to Planned Parenthood of Indiana pending the outcome of that organization’s challenge to the law. *Planned Parenthood of Ind. v. Comm’r of Ind. State Dep’t of Health*, 794 F. Supp. 2d 892, 921 (S.D. Ind. 2011). The court held that the plaintiff was likely to succeed on its First Amendment challenge to the requirement. Because Planned Parenthood of Indiana only performs first-trimester abortions and there is no evidence that a fetus can feel pain in the first trimester, the statement in question would be “false, misleading, and irrelevant” for its patients. 794 F. Supp. 2d at 920.

103. TEX. DEP’T OF HEALTH, *supra* note 57, at 4; *see also id.* at 5 (“Some experts have concluded that the unborn child is probably able to feel pain [at twenty weeks].”). The statute governing the production of this booklet does not require statements about fetal pain to be included. *See* TEX. HEALTH & SAFETY CODE ANN. § 171.014 (West 2011). Interestingly, the law directing the Department to produce this booklet does not require that the information in it be medically or scientifically accurate, with the exception that the required fetal descriptions must be “designed to convey only accurate scientific information.” *Id.* at § 171.016(c).

104. S.D. Dep’t of Health, *supra* note 58; *see also* Gold & Nash, *supra* note 55, at 6, 12.

These fetal pain statements are misleading; they are designed to make patients think that it is likely that a fetus of a certain gestational age can feel pain in circumstances when in fact the scientific evidence does not support that proposition.<sup>105</sup> For example, biased counseling materials that mention fetal pain frequently make the claim that fetuses at some stage of gestation—often twenty weeks—have the necessary physical structures to feel pain.<sup>106</sup> There is scientific evidence that the neural pathways that are necessary for pain perception form as early as the twentieth week of gestation, although other studies place this development later, between twenty-three and thirty weeks.<sup>107</sup> But even if the structures are in place at twenty weeks, that does not necessarily mean that they are *functioning* at that time; lungs, for example, are physically formed before they function. One review of scientific studies found that the “arrival of sensory impulses” in the brain could not be “detected before twenty-nine weeks.”<sup>108</sup> Furthermore, there is data suggesting that fetuses are in a constant sleep-like state and unable to experience pain,<sup>109</sup> and that biochemicals in the *in utero* environment may sedate and anesthetize the fetus.<sup>110</sup>

Similarly, many experts believe that fetal reactions to tactile stimuli are reflexes that do not indicate a sensation of pain.<sup>111</sup> Such reflexes are exhibited in humans who have no forebrain due to anencephaly or whose cortex is not functioning.<sup>112</sup> Since most experts believe the cortex

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105. See Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 143–48 (2008).

106. See, e.g., ARK. CODE ANN. § 20-16-1105(a)(1)(A) (2011); GA. CODE ANN. § 31-9A-4(a)(3) (2011); OKLA. STAT. tit. 63, § 1-738.10(A) (2011); LA. REV. STAT. ANN. § 40:1299.35.6(C)(1)(a)(ii) (2011).

107. Tobin, *supra* note 105, at 143–44.

108. Michelle C. White & Andrew R. Wolf, *Pain and Stress in the Human Fetus*, 18 BEST PRACTICE & RES. CLINICAL ANESTHESIOLOGY 205, 207 (2004); see also ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, *FETAL AWARENESS: REVIEW OF RESEARCH AND RECOMMENDATIONS FOR PRACTICE* viii (2010) [hereinafter *FETAL AWARENESS*] (concluding that neural connections to the cortex necessary for pain perception are not present before twenty-four weeks).

109. *FETAL AWARENESS*, *supra* note 108, at 23; Tobin, *supra* note 105, at 144–45.

110. See Annie Murphy Paul, *The First Ache*, N.Y. TIMES MAGAZINE, Feb. 10, 2008, available at <http://www.nytimes.com/2008/02/10/magazine/10Fetal-t.html?pagewanted=all> (quoting David Mellor, founding director of the Animal Welfare Science and Bioethics Center at Massey University in New Zealand). This Article also quotes experts who believe that fetuses can feel pain by twenty weeks or even earlier.

111. Cf., e.g., ARK. CODE ANN. § 20-16-1105(a)(1)(A) (2011) (requiring counseling materials to state, “There is evidence that by twenty (20) weeks gestation unborn children seek to evade certain stimuli in a manner that in an infant or an adult would be interpreted to be a response to pain.”).

112. See *FETAL AWARENESS*, *supra* note 108, at 9; Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. AM. MED. ASS’N 947, 950 (2005).



is necessary for awareness of pain,<sup>113</sup> the presence of reflexes in individuals without functioning cortexes is evidence that those reflexes are not necessarily indicative of the sensation of pain.<sup>114</sup> In addition, the statement that fetal anesthesia is routine during fetal surgery<sup>115</sup> is misleading. Fetal anesthesia and analgesia serve purposes other than pain reduction, such as inhibiting fetal movement and preventing hormonal stress responses. Their use in surgery is not evidence that surgeons believe that fetuses feel pain,<sup>116</sup> although any reader not familiar with the science behind the practice of fetal surgery would take the statements in the counseling materials as evidence that doctors believe fetuses feel pain.<sup>117</sup>

While there is a controversy among experts regarding fetal pain past twenty weeks,<sup>118</sup> the statements made in some states' counseling materials do not notify patients of the controversy. They either articulate only one side of the controversy or selectively refer to certain facts without adequately explaining their implications for the possibility of fetal pain. South Dakota's complete lack of qualification of the statement that "the unborn fetus may feel physical pain"<sup>119</sup> makes it misleading to the point of falsehood, since it is uncontroversial that embryos and fetuses early in gestation cannot feel pain.<sup>120</sup> The Texas booklet's claim that it is "unknown" whether fetuses can feel pain at twelve weeks<sup>121</sup> is equally misleading, since there is not even scientific debate about fetal pain that early. Furthermore, while some statutes require that women be notified of the option of fetal anesthesia, they do not require disclosure of the risk that fetal anesthesia carries for the pregnant woman.<sup>122</sup> Yet again, the

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113. See FETAL AWARENESS, *supra* note 108, at viii.

114. See Tobin, *supra* note 105, at 145–46.

115. See, e.g., LA. REV. STAT. ANN. § 40:1299.35.6(D)(3)(a)(ii) (2011) (requiring counseling materials to state: "Anesthesia is routinely administered to unborn children who are twenty weeks gestational age or older who undergo prenatal surgery.").

116. See Paul, *supra* note 110 (quoting anesthesiologist Mark Rosen concerning the purposes of fetal anesthesia).

117. See Tobin, *supra* note 105, at 148. Some experts do believe that fetal anesthesia relieves fetal pain. See Paul, *supra* note 110 (quoting anesthesiologist Ray Paschall).

118. Cf. Teresa Stanton Collett, *Fetal Pain Legislation: Is It Viable?*, 30 PEPP. L. REV. 161, 163–68 (2003) (citing expert statements that support the existence of fetal pain even before twenty weeks' gestation).

119. S.D. Dep't of Health, *supra* note 58; see also Gold & Nash, *supra* note 55, at 6, 12.

120. FETAL AWARENESS, *supra* note 108, at 5 ("The presence of nociceptors is necessary for perception of acute surgical pain and so pain is clearly not possible before the nociceptors first appear at 10 weeks.").

121. TEX. DEP'T OF HEALTH, *supra* note 57, at 4.

122. See Stuart W.G. Derbyshire, *Fetal Pain: Do We Know Enough to Do the Right Thing?*, 16 REPROD. HEALTH MATTERS 117, 124 (2008) (stating that fetal pain relief prior to abortion is not supported by evidence and increases risk to the patient as well as cost);

bias in favor of childbirth in these laws is clear; there is no real effort to give patients all of the information that might inform their choice. Legislators bend over backward to include anything that might discourage a woman from choosing abortion but omit corresponding risks on the other side of the scale.

#### *D. Ideological or Moral Statements*

Since 2005, South Dakota's biased counseling statute has required that the physicians tell their abortion patients "[t]hat the abortion will terminate the life of a whole, separate, unique, living human being."<sup>123</sup> In 2009, North Dakota added an identical mandatory disclosure.<sup>124</sup>

Some biased counseling laws convey ideological speech in slightly more subtle ways. Biased counseling materials frequently use anti-abortion language, especially by referring to the pregnancy as an "unborn child."<sup>125</sup> Some state-produced materials direct patients to crisis pregnancy centers that are devoted to persuading women not to have abortions.<sup>126</sup> South Dakota went much further in 2011 when it enacted a law that requires abortion patients to be subjected to private ideological speech.

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Paul, *supra* note 110 (naming infection and uncontrolled bleeding as risks of fetal anesthesia during abortion).

123. S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (2011). *See also* MO. REV. STAT. § 188.027(1)(2) (2011).

124. N.D. CENT. CODE §§ 14-02.1-02(8)(a)(2), -03(1) (2011). This biased counseling requirement is subject to a medical emergency exception, as are most. However, in 2011 the North Dakota legislature expressly excluded the risk that the woman commit suicide from definition of "medical emergency," N.D. CENT. CODE § 14-02.1-02(9) (2011), expressing its callous judgment that there are circumstances in which it is acceptable for a woman to die because of restrictions on the provision of abortion. North Carolina's 2011 biased counseling statute includes a similar exception to the definition of "medical emergency." H.B. 854, Sess. Law 2011-405 sec. 1 (N.C. 2011) (to be codified at N.C. GEN. STAT. 90-21.81(5)). It might be argued that the legislative purpose of this exception is to prevent women from escaping the counseling requirement by dishonestly claiming to intend suicide. But even if that is true, the legislation as written prevents health care professionals from doing what they believe is necessary to preserve the life of a woman who is actually at risk of killing herself.

125. For example, the counseling materials in Kansas, which the statute requires be given to abortion patients, KAN. STAT. ANN. § 65-6709(d) (2011), consistently use the term "unborn child." KAN. DEP'T OF HEALTH & ENVR., IF YOU ARE PREGNANT (2009), *available at* [http://www.kansaswomensrighttoknow.org/download/Handbook\\_English.pdf](http://www.kansaswomensrighttoknow.org/download/Handbook_English.pdf). The term appears on virtually every page, while the word "fetus" does not appear at all.

126. *See, e.g.*, TEX. DEP'T OF HEALTH, *supra* note 57, at 3; OKLA. DEP'T OF HEALTH, A WOMAN'S RIGHT TO KNOW: RESOURCE DIRECTORY 8, *available at* <http://www.awomansright.org/pdf/ResourceDirectory.pdf>.

The statute provides that, before they consent to an abortion, patients must “have a consultation at a pregnancy help center,”<sup>127</sup> which the law defines, *inter alia*, as an organization dedicated to helping “a pregnant mother maintain her relationship with her unborn child and care for her unborn child.”<sup>128</sup> Thus, the state requires that patients be subjected to private speech that will make claims about the moral status of the embryo or fetus in order to discourage them from carrying out their decision to terminate their pregnancies.

These laws mandate that physicians make ideological statements they may not agree with and that are not part of their duty to disclose medically relevant information.<sup>129</sup> They are meant to convey the meta-physical proposition that the embryo or fetus is a person or the normative proposition that it is an entity with a particular moral status. Even taking it as a given that the state has the power to engage in such speech, it should not intrude into the doctor-patient relationship to do so.

These laws are sometimes defended as not being ideological at all. For example, South Dakota’s “unique human being” statement was upheld in the face of a challenge that it violated doctors’ First Amendment rights not to be compelled to utter the state’s ideological speech.<sup>130</sup> In order to avoid the seemingly obvious conclusion that the statement was ideological, the court looked to the statutory definition of “human being” and concluded that the statement was meant in a biological sense, as referring to a “member of the species of *Homo sapiens*.”<sup>131</sup> However, the average person would not understand the words “separate, unique, living human being” to have a purely biological meaning unless the stat-

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127. H.B. 1217, 2012 Leg., 87th Sess. (S.D. 2012). This law is subject to a preliminary injunction during the pendency of a constitutional challenge. *Planned Parenthood of Minn. v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011). In finding the plaintiffs are likely to succeed on their claim that this law constitutes an undue burden on the right to abortion, the court said that the requirement that an abortion patient visit a crisis pregnancy center “humiliates and degrades her as a human being.” *Id.* at 1060.

128. H.B. 1217, 2012 Leg., 87th Sess. (S.D. 2012).

129. *Cf. Doe v. Planned Parenthood/Chi. Area*, 956 N.E. 2d 564, 573 (Ill. App. Ct. 2011) (“No court, regardless of where it sits, has found a *common law duty* requiring doctors to tell their pregnant patients that aborting an embryo, or fetus, is the killing of an existing human being.”); *Acuna v. Turkish*, 930 A.2d 416, 418, 427–28 (N.J. 2007) (rejecting claim that the tort doctrine of informed consent requires physicians to inform abortion patients that abortion kills a “complete, separate, unique and irreplaceable human being” on the ground that such a statement is not material medical information).

130. *Planned Parenthood of Minn. v. Rounds*, 530 F.3d 724, 737–38 (8th Cir. 2008) (vacating preliminary injunction).

131. *Rounds*, 530 F.3d at 735–37.

utory definition were also read to her. Even then, the words “separate” and “unique” seem clearly intended to convey moral or metaphysical meaning—not least because, on a biological understanding of the word, an embryo or fetus is not obviously “separate” from the pregnant woman since it is inside her body and connected to her via the umbilical cord and placenta.

Furthermore, the argument that these statements convey only the biological fact that the embryo or fetus is a member of the species *Homo sapiens* makes the statements utterly pointless.<sup>132</sup> There is no competent person who thinks that a woman’s embryo or fetus might be a member of some other species,<sup>133</sup> and no one who knows what pregnancy is fails to know that, in the usual course, a pregnancy results in the birth of a human being. Those who would defend the statements in question as non-ideological cannot provide a sensible reason why such a trivial fact ought to be disclosed to abortion patients.

Generally, informed consent laws do not require health care professionals to make moral or philosophical statements. For example, end-of-life decisions implicate profound moral questions about the termination of human life, but doctors are not required to lecture patients about the moral considerations, much less to present the state’s moral views as medical fact.<sup>134</sup> Imagine a legislature dominated by Jehovah’s Witnesses requiring doctors to tell patients who need blood transfusions that the procedure is prohibited by God.<sup>135</sup> Objections to such a law would be fierce, because even a religious majority should not intrude into the doctor-patient relationship and use doctors to present the majority’s moral views to patients. Whether the proposition is philosophically or morally correct is not the issue; making such statements is not part of the physician’s duty to convey the medical considerations relevant to a patient deciding whether to consent to a medical intervention.<sup>136</sup>

Patients are capable of seeking guidance regarding the moral dimensions of their decisions from the appropriate people, such as family members, clergy, or even health care professionals who provide abortions,

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132. See Post, *supra* note 3, at 954–55 (arguing that South Dakota’s “human being” statement is either trivially true or states a controversial moral proposition).

133. See *id.* at 954.

134. See Dresser, *supra* note 92, at 1619 (noting that informed consent to the removal of life-sustaining treatment does not require the disclosure of moral judgments).

135. *Cf., e.g.,* Campbell v. Delbridge, 670 N.W.2d 108, 109 (Iowa 2003) (discussing religious belief of Jehovah’s Witness that precludes the use of blood transfusions).

136. *Cf.* Post, *supra* note 3, at 958–60 (arguing that disclosures required by South Dakota’s biased counseling statute concern ideological and moral propositions rather than medical facts).

if they so desire. Women do not need a mandatory disclosure to inform them of the fact that the abortion decision is a morally weighty one. Women have an interest in choosing where to get their moral guidance from as opposed to having the state's view thrust upon them with their physician as the mouthpiece.

### *E. Descriptions of Ultrasounds*

Several states require that women undergo ultrasounds, sometimes called "sonograms," before obtaining abortions.<sup>137</sup> In the context of abortion care, ultrasounds are primarily used to confirm that the pregnancy is in the uterus (as opposed to being ectopic) and the gestational age of the pregnancy. Ultrasounds intended to view a pregnancy may be performed vaginally, by inserting a wand-shaped transducer into the vagina, or abdominally, by moving a broad transducer over the abdomen. Early in a pregnancy, a vaginal ultrasound provides a better view of the uterus and its contents.<sup>138</sup> The majority of abortion providers routinely perform ultrasounds on their patients.<sup>139</sup>

Some states go further than requiring a pre-abortion ultrasound be performed. North Carolina, Oklahoma, and Texas have enacted statutes that require women to have their ultrasound described to them, even if they do not want to hear such a description. The Oklahoma statute, which has been struck down,<sup>140</sup> provided that, "[i]n order for the woman

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137. See, e.g., ALA. CODE §§ 26-23A-4(b)(4), 26-23A-6(b) (2011) (requiring the physician who will perform the abortion or the referring physician to "perform an ultrasound on the unborn child" and give the woman an opportunity to view the ultrasound); LA. REV. STAT. ANN. §§ 40:1299.35.2(D), .6(B) (2011) (providing that consent to an abortion "is voluntary and informed only if an obstetric ultrasound is performed" at least two hours prior to the abortion); MISS. CODE ANN. § 41-41-34 (2011) (requiring a pre-abortion ultrasound be performed and the patient be offered the chance to see it).

138. See Harm-Gerd K. Blaas & José M. Carrera, *Investigation of Early Pregnancy*, in *ULTRASOUND IN OBSTETRICS AND GYNAECOLOGY* 57, 58 (Juriy Wladimiroff & Sturla Eik-Nes, eds., 2009).

139. See Katharine O'Connell et al., *First-Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members*, 79 *CONTRACEPTION* 385, 388 (2009). Although the routine use of ultrasounds in abortion care shows that they are useful, they are not medically necessary. See Bliss Kaneshiro et al., *Expanding Medical Abortion: Can Medical Abortion Be Effectively Provided Without the Routine Use of Ultrasound?*, 83 *CONTRACEPTION* 194 (2011) (concluding that physical examination and patients' reports of last menstrual period can be used to estimate gestational age and that non-ultrasound methods can effectively confirm complete pregnancy expulsion after medical abortion).

140. OKLA. STAT. tit. 63, §§ 1-738.1A, 1-738.3d, & 1-738.3e (West 2011). This law has been found to violate the state constitution's special law provisions. See *Nova Health*

to make an informed decision,”<sup>141</sup> an ultrasound must be performed at least one hour before the abortion, “using either a vaginal transducer or an abdominal transducer, whichever would display the embryo or fetus more clearly.”<sup>142</sup> It required the physician or technician to place the ultrasound in the woman’s line of sight<sup>143</sup> and to describe the image, including “the dimensions of the embryo or fetus, the presence of cardiac activity, if present and viewable, and the presence of external members and internal organs, if present and viewable.”<sup>144</sup>

Oklahoma state Senator Todd Lamb introduced a substantially identical, prior version of this law in the state senate.<sup>145</sup> Lamb has acknowledged that “the purpose of the ultrasound requirement was to reduce the number of abortions.”<sup>146</sup> He also stated that ultrasounds allow doctors to “disclose fully the information regarding the woman’s pregnancy” and that requiring a woman to have an ultrasound would benefit her mental health, apparently by protecting her from “later regretting the taking of a human life.”<sup>147</sup>

Senator Lamb’s comments fit with the way anti-abortion activists seem to view ultrasound requirements: they think that an ultrasound contributes to informed consent by conveying the moral status of the embryo or fetus to the woman, who will then decide to carry the pregnancy to term.<sup>148</sup> Two assumptions of this line of thought should be

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*Systems v. Pruitt*, No. 2:12-CV-00395., 2012 WL 1034022 (Okla. Dist. Ct. Okla. Cnty. Mar. 28, 2012) (enjoining statute’s enforcement permanently). The statute deserves discussion here despite being enjoined for a number of reasons. First, the legislative history of the law provides an illustrative example of the use of informed consent as a justification for limiting access to abortion. Second, this statute was passed after the Oklahoma Supreme Court struck down a substantially identical statute, *see Nova Health Sys. v. Edmonson*, 233 P.3d 380 (Okla. 2010), so the legislature may simply pass another version in the future. And finally, the district court’s decision will almost certainly be appealed, so the statute discussed here may eventually be enforced, depending on the decision of the state’s high court.

141. OKLA. STAT. tit. 63, § 1-738.3d(B) (2011).

142. *Id.* at § 1-738.3d(B)(1).

143. *Id.* at § 1-738.3d(B)(3). The woman is allowed to “avert her eyes.” *Id.* at § 1-738.3d(C).

144. *Id.* at § 1-738.3d(B)(4).

145. Okla. Sen. 1878 History, 51st Leg., 2d Sess. § 12 (2008). This bill passed over the governor’s veto but was invalidated because it violated the Oklahoma Constitution’s rule that the legislation must have only a single subject. *Nova Health Sys. v. Edmonson*, 233 P.3d 380 (Okla. 2010).

146. Weber, *supra* note 2, at 365 (paraphrasing Lamb’s statements from a 2008 interview).

147. *Id.*; *see also id.* at 369 (“[Lamb] described the mental torment that some women go through after aborting their child.”).

148. *See* Kevin Sack, *In Ultrasound, Abortion Fight Has New Front*, N.Y. TIMES, May 27, 2010, at A1 (quoting Focus of the Family spokesperson as saying, in support of

made explicit. First, anti-abortion activists apparently think that some women fail to understand that abortion is wrong but if that message is conveyed to them, they will not terminate their pregnancies. This disrespects the effort that women put into decisions about their pregnancies without the help of the state. There is also evidence that this assumption is false, since states with ultrasound requirements do not see a significant reduction in the number of abortions.<sup>149</sup> Second, anti-abortion activists seem to believe that it is acceptable to characterize a protocol as “informed consent” when their primary reason for favoring it is that it will encourage patients to make the decision the activists approve of—that is, carry the pregnancy to term—rather than ensuring that patients exercise their own autonomy.<sup>150</sup>

Oklahoma’s statute required a vaginal ultrasound in some cases, because there will be circumstances in which a vaginal ultrasound provides a clearer image<sup>151</sup> than an abdominal one. Thus, the law required women to submit to vaginal penetration without consent. This is a violation of bodily integrity<sup>152</sup> and brings up disturbing connotations of rape.

In 2011, Texas followed Oklahoma and amended its biased counseling statute to require that an ultrasound be performed at least twenty-four hours before any abortion.<sup>153</sup> The provider is also required to “display[] the sonogram images . . . in a manner that the pregnant

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mandatory ultrasound law: “To be able to put a face on that baby humanizes this process and really allows the mother to connect.”).

149. *Id.* (noting that Alabama’s forced ultrasound law “had no apparent impact on the number of abortions”).

150. *Cf.* Emily Ramshaw, *Required Delay Between Sonogram and Abortion Creates Logistical Issues*, N.Y. TIMES, Jan. 28, 2012, <http://www.nytimes.com/2012/01/29/us/required-delay-between-sonogram-and-abortion-creates-logistical-issues-in-texas.html> (quoting supporter of ultrasound law claiming that seeing an ultrasound image will change woman’s mind regarding abortion).

151. The statute required either an abdominal or vaginal ultrasound, “whichever would display the embryo or fetus more clearly.” OKLA. STAT. tit. 63, § 1-738.3d(B)(1) (West 2011). Early in pregnancy, vaginal ultrasounds tend to provide clearer images. *See* Weber, *supra* note 2, at 379. Most abortions in the United States occur during the first trimester. *See* FACTS ON INDUCED ABORTION IN THE UNITED STATES, *supra* note 37.

152. *See* *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990) (“Th[e] notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment.”); Weber, *supra* note 2, at 375–81 (arguing that a prior version of Oklahoma’s forced ultrasound law violated individuals’ Fourteenth Amendment right to refuse medical treatment); *cf.* *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997) (noting “the common-law rule that forced medication was a battery . . . and the long legal tradition protecting the decision to refuse unwanted medical treatment”).

153. H.R. 15, 82d Leg., 1st Special Sess. (Tex. 2011). The ultrasound requirement is to be codified at TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4).

woman may view them,” explain the ultrasound image, make the embryonic or fetal heartbeat audible (a process called “auscultation”), and provide a verbal explanation of the sound.<sup>154</sup> The North Carolina legislature enacted a similar law over Governor Beverly Perdue’s veto in 2011.<sup>155</sup> The laws in all three of these states apparently require that patients listen to a description of the ultrasound or the heartbeat even if they do not want to. This takes the choice of what information the patient will receive away from physician and patient.

### *F. Waiting Periods*

States with biased counseling laws typically impose mandatory waiting periods.<sup>156</sup> For example, Arizona passed a biased counseling law in 2009 that requires counseling disclosures be made “orally and in person” at least twenty-four hours prior to the abortion.<sup>157</sup> In 2011, South Dakota enacted a law that mandates that physicians meet with patients in person to provide the required biased counseling and then wait *seventy-two* hours before performing an abortion.<sup>158</sup> The legislator who drafted the South Dakota law claimed that it serves the purpose of informed consent, saying, “There’s greater assurance that a woman considering an abortion is going to be fully informed about all the risks and about all

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154. *Id.* (to be codified at TEX. HEALTH & SAFETY CODE ANN. § 171.012 (a)(4)(B), (C); § 171.022(b), (c), (d)). These requirements have been upheld against a constitutional challenge. *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, No. A-11-CA-486, 2012 WL 373132, at \*5 (W.D. Tex. Feb. 6, 2012) (expressing district court’s disagreement with Fifth Circuit decision finding no constitutional infirmities in statute, but noting that district court was compelled to defer).

155. N.C. H.B. 854, Sess. Law 2011-405 (to be codified at N.C. GEN. STAT. § 90-21.80-.92); see also Lynn Bonner, *Override Vote Enacts Abortion Law*, THE CHARLOTTE OBSERVER, July 29, 2011, <http://www.charlotteobserver.com/2011/07/29/2488568/senate-overrides-veto-on-abortion.html>. These requirements, like those of Oklahoma, are not being enforced as of this writing because of a preliminary injunction. *Stuart v. Huff*, No. 1:11CV804, 2011 WL 6330668 (M.D.N.C. Dec. 19, 2011).

156. COUNSELING AND WAITING PERIODS FOR ABORTION, *supra* note 86.

157. ARIZ. REV. STAT. ANN. § 36-2153(A)(1), (2) (2011). Ultrasound laws also often impose waiting periods of their own. In 2010, Louisiana passed a mandatory ultrasound law that requires a two-hour wait between the ultrasound and the abortion. LA. REV. STAT. ANN. §§ 40:1299.35.2(D)(2) (2011).

158. H.B. 1217, 2012 Leg., 87th Sess. (S.D. 2012). As of this writing, the statute is enjoined pending a constitutional challenge. *Planned Parenthood of Minn. v. Daugaard*, 799 F. Supp. 2d 1048, 1066 (D.S.D. 2011) (holding that plaintiffs are likely to succeed on their “undue burden” claim because of logistical obstacles created by waiting period, including financial burden and danger to abused women); Joey Ferguson, *South Dakota Federal Judge Blocks Abortion Law in Wake of Kansas Controversy*, DESERET NEWS, July 1, 2011, <http://www.deseretnews.com/article/700148624/South-Dakota-federal-judge-blocks-abortion-law-in-wake-of-Kansas-controversy.html>.



the options.”<sup>159</sup> The legislative findings mention ensuring that the patient’s decision is “truly voluntary, uncoerced, and informed,”<sup>160</sup> but they also make clear that the statute’s purpose is to discourage abortions.<sup>161</sup> In 2012, Utah also enacted a seventy-two hour waiting period, which is being enforced as of this writing.<sup>162</sup> When Governor Gary Herbert signed the bill, his spokesperson said, “The governor is an adamant supporter of rights for the unborn and felt the bill appropriately allows a woman facing such a decision time to fully weigh her options, as well as the implications of the decision.”<sup>163</sup>

It is deeply patronizing to require that women wait for a set amount of time before carrying out their decisions. For legislators to believe that such laws are needed, they must think that women are impulsive, thoughtless creatures who need to be forced to sleep on it when they attempt make an important decision. There is no reason to think that abortion patients have not already carefully thought about the decision to terminate their pregnancies before they visit an abortion provider.

Waiting periods pose significant practical obstacles to abortion access for many women.<sup>164</sup> When they are combined with a requirement that counseling be given in person or that an ultrasound be performed, waiting periods require women to make two trips to the abortion provider. This can present a serious hardship to women who need to travel a long distance to the abortion provider, who have difficulty taking time off from work or securing child care, or who seek confidentiality regarding their abortion. Waiting periods offer no benefit to balance these harms, since women have the capacity to make decisions about the

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159. A.G. Sulzberger, *Women Seeking Abortions in South Dakota to Get Anti-Abortion Advice*, N.Y. TIMES, Mar. 22, 2011, at A16 (quoting Roger Hunt).

160. H.B. 1217, 2012 Leg., 87th Sess. (S.D. 2012).

161. *See id.* at § 1(5) (“It is a necessary and proper exercise of the state’s authority to give precedence to the mother’s fundamental interest in her relationship with her child over the irrevocable method of termination of that relationship by induced abortion.”).

162. Act of March 20, 2012, Utah Laws H.B. 461 (West’s No. 232).

163. Robert Gehrke, *Guv Signs Bill Requiring 72-Hour Wait for Abortions*, SALT LAKE TRIB., Mar. 20, 2012, <http://www.sltrib.com/sltrib/politics/53758618-90/period-waiting-utah-women.html.csp>

164. *Cf.* *Planned Parenthood of Middle Tenn. v. Sundquist*, 38 S.W.3d 1, 23–24 (Tenn. 2000) (striking down two-day waiting period under state constitution, in part because of the burdens it would impose on women in terms of mortality, health, emotional well-being, and finances).

course of their reproductive lives and the exercise of their fundamental rights without being sent home to think about it.<sup>165</sup>

### III. ETHICAL ACCOUNTS OF INFORMED CONSENT

Part III is a survey of some of the most influential and well-developed accounts of informed consent in medical ethics. None of these accounts provides an ethical justification for the features of biased counseling laws discussed above. This Part analyzes a number of different approaches to informed consent. I chose these views to focus on either because they are highly influential in the field of medical ethics or because they are well-developed accounts that exhibit significant philosophical differences from the highly influential accounts, providing a diversity of approaches to examine. For present purposes, I am agnostic as to which, if any, of these accounts of informed consent is correct. My purpose is to survey well-developed views of the concept in the field of medical ethics and to argue that biased counseling laws fail to serve the purposes of the ethical concept on any of these different views.<sup>166</sup>

#### *A. Consent as Autonomous Authorization*

Perhaps the most influential account of informed consent in the field of medical ethics is the theory presented by Ruth Faden and Tom Beauchamp in *A History and Theory of Informed Consent*.<sup>167</sup> Faden and

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165. Cf. *Sundquist*, 38 S.W.3d at 23 (quoting with approval trial court's statement that mandatory waiting period "insults the intelligence and decision-making capabilities of a woman").

166. I am not claiming that the authors discussed here have expressed disapproval of biased counseling laws or that they have any particular position on the morality of abortion itself. I claim only that conclusions about the morality of certain characteristics of biased counseling laws follow from these authors' views on informed consent.

167. FADEN & BEAUCHAMP, *supra* note 5. Scholars discussing informed consent frequently note the importance of this work. See, e.g., Franklin G. Miller & Alan Wertheimer, *Preface to a Theory of Consent Transactions: Beyond Valid Consent*, in THE ETHICS OF CONSENT (Franklin G. Miller & Alan Wertheimer eds., 2009) (describing Faden and Beauchamp as having "best developed" the "prevailing theory" of informed consent); Steven Joffe & Robert D. Truog, *Consent to Medical Care: The Importance of Fiduciary Context*, in THE ETHICS OF CONSENT, *supra*, at 347–49 (describing Faden and Beauchamp as offering the "standard conception" of informed consent); Jeffrey Kahn, *Informed Consent in Human Gene Transfer Clinical Trials*, 19 HUMAN GENE THERAPY 7, 7 (2008) (referring to Faden and Beauchamp's "now standard analysis of what constitutes adequate informed consent"); NEIL C. MANSON & ONORA O'NEILL, *RETHINKING*

Beauchamp offer a conceptual analysis of informed consent, explaining the logical and philosophical contours of the concept. Informed consent, in the sense I am concerned with, is an autonomous authorization by the patient for a medical professional<sup>168</sup> to undertake an intervention.<sup>169</sup> Faden and Beauchamp develop their account of moral philosophy from a framework in which principles are fundamental. Rights, duties, and obligations—as well as professional codes and legal regulations—are derived from or evaluated with reference to principles.<sup>170</sup> Three principles are relevant to informed consent: respect for autonomy, beneficence, and justice. Although these principles are of equal prima facie weight and none necessarily trumps the others as a general matter, when it comes to informed consent, respect for autonomy “is the single most important moral value.”<sup>171</sup> This “three principles” approach,<sup>172</sup> also called “pluralistic principlism,”<sup>173</sup> is the dominant philosophical framework in the medical ethics field.<sup>174</sup>

The principle of *respect for autonomy* requires that individuals be “free to choose and act without controlling constraints imposed by oth-

INFORMED CONSENT IN BIOETHICS 18 n.17 (2007) (listing Faden and Beauchamp’s book as one of the “most cited works on autonomy and informed consent”).

168. For some purposes, ethicists make a distinction between physicians and other health care professionals. There is no reason to maintain such a distinction for the purposes of this Article. Throughout my descriptions of ethical accounts in this Part, I largely follow authors’ usage; nothing hinges on the term used to pick out medical professionals, even where “physician” is used.
169. FADEN & BEAUCHAMP, *supra* note 5, at 293. Faden and Beauchamp’s account covers consent to participate in research as well as medical interventions. Because I am concerned only with the clinical context, I have left consent to research out of my discussion of their theory.
170. *Id.* at 4–6.
171. *Id.*; see also Tom L. Beauchamp, *Autonomy and Consent*, in THE ETHICS OF CONSENT, *supra* note 167, at 55, 61 (“[T]he protection of autonomous choice is fundamental to the justification of rules of informed consent.”). Other ethics scholars have questioned the notion that respect for autonomy is the value underlying informed consent requirements; I discuss some prominent examples below.
172. It is sometimes referred to as a “four principles” approach, depending on whether nonmaleficence, the avoidance of doing harm, is considered a principle distinct from beneficence or subsumed under it. See, e.g., Tom L. Beauchamp, *The ‘Four Principles’ Approach to Health Care Ethics*, in PRINCIPLES OF HEALTH CARE ETHICS 3, 4–6 (Richard E. Ashcroft et al. eds., 2d ed. 2007).
173. See James F. Childress, *Methods in Bioethics*, in THE OXFORD HANDBOOK OF BIOETHICS 15, 21–22 (Bonnie Steinbock ed., 2007). Faden and Beauchamp’s approach is “pluralistic” in that it does not consider a single one of the principles to have primacy.
174. Cf., e.g., ALFRED I. TAUBER, PATIENT AUTONOMY AND THE ETHICS OF RESPONSIBILITY 25 (2005) (“[P]rinciplism has become the preferred theoretical structure of medical ethics . . . .”); Childress, *supra* note 173, at 17 (addressing the claim that principle-based methods are the dominant type of method in bioethics).

ers.”<sup>175</sup> It is the recognition of this principle that has led to the acceptance of a requirement for informed consent in clinical medicine.<sup>176</sup>

*Beneficence*, the promotion of the welfare of others, is clearly fundamental to the practice of medicine, which is at heart the attempt to make patients better.<sup>177</sup> In the informed consent context, the principle of beneficence can easily come into conflict with the principle of autonomy: a physician may want to undertake a medical intervention because it is what is best for the patient, regardless of whether the patient consents to the intervention or whether the patient has the information necessary to make her own decision. This is the problem of paternalism, and the question of how to balance the competing values of pursuing patient welfare and protecting patient autonomy pervades discussions of informed consent.<sup>178</sup>

The third principle, *justice*, requires that individuals be “treated according to what is fair, due, or owed.”<sup>179</sup> This principle has implications regarding the allocation of scarce medical resources, although Faden and Beauchamp also note that it is unjust to impose an “undue burden” on the ability to exercise a right, for example, by making “a piece of information owed to a person unreasonably difficult to obtain.”<sup>180</sup>

Since their account of informed consent emphasizes the principle of respect for autonomy, Faden and Beauchamp offer a conceptual analysis of autonomous action. An action is autonomous only if it satisfies three conditions: intentionality, understanding, and noncontrol.<sup>181</sup> Because the latter two conditions admit of degrees rather than being all-or-nothing, actions may be more or less autonomous on this account.

An action is *intentional* if it is “willed in accordance with a plan.”<sup>182</sup> The second condition, *understanding*, is a matter of degree in that individuals can have more or less understanding. An individual acts with

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175. FADEN & BEAUCHAMP, *supra* note 5, at 8.

176. See FADEN & BEAUCHAMP, *supra* note 5, at 101; see also BEAUCHAMP & CHILDRESS, *supra* note 9, at 118 (“[S]ince the mid-1970s the primary justification advanced for requirements of informed consent has been to protect autonomous choice . . .”).

177. FADEN & BEAUCHAMP, *supra* note 5, at 9–10.

178. See *id.* at 13; cf. BEAUCHAMP & CHILDRESS, *supra* note 9, at 206–16 (discussing conflicts between beneficence and respect for autonomy, including the problem of paternalism, in the context of a principle-based account of medical ethics).

179. FADEN & BEAUCHAMP, *supra* note 5, at 14.

180. *Id.* at 14–15.

181. *Id.* at 238. Faden and Beauchamp entertain the possibility that another condition, authenticity, may be necessary. *Id.* at 262–68. While the condition of noncontrol is focused on control by other people, authenticity would require autonomous actions not to be brought about by internal forces like addiction or neurotic compulsion. *Id.* at 264.

182. *Id.* at 243.

complete understanding if she has an adequate apprehension of all the relevant descriptions of both the nature of the action and the foreseeable consequences of taking and not taking the action.<sup>183</sup> The substantial understanding necessary for informed consent requires that the patient understand all the material or important propositions that add to her comprehension of her situation.<sup>184</sup> False beliefs are detrimental to understanding. When an individual takes an action while believing a false proposition relevant to that action, the action is less than fully autonomous.<sup>185</sup> Whether a proposition is material is determined by whether it subjectively matters to the patient's evaluation of her options.<sup>186</sup> Third, the condition of *noncontrol* means that actions are less than fully autonomous to the extent that they are controlled by external factors, especially other people.<sup>187</sup> For Faden and Beauchamp, some external influences do not prevent actions from being autonomous: those that the individual can resist,<sup>188</sup> those that do not cause the individual to fail the condition of substantial understanding,<sup>189</sup> and those that appeal to reason that the individual freely accepts.<sup>190</sup>

### 1. Informed Consent

Faden and Beauchamp define informed consent as a patient's autonomous action authorizing a health care professional to do something. Using the analysis of autonomous action discussed above, a patient gives informed consent if she "with (1) substantial understanding and (2) in substantial absence of control by others (3) intentionally (4) authorizes a professional" to undertake a medical intervention.<sup>191</sup> A person who satis-

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183. *Id.* at 252.

184. *Id.* at 302.

185. *Id.* at 253.

186. *Id.* at 302. There will be relevant propositions about a medical intervention, such as the exact number of sutures used in a surgery, that will not be material to the patient, because she does not consider it important that there are twenty as opposed to nineteen sutures. *See id.* at 304.

187. *Id.* at 256.

188. *Id.* at 261–62, 339.

189. *Id.* at 362.

190. *Id.* at 260–62, 347–48.

191. *Id.* at 278. The authors distinguish two senses of informed consent. In addition to the first sense, defined in the quoted passage, they discuss a sense of informed consent that concerns whether an authorization is effective in that it satisfies the relevant procedural rules in some institutional context. *See id.* at 280–87. To put it crudely, this second sense asks, "Did the patient sign the right form?" In examining whether biased counseling laws fit with Faden and Beauchamp's account of informed consent in the first sense, I am following the authors' conviction that the first sense, autonomous

fies the first three conditions but refuses the intervention gives an informed refusal.<sup>192</sup>

Faden and Beauchamp reject the notion that professionals should attempt to instill the substantial understanding necessary for informed consent through a standard set of disclosures.<sup>193</sup> Rather than check off a list of disclosures, professionals should focus on effective communication, which requires an informational exchange: physicians must ask questions to learn what is important to patients and must elicit questions from the patients themselves.<sup>194</sup> However, a core disclosure is still necessary to initiate the communication process, and it should be guided by three considerations: (1) propositions that patients usually think are material regarding the proposed intervention; (2) what the professional thinks is material, including a recommendation regarding treatment; and (3) an explanation about the purpose of seeking consent and the nature of the authorization.<sup>195</sup> These disclosures lead to a dialogue intended to bring about a shared understanding between patient and professional.

This account does not require that patient and professional believe all the same propositions; it is enough that they each understand the material propositions the other believes without necessarily accepting

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authorization, ought to be the basis of a moral evaluation of the second sense, procedurally effective consent. *Id.* at 284; Tom L. Beauchamp, *Autonomy and Consent*, in *THE ETHICS OF CONSENT*, *supra* note 167, at 55, 58 (“I take it as axiomatic that the model of autonomous choice . . . ought to serve as the benchmark for the moral adequacy of institutional rules.”).

192. These conditions overlap significantly with common textbook sketches of informed consent. *See, e.g.*, BEAUCHAMP & CHILDRESS, *supra* note 9, at 120–21 (providing seven-factor definition consisting of competence, voluntariness, disclosure, recommendation, understanding, decision, and authorization); BERNARD GERT, CHARLES M. CULVER & K. DANNER CLOUSER, *BIOETHICS: A SYSTEMATIC APPROACH* 213 (2d ed. 2006) (“It is widely accepted in bioethics and in health law that three criteria must be satisfied in order for a patient’s consent to be valid: the patient must be given adequate information about the decision she is being asked to make; the patient must be fully competent to consent to or refuse the diagnostic or therapeutic intervention that is being suggested; and coercion must not be employed in obtaining her decision.”); Robert Young, *Informed Consent and Patient Autonomy*, in *A COMPANION TO BIOETHICS* 441, 442 (Helga Kuhse & Peter Singer eds., 1998) (“For a patient to be capable of giving informed consent she must be competent, must understand the information disclosed to her and must give (or withhold) her consent freely.”).

193. *See* FADEN & BEAUCHAMP, *supra* note 5, at 305–07 (rejecting the professional practice standard and reasonable patient standard, each of which determines the disclosures required by tort law in some jurisdictions). The authors deny that they are proposing “legal reforms or generally applicable policies” but nevertheless argue that their strategies for encouraging patient understanding “can and should be broadly implemented.” *Id.* at 298.

194. *See id.* at 307.

195. *Id.* at 307–08; *cf.* BEAUCHAMP & CHILDRESS, *supra* note 9, at 121.

them as true, as long as the beliefs in question are “inherently contestable.”<sup>196</sup> If, on the other hand, a patient has an unjustifiable false belief about a material proposition, then a shared understanding has not been achieved and informed consent is not possible.<sup>197</sup> For example, a patient’s refusal to consent to cancer treatment because of an unjustifiable belief that she could not have cancer because she did not feel sick would not be an informed refusal because the patient holds an unjustified, material, false belief.<sup>198</sup> Regarding inherently contestable material propositions, Faden and Beauchamp’s account requires the professional to communicate her view and the patient to understand that the professional believes the proposition, although it does not require that the patient believe the proposition herself.<sup>199</sup>

One phenomenon that can cause a problem for patient understanding is the framing effect: a person’s choice can be affected by the way the options are described.<sup>200</sup> For example, people are more likely to choose an option presented as a seventy-five percent chance of survival than an option presented as a twenty-five percent chance of death, even though the risk is exactly the same.<sup>201</sup> Faden and Beauchamp note that the framing effect can be used to manipulate patient choice, and they recognize that framing may endanger substantial understanding.<sup>202</sup> They recommend that professionals attempt to avoid the effect by presenting “both sides of the story,” the positive frame as well as the negative frame.<sup>203</sup> Generally, the manipulation of information—the modification of a person’s perceptions of the options available to her—is incompatible with informed consent where it causes the person to fail to have substantial understanding.<sup>204</sup> Faden and Beauchamp contend that manipulation of information is unlikely to be compatible with informed consent and recommend against this practice.<sup>205</sup>

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196. FADEN & BEAUCHAMP, *supra* note 5, at 310.

197. *Id.*

198. *See id.* at 311.

199. *Id.* at 310.

200. *See, e.g.*, Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 *SCIENCE* 453 (1981); Nicholas Bakalar, *Translation Matters in Choices on Data*, *N.Y. TIMES*, May 30, 2011, at D5 (explaining differences in persuasiveness and patient understanding among ways of conveying statistical information about treatment effectiveness).

201. *See* FADEN & BEAUCHAMP, *supra* note 5, at 320; Young, *supra* note 192, at 444.

202. FADEN & BEAUCHAMP, *supra* note 5, at 320–21; BEAUCHAMP & CHILDRESS, *supra* note 9, at 130, 134.

203. FADEN & BEAUCHAMP, *supra* note 5, at 321.

204. *Id.* at 362–63.

205. *Id.* at 363; BEAUCHAMP & CHILDRESS, *supra* note 9, at 134. Faden and Beauchamp recognize that there may be circumstances in which informational manipulation is

Other forms of manipulation do not necessarily act through an effect on the understanding, in contrast to the phenomena discussed immediately above; Faden and Beauchamp call this category “psychological manipulation,” and it includes such strategies as “appeals to emotional weaknesses[] and the inducing of guilt or feelings of obligation.”<sup>206</sup> If an instance of psychological manipulation is not easily resistible by the target, then it is incompatible with the condition of substantial noncontrol required for autonomous action.<sup>207</sup> As with informational manipulation, Faden and Beauchamp advise that professionals completely avoid using psychological manipulation.<sup>208</sup>

With this summary of Faden and Beauchamp’s analysis of informed consent in hand, this Article will now evaluate the degree to which biased counseling laws ensure that patients’ consent to abortion is properly informed.

## 2. Biased Counseling Laws’ Obstacles to Informed Consent

Faden and Beauchamp see the process of informing a patient as one that should strive toward effective communication between a professional and patient. The professional makes disclosures based on what she finds important and what she predicts that the patient will find important, and the patient communicates what she finds important.<sup>209</sup> A list of statements inserted into the professional-patient dialogue by a legislature does not fit with the model. This fact shows why irrelevant and immaterial statements or disclosures, such as descriptions or pictures of embryos and fetuses at later gestational stages than the patient’s pregnancy, should not be required by informed consent laws. Nor should ideological or moral statements, which may not conform to the professional’s beliefs and may be unwelcome for the patient. A patient who subjectively finds such statements relevant should of course mention that in discussions with the health care professionals treating her and receive the information. The physician has an obligation to answer

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justifiable even though it will not result in an informed consent, perhaps because a principle other than respect for autonomy is controlling. FADEN & BEAUCHAMP, *supra* note 5, at 363.

206. FADEN & BEAUCHAMP, *supra* note 5, at 365–66. The authors also discuss a third category of manipulation: the manipulation of options, which involves direct control over another option, for example through the use of punishment or reward. *Id.* at 355. This category is not relevant to my purposes here.

207. *Id.* at 367.

208. *Id.* at 368.

209. *Supra* text accompanying note 195.



the patient's questions, but she should not be legally mandated to provide information the patient does not find material or want to hear. Furthermore, some features of biased counseling laws actively stand in the way of patient autonomy and informed consent, as I explain below.

a. Deception

According to Faden and Beauchamp's account, deception is a form of manipulation of information that "uses such intentional strategies as lying, withholding of information, true assertion that omits a vital qualification, and misleading exaggeration in order to cause persons to believe what is false."<sup>210</sup> While not every instance of deception of a patient is incompatible with informed consent, these techniques are likely to inhibit substantial understanding and therefore threaten the degree to which the patient's consent is autonomous. As shown above, many statements that biased counseling laws require professionals to make or present to patients are deceptive. Inasmuch as these statements cause patients to have false beliefs that are material to their decisions, they decrease patient understanding and thereby decrease patient autonomy. Deceptive statements that are required by laws purported to guarantee informed consent to abortion therefore make informed consent *less* likely and are in direct opposition to the laws' declared purpose.

For example, imagine that a Michigan woman with no history of mental illness or trauma becomes pregnant and believes that having a baby does not fit with her life plan at the time. She arranges to have an abortion and is given counseling materials as required by state law.<sup>211</sup> In those materials, she reads that an abortion may cause her to experience "depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger."<sup>212</sup> As a result, she forms the false belief that terminating her pregnancy will significantly increase the likelihood that she experi-

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210. FADEN & BEAUCHAMP, *supra* note 5, at 363. The intent of the speaker to control the listener is a necessary feature of deception and all other forms of influence that might threaten autonomy. Health care professionals who make statements that are required by law do not necessarily have the intent to control patients' actions—in fact, it is highly unlikely that they do. However, for my purposes here—as well as for other, analogous intent requirements in Faden and Beauchamp's theory—I take it that the intent of the legislature or other government body to discourage abortion satisfies this intent requirement for biased counseling statements. The professional is a mere intermediary.

211. See MICH. COMP. LAWS § 333.17015(3)(c) (2011).

212. *Id.* § 333.17015(11)(b)(iii). As another example, Missouri includes "possible adverse psychological effects associated with the abortion" in its list of risks that must be disclosed. MO. REV. STAT. § 188.027(1)(1)(b)(b) (2011).

ence these negative effects. She considers the risk of depression, sleep disturbance, and the other effects to be material to her decision regarding whether to have an abortion. After weighing her belief about the risks together with all the other factors, she changes her mind and decides to carry her pregnancy to term. This decision is not substantially autonomous because the woman fails the condition of substantial understanding:<sup>213</sup> she has a false belief about a proposition that is material to her decision. Because Michigan's biased counseling law caused her to form that false belief, she refused to have the abortion. According to Faden and Beauchamp's model, her decision failed to qualify as an informed refusal. For this woman, the law was an obstacle to autonomy and therefore to informed consent. The same analysis applies to all the other deceptive statements that biased counseling laws require be made or offered to patients, such as that abortion increases the risk of breast cancer or fertility problems.<sup>214</sup>

In addition to falsehoods like those mandated in Michigan, some biased counseling laws use true statements that are calculated to mislead. For example, statements about fetal pain in biased counseling laws are carefully crafted to present information that is strictly speaking true but misleading because it does not include key qualifications, including the fact that there is medical controversy over the ability of fetuses to feel pain at various stages of gestation. As Faden and Beauchamp recognize, the manipulation of information is a threat to informed consent when it prevents patients from achieving substantial understanding. To tell the patient that, at twenty weeks, a fetus has the anatomical structures necessary to feel pain (which is contested) without going on to explain the reasons to doubt that the fetus actually does feel pain is to mislead the patient—that is, to make her think the scientific evidence clearly favors the conclusion that the fetus can feel pain. If the patient thinks that fetal pain is relevant to her decision regarding whether to terminate her pregnancy, then the disclosure is detrimental to her understanding of a material fact and as such makes her decision less likely to be a substantially autonomous action.

#### b. Other Informational Manipulation

Biased counseling materials also attempt to make use of framing effects to discourage abortions. The Texas materials discuss the negative risks of abortion procedures at length. The booklet notes the risk of

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213. See *supra* text accompanying notes 183–84.

214. See *supra* Part II.A.

death for abortions at various gestational stages, rather than presenting the information in terms of chances of survival.<sup>215</sup> Lists of other risks are given for each type of abortion procedure with no information about the likelihood of occurrence for each listed risk.<sup>216</sup> The only discussion of the positive effects of abortion is a brief mention that some women “may feel relief that the procedure is over.”<sup>217</sup> The risks of childbirth are also mentioned after the statement: “Pregnancy and birth is usually a safe, natural process although complications can occur.”<sup>218</sup> Abortion is also usually a safe procedure,<sup>219</sup> but the booklet does not make that statement because its wording and organization are designed to discourage abortions. This use of framing may lead some patients to have false beliefs about the relative risks of abortion and childbirth, which could prevent them from achieving the substantial understanding necessary to make an autonomous choice regarding pregnancy termination.

Biased counseling materials usually include information about all the types of abortion procedures, including procedures that are only used for later-term pregnancies and which are therefore irrelevant to the vast majority of abortion patients.<sup>220</sup> It is possible that the inclusion of this information, such as descriptions of dilation and extraction,<sup>221</sup> could confuse a patient and make her think that the procedure she will undergo will be more involved or more risky than it actually will be. This confusion would threaten her ability to arrive at a substantial understanding.

### c. Psychological Manipulation

Psychological manipulation differs from deception and the other forms of informational manipulation discussed above in that it does not necessarily threaten the substantial understanding necessary for autonomous action. Faden and Beauchamp advise against its use in an informed consent process because of the risk that the patient will not be

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215. TEX. DEP'T OF HEALTH, *supra* note 57, at 10.

216. *Id.* at 10–17.

217. *Id.* at 16.

218. *Id.* at 17. Similarly, the Louisiana materials state that “[c]ontinuing a pregnancy and delivering a baby is usually a safe, healthy process,” LA. DEP'T OF HEALTH & HOSPS., *supra* note 93, at 19.

219. See David A. Grimes, *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999*, 194 AM. J. OBSTETRICS & GYNECOLOGY 92 (2006) (finding that abortion has the lowest risk of maternal death of all pregnancy outcomes studied).

220. See, e.g., LA. DEP'T OF HEALTH & HOSPS., *supra* note 93, at 11–15.

221. See *id.* at 14–15.

able to resist the influence.<sup>222</sup> If a professional's psychological manipulation is irresistible for a patient, her decision will be controlled by the professional and therefore will not be autonomous.

Empirical research shows that appeals to fear can be highly likely to elicit the recommended course of action due to the power of the negative emotional response, as opposed to persuasion through reasons.<sup>223</sup> This effect may be intensified when the source of the message is perceived as having a high degree of credibility such as health care professionals or the government.<sup>224</sup> Some statements about risk in counseling materials seem to be intended to elicit fear rather than provide information for weighing risks. For example, the West Virginia booklet characterizes abortion as a "traumatic experience" and warns women that they may develop PTSD.<sup>225</sup> This statement does not present objective information that can be used to weigh the risks of various options;<sup>226</sup> it just makes abortion seem frightening.

Pictures of embryos and fetuses at various stages of development do not convey any information about risks or treatment alternatives. Anti-abortion forces believe that they convey emotional content that personifies the embryo or fetus.<sup>227</sup> Ultrasound laws in North Carolina, Oklahoma, and Texas are designed to force patients to listen to a description of the embryo or fetus, presumably assuming that this will generate an emotional reaction that will make it harder for patients to go through with abortions.<sup>228</sup> Similarly, fetal pain disclosures are framed to make it seem more likely that the fetus will feel pain than is true for the precise reason that their authors intend to increase feelings of guilt, either to punish the patient or to discourage her from obtaining an abortion.<sup>229</sup> These pictures and statements may stimulate an emotional

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222. *Supra*, text accompanying notes 204–06.

223. Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 13–20 (2008) (discussing empirical research on emotional influence and the power of fear and threats).

224. *Id.* at 21–22.

225. W. VA. DEP'T OF HEALTH & HUMAN RES., *supra* note 68, at 15.

226. See *supra* text accompanying notes 73–81 (showing that negative psychological conditions like PTSD are not made more likely by abortion).

227. See CELESTE MICHELLE CONDIT, *DECODING ABORTION RHETORIC: COMMUNICATING SOCIAL CHANGE* 82 (1990); Sack, *supra* note 148 (quoting Focus on the Family spokesperson as saying, in support of a mandatory ultrasound law: "To be able to put a face on that baby humanizes this process and really allows the mother to connect.").

228. See *supra* Part II.E.

229. Tobin, *supra* note 105, at 125. Inasmuch as statements about fetal pain encourage patients to seek fetal anesthesia or analgesia, they serve to increase the cost of abortion, see Hannah Stahle, *Fetal Pain Legislation: An Undue Burden*, 10 QUINNIPIAC

reaction such as guilt. If this emotional reaction were actually impossible for the patient to resist as she attempts to decide, it would cause her to fail the condition of noncontrol necessary for autonomous action.<sup>230</sup> This is because an individual who acts in accord with an emotion that is irresistible does not make a choice at all. Unlike being rationally persuaded of prudential or moral considerations, an irresistible emotion unavoidably compels an action and prevents the exercise of autonomy.

#### d. Removal of Patient Control over Procedures and Their Timing

Some features of biased counseling laws remove the patient's ability to control the course of medical interventions. Many biased consent laws require patients to wait a fixed amount of time after receiving counseling or an ultrasound.<sup>231</sup> Faden and Beauchamp recognize that placing a time pressure on patients' decisions is not conducive to informed consent.<sup>232</sup> Patients have made a "behavioral commitment" by going to the provider and may be resistant to information that "challenges the original decision," or they may need time to make a decision.<sup>233</sup> However, nothing in Faden and Beauchamp's account provides support for mandatory waiting periods of fixed length; not every patient in a given state needs twenty-four hours. Rather, health care professionals should be sensitive to the possibility that a given patient will benefit from having more time to decide after the informed consent dialogue has taken place and tailor the scheduling of the medical intervention accordingly.

#### e. Failure of Biased Counseling Laws to Promote Well-Being

Faden and Beauchamp allow that the "need to balance competing moral principles" makes it "possible to have a *morally acceptable* set of requirements" for legally effective informed consent that differs from the view that informed consent is an autonomous authorization.<sup>234</sup> In this section, I examine the possibility that the principle of beneficence might

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HEALTH L.J. 251, 268–69 (2007), which is a key strategy in the anti-abortion legislator's playbook.

230. See *supra* text accompanying notes 187–190.

231. See *supra* Part II.F.

232. FADEN & BEAUCHAMP, *supra* note 5, at 325.

233. *Id.*

234. *Id.* at 286.

justify the features of biased counseling laws that threaten patient autonomy.

The principle of beneficence requires physicians to avoid, prevent, and remove harm while also promoting well-being.<sup>235</sup> Beneficence would *prima facie* justify, for example, a doctor withholding information about a treatment alternative that she knows is markedly less effective than her recommended treatment in order to prevent the patient from choosing a course of action that is not the most conducive to the patient's well-being. This example shows the potential conflict between beneficence and the principle of respect for autonomy: the patient who is not informed of the available alternatives when she would consider this information material does not make an autonomous choice to pursue the physician's recommended treatment. While many would maintain that respect for autonomy should overcome the *prima facie* force of beneficence in such circumstances, a paternalistic view of medicine would allow the infringement on autonomy in order to benefit the patient's health.<sup>236</sup>

Since biased counseling laws are often criticized for being paternalistic,<sup>237</sup> it might seem that they can be justified by a model of informed consent that emphasizes beneficence rather than autonomy. That is, an ethical position that sees paternalism as positive because it helps patients do what is in their best interests even when they do not will it, might provide an ethical grounding for biased counseling laws.<sup>238</sup> There are two ways that beneficence might justify features of biased counseling laws that threaten patient autonomy. First, they might discourage abortions, which would contribute to patient well-being if abortion is always or at least usually detrimental to well-being. Second, they might allow pa-

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235. *Id.* at 10.

236. *Cf.* BEAUCHAMP & CHILDRESS, *supra* note 9, at 210 (mentioning arguments that support "the physician's manipulation of some patients to select proper goals of care").

237. *See, e.g.*, Paula Abrams, *The Tradition of Reproduction*, 37 ARIZ. L. REV. 453, 489 (1995) (describing *Casey* and the biased counseling law it upheld as "paternalism [that] undermines the independence of women as decisionmakers and furthers the stereotype that women are emotional and irrational decisionmakers, easily swayed by authority figures").

238. Beauchamp and Childress, in their influential text discussing the principles of medical ethics, offer a set of conditions that are necessary for paternalistic acts that damage patients' autonomy interests to be ethically justified. BEAUCHAMP & CHILDRESS, *supra* note 9, at 215–16. In my examination of whether biased counseling laws can be justified by beneficence, my focus corresponds to two of their conditions: that "[a] patient is at risk of a significant, preventable harm" and that "[t]he paternalistic action will probably prevent the harm." *Id.* at 216. It is likely that the autonomy-damaging features of biased counseling laws fail every one of Beauchamp and Childress's conditions.

tients who terminate their pregnancies to have better outcomes by preparing them for the experience of having an abortion and the consequences. However, as I will show, neither justification warrants a paternalistic application of the principle of beneficence as overruling the principle of respect for autonomy.

Turning to the first justification, there is little or no evidence that biased counseling laws actually discourage significant numbers of women from deciding to terminate their pregnancies. Waiting periods create a logistical obstacle that can significantly delay abortions and may prevent some women from getting abortions altogether,<sup>239</sup> but I distinguish that from *discouraging* women from *deciding* in favor of terminating their pregnancies, just as locking someone in a room may stop them from taking an action without changing their mind or stopping them from willing that action. But even assuming that these laws make women less likely to choose abortions, they cannot be justified by the principle of beneficence because it is not the case that induced abortion is more detrimental to women than childbirth or miscarriage.<sup>240</sup> By inventing and publicizing the idea of “Post-Abortion Syndrome,” a supposedly common negative psychological reaction to abortion,<sup>241</sup> the anti-abortion movement would argue that abortion is harmful to women, but abortion is an extremely safe procedure.<sup>242</sup> The empirical evidence debunking anti-abortion activists’ myths about the harms of abortion is discussed above. Furthermore, the alternative of childbirth is not without its risks and burdens.<sup>243</sup>

As for the second argument, that biased counseling can improve patient outcomes after abortion, there is little or no evidence supporting this proposition. It is generally true that informed consent disclosures can help patients by letting them know what to expect, encouraging

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239. Cf. Mandy S. Coles et al., *How are Restrictive Abortion Statutes Associated with Unintended Teen Birth?*, 47 J. ADOLESCENT STUD. 160 (2010) (finding that mandatory waiting periods are associated with increased rates of unintended birth in teenagers); Theodore Joyce et al., *The Impact of Mississippi’s Mandatory Delay Law on Abortions and Births*, 278 J. AM. MED. ASS’N 653 (1992) (finding that Mississippi’s mandatory waiting period “was responsible for a decline in abortion rates and an increase in abortions performed later in pregnancy”).

240. See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 215 (2012) (“Legal induced abortion is markedly safer than childbirth.”).

241. See *supra* note 73.

242. See Grimes, *supra* note 219; Grimes & Creinin, *supra* note 61; Henshaw, *supra* note 61.

243. See, e.g., *Roe v. Wade*, 410 U.S. 113, 153 (1973) (explaining the psychological and physical detriments of raising an unintended child).

treatment compliance, and so on.<sup>244</sup> Certainly, patients should be informed about what the procedure will entail and its likely side effects. Many biased counseling laws go further, however, and they do so in ways that are unlikely to contribute to patient well-being. For one thing, making a patient believe that a procedure is more dangerous than it really is—as misleading risk statements do—will only add fear and stress to her experience of the procedure and potentially make negative effects more likely through the power of suggestion.<sup>245</sup> Similarly, misleading statements about fetal pain are only likely to increase patient anxiety without any offsetting benefit.

A waiting period, by itself, does not contribute to positive patient outcomes after abortion. In addition to the fact that mandatory waiting periods demean women by assuming they will not take sufficient time to make their decisions without being forced to, they do nothing to guarantee women engage in further consideration of the decision during the waiting period.

Requiring women to listen to a description of their ultrasound or to the embryonic or fetal heartbeat might also seem to be justified by the notion that these requirements inform the patient about the moral status of the embryo or fetus or facilitate an emotional connection with it.<sup>246</sup> Such effects might be thought to ensure that the patient understands what she is destroying. The notion that an unwanted ultrasound description or auscultation will encourage positive psychological outcomes through increased patient understanding is one I am aware of no evidence for. Every abortion patient understands that the procedure will terminate her pregnancy and that foregoing an abortion will, in the usual course, result in the birth of a child. If a patient does not already understand these facts when she seeks out an abortion, the generally-applicable informed consent process requires health care providers to inform her so.<sup>247</sup> An ultrasound description or auscultation offers no new material information.<sup>248</sup> Some women may feel better if they hear a

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244. See STEPHEN WEAR, *INFORMED CONSENT: PATIENT AUTONOMY AND CLINICIAN BENEVOLENCE WITHIN HEALTH CARE* 54 (2d ed. 1998) (noting empirical evidence that anxiety is reduced by informed consent and that the felt intensity of pain is decreased if the patient is warned of its occurrence).

245. *Id.* at 51 (“[I]f a certain possible side effect of a drug is mentioned, the likelihood that that side effect will occur is increased.”).

246. It is unclear what else an ultrasound could convey to the patient in aid of decision making. The visual or auditory features of body parts to be operated upon are not typically thought to be so important to informed consent that the patient should have them conveyed to her regardless of her wishes.

247. See *supra* text accompanying note 191.

248. Cf. Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to Protected Choice*, 56 U.C.L.A. L. REV. 351, 381 (2008) (arguing against the idea that



description of a pre-abortion ultrasound, and some women may feel worse.<sup>249</sup> And health care professionals may be able to predict when exposure to the results of an ultrasound will be distressing for the patient as a result of their consultation with her; they should have the medical discretion to refrain from describing it or making the heart tones audible. Without evidence that all or even most women would fare better as a result of exposure to pre-abortion ultrasound, supporters of ultrasound description or auscultation laws cannot claim that such laws are justified by the principle of beneficence.

Finally, it is difficult to imagine how statements conveying the state's view of the moral status of the embryo or fetus could improve patient well-being. One possibility is that such a statement allows the patient to weigh the state's moral view while making her decision and prevents her from later learning and being upset by the fact that, in the eyes of the state she has "terminate[d] the life of a whole, separate, unique, living human being."<sup>250</sup> Of course, there are other views of abortion. A woman who is told that abortion terminates the life of a human being and chooses childbirth might later be upset to learn that other states do not articulate that view or that many moral authorities espouse contrary views.<sup>251</sup> Concern for patient well-being cannot justify compelling patients to listen to the state's moral views based on speculative and tenuous future possibilities.

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ultrasound provides objective information, because, *inter alia*, there is "preexisting public and personal familiarity with and affection for fetal imagery"). Information conveyed by an ultrasound may be subjectively considered material by some patients; these patients should convey that to their abortion providers, who would then have an ethical obligation to provide the information. As I have tried to make clear throughout this Article, my position that there are ethical problems with the statements that biased counseling laws require does not entail that I oppose such statements, inasmuch as they are truthful and not misleading, being made to those patients who request the information.

249. See Post, *supra* note 3.

250. S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (2011). The argument offered in the text is similar to one used by the Supreme Court to uphold disclosures about embryonic and fetal development stages. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

251. See, e.g., DAVID FELDMAN, BIRTH CONTROL IN JEWISH LAW 253–55, 265–66 (1998) (discussing authorities' views that the embryo or fetus is not a person according to Jewish law at certain stages of pregnancy); Mary Anne Warren, *On the Moral and Legal Status of Abortion*, in BIOMEDICAL ETHICS 434–40 (Thomas A. Mappes & David DeGrazia eds., 4th ed. 1996) (arguing that fetuses are not persons and therefore have no right to life); *Roe v. Wade*, 410 U.S. 113, 133–34 (1973) (discussing the traditional Christian theological view that, early in pregnancy, the embryo or fetus is not a person but merely part of the pregnant woman).

## f. The Embryo or Fetus as the Object of Beneficence

Anti-abortion legislators might argue that the beneficence principle's requirement to avoid harm justifies biased counseling laws that are intended to make abortion less likely because they prevent harm to embryos and fetuses. The position is that the embryo or fetus is an appropriate object of beneficence—that is, an entity to which there is a moral obligation to prevent harm. Therefore, actions that prevent harm to the embryo or fetus are justified by the principle of beneficence even where they violate the principle of respect for autonomy. This position may be grounded on a tenable balancing of the two principles (although it is a balancing that I believe is incorrect), but the protocols generated by it cannot legitimately be called “informed consent.” This is because the position justifies controlling an individual's actions in order to protect others. Indeed, the logical extension of the position is to eliminate abortion as a choice for women because abortion harms embryos and fetuses. The position endorses the *suspension* of autonomy-protective features of informed consent practices in order to protect the well-being of embryos and fetuses; it holds that beneficence toward embryos and fetuses requires that women's ability to consent to abortion be *less than* fully voluntary and informed. For those who believe that the destruction of an embryo or fetus is a moral wrong that outweighs the moral value of a woman's exercise of self-determination, this may be an attractive policy position, but it is not one that enhances informed consent.

### B. Consent as Shared Decision Making

After Faden and Beauchamp's book, possibly the next most-cited work on informed consent is *Informed Consent: Legal Theory and Clinical Practice*, a guide to the law and ethics of informed consent for clinicians.<sup>252</sup> In this book, Jessica Berg and her co-authors present a view of informed consent as shared decision making between health care professionals and patients,<sup>253</sup> one based squarely on the values of autonomy and patient

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252. BERG ET AL., *supra* note 9, at 4. The first edition of the book has a different author list, including a different lead author. PAUL S. APPELBAUM ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* (1987). The work is routinely cited in discussions of informed consent. See, e.g., Joffe & Truog, *supra* note 167, at 347, 349; James Stacey Taylor, *Autonomy and Informed Consent: A Much Misunderstood Relationship*, 38 J. OF VALUE INQUIRY 383, 383 (2004).

253. BERG ET AL., *supra* note 9, at 11. In using joint decision making between physician and patient as the basis of their view of informed consent, the authors follow physician Jay Katz, who has strenuously criticized the law's failure to usher in a regime of

well-being.<sup>254</sup> Health care professionals should promote the conditions that allow autonomous decisions, which includes “avoiding as much as possible pressures of time [and] dictatorial presentations of information and options.”<sup>255</sup> Berg and her co-authors contend that autonomous decision making is a right of patients, not an obligation; patients should be allowed to delegate informed decision making to others whom they trust.<sup>256</sup>

When it comes to the information that should be disclosed to patients, Berg and her co-authors do not provide a firm ethical position but rather glean “generalizations” from tort cases to offer topics that physicians should consider.<sup>257</sup> They note at the outset that “[t]oo much information can be as harmful as too little,” and warn that information should be “put into context.”<sup>258</sup> Physicians should disclose the nature of the procedure, including expected benefits.<sup>259</sup> They should discuss risks, and when deciding whether to disclose a particular risk, they should consider its nature, magnitude, probability, and imminence.<sup>260</sup> Risks that are “common, known, remote, or minor” need not be disclosed.<sup>261</sup> This means that exaggerated risk statements like those found in some biased counseling laws are not warranted. Patients should be informed about

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shared decision making. See, e.g., Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL’Y 69 (1994); Jay Katz, *Informed Consent—A Fairy Tale? Law’s Vision*, 39 U. PITT. L. REV. 137 (1977). Another model that takes shared decision making as crucial is that of Howard Brody, whose view is centered around the requirement that the physician make her reasoning transparent to the patient, and the patient must be able to participate in that decision to the extent that she desires. Howard Brody, *Transparency: Informed Consent in Primary Care*, 19 HASTINGS CENTER REP. 5, 7 (1989).

254. See, e.g., BERG ET AL., *supra* note 9, at 18–19, 24, 26. At times, Berg and her co-authors seem to think that autonomy is the only justification. See, e.g., *id.* at 319, 324.

255. *Id.* at 25.

256. *Id.* at 30–32.

257. *Id.* at 53–65. A key purpose of their discussion seems to be assisting physicians in avoiding liability for medical malpractice, although occasionally they acknowledge that ethical and legal requirements may diverge. See, e.g., *id.* at 58. A comparable view of the disclosures that are morally required can be found in bioethics textbooks. See, e.g., GERT ET AL., *supra* note 192, at 214 (requiring that patients be told about “significant harms and benefits[,] . . . alternative intervention(s) [and] the nature of the malady”).

258. BERG ET AL., *supra* note 9, at 53.

259. *Id.* at 54–55, 60–61. “In addition to the type of procedure, relevant information also includes the duration of the procedure, where it will take place (the physician’s office or a hospital), the need for anesthesia, the type of instruments to be used, and an explanation of the bodily parts affected by the procedure.” *Id.* at 55.

260. *Id.* at 56.

261. *Id.* at 57.

alternatives to the proposed intervention, so that they may make decisions according to their values and goals.<sup>262</sup> Berg and co-authors expressly disapprove of government-adopted lists of required disclosures like those in biased counseling laws, calling them “contrary to the spirit of the informed consent doctrine” because they detract from the need for personalized communication.<sup>263</sup>

Berg and her co-authors also summarize other legal requirements of informed consent, noting that patient understanding and voluntariness are required, although they provide little ethical insight into these concepts beyond pointing out that they are important to patient decision making.<sup>264</sup> They discuss the waiver exception to the legal requirement of informed consent as well, arguing that the doctrine’s “primary objective . . . to promote individual self-determination” means that patients should not be compelled “to receive information they do not want or to make decisions they do not wish to make.”<sup>265</sup> This means that mandatory descriptions and auscultations of ultrasounds are unethical, as is any irrelevant information that is unwanted, such as detailed descriptions of surgical procedures or pictures of embryos and fetuses.

The ethical model of informed consent that Berg and her co-authors prefer is a “process” model, one that assumes that medical decision making is not a discrete event.<sup>266</sup> It emphasizes a two-way transfer of information between patient and physician that the authors refer to as “mutual monitoring.”<sup>267</sup> Physicians must offer information in a way that facilitates patient decision making; Berg and co-authors warn against greeting patients at the first encounter “with a terrifying list of potential diagnoses, including remote and usually fatal possibilities.”<sup>268</sup> The patient retains the power to refuse the recommended intervention.<sup>269</sup>

Berg and her co-authors find it appropriate for discussions between professional and patient to cover values; they think patients may benefit

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262. *Id.* at 59.

263. *Id.* at 58; *see also id.* at 185 (recommending that physicians “individualize disclosures to meet patients’ needs [and] avoid sterile repetition”).

264. *Id.* at 65–70.

265. *Id.* at 88. Berg and her co-authors also provide a beneficence-based justification for waiver: it can protect patients from the potential harmful impact of information or anxiety of decision making. *Id.* at 90.

266. *Id.* at 171; *see also id.* at 174 (“The basic principle of the process model of informed consent is that patients should be able to participate in decision-making in every phase of patient care.”).

267. *Id.* at 171–72. Physicians disclose information about treatment, and patients convey their concerns, values, and level of understanding of their choices.

268. *Id.* at 172.

269. *Id.* at 227; *see also id.* at 241 (“[O]ne might say that the opportunity to refuse is the point of the whole thing.”).

from the physician's perspective on "religious, moral, or emotional issues" when the physician has dealt with a certain situation repeatedly.<sup>270</sup> However, the model does not provide support for a law compelling the doctor to be the mouthpiece for the government's ideological views. Berg and her co-authors consider the benefit of value discussions to be based on the patient's desire for input and the doctor's experience with similar situations.

Berg and her co-authors express concern about the possible pressure on patients created by receiving information shortly before a surgery to which they have already committed.<sup>271</sup> The process model addresses this by recommending keeping patients well informed throughout the treatment process. It may seem that the process model would provide support for a mandatory waiting period of some fixed length. Certainly the process model is in favor of early discussion of relevant information and giving patients the time they need to decide. However, not every patient needs the same amount of time. The solution to time pressures is to give patients control over time by letting them go home and, if they decide to proceed, schedule another appointment.

### *C. Consent as a Benefit to Patients*

Not all ethicists accept autonomy as the theoretical foundation for informed consent. Stephen Wear, a philosopher with experience as an ethical consultant to clinicians, offers an operational account of informed consent. This account seeks to articulate a model of informed consent that responds to practical problems that clinicians face and offers effective guidance.<sup>272</sup> Wear's account is based on beneficence, in that it derives from a recognition of the ways that informed consent benefits patients.<sup>273</sup> He expresses skepticism about the "new ethos of patient au-

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270. *Id.* at 180. Jay Katz, another supporter of the shared decision making view of informed consent, has expressed doubt that physicians are truly able to understand their patients' values. See Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 75, 88 (1994). Robert Veatch has embraced the radical proposition that "there is no reason to believe that a physician or any other expert in only one component of well-being should be able to determine what constitutes the good for another being." Robert M. Veatch, *Abandoning Informed Consent*, 25 HASTINGS CENTER REP. 5, 7 (1995).

271. BERG ET AL., *supra* note 9, at 182–83.

272. WEAR, *supra* note 244.

273. See *id.* at 89; see also *id.* at 84–85 (stating that his model is justified not by theoretical arguments, but whether "it credibly provide[s] for and pursue[s] the goods and values identified"). Since it is based ultimately on beneficence, Wear's model is arguably an example of principlism, and more specifically, rule utilitarianism. See *id.* at 88–89

tonomy,” which emphasizes patients’ interest in freedom from interference and assumes that “if only physicians would stop paternalizing their patients and provide them with sufficient information, patient autonomy would blossom forth.”<sup>274</sup>

Wear explains that many clinicians view the version of informed consent resulting from the new ethos to be unattainable and see dangers in disclosing too much to patients. For example, a version of the placebo effect means that informing patients of risks and complications makes them more likely to occur.<sup>275</sup> Clinicians also may doubt the benefit to patients of protecting patient autonomy in cases where its exercise leads to the imprudent refusal of treatment and a tragic outcome.<sup>276</sup> On the other hand, autonomy is an important value in our society, and participation in decision making can have medical benefits for patients. There is evidence that both patient anxiety and the experience of pain are reduced when patients are well-informed and that well-informed patients are better satisfied and better able to adapt to new situations.<sup>277</sup> The informed consent process can also improve the physician-patient relationship, alert physicians to useful information about patients, improve patient compliance with treatment regimes, and aid the pursuit of preventive goals.<sup>278</sup> Wear articulates a model of informed consent that can be used as a medical management tool to reap these benefits.

Wear’s model views informed consent as a structured discussion between physician and patient that takes place in a process of establishing trust and information sharing and may lead to a longer, more wide-ranging discussion over time.<sup>279</sup> The informed consent event proceeds in three stages. First, a comprehensive disclosure broadly informs the patient about her diagnosis, the recommended treatment and its risks and benefits, and alternative treatment options.<sup>280</sup> The interaction at this stage is designed to alert the clinician to patient hesitance, misconcep-

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(discussing the relationship of the model to prior theoretical commitments and the principle of beneficence). Although there are many formulations of rule utilitarianism, the basic thrust of the theory is that the ethical character of an act is determined by whether it is in compliance with a rule that would lead, in most applications, to the greatest good for the greatest number. Childress, *supra* note 173, at 19–20.

274. WEAR, *supra* note 244, at 171–72. See also James Stacey Taylor, *Autonomy and Informed Consent: A Much Misunderstood Relationship*, 38 J. VALUE INQUIRY 383 (2004) (arguing that concern for human well-being, rather than autonomy, is the conceptual basis for informed consent).

275. WEAR, *supra* note 244, at 51 (describing “nocebo” effect); see also *id.* at 107.

276. *Id.*

277. See *id.* at 54 (citing studies).

278. *Id.* at 72–76.

279. *Id.* at 96–98.

280. *Id.* at 101–16.

tions, or a desire for more information.<sup>281</sup> Second, the core disclosure focuses on the actual choice the patient must make and requires the physician to explain her recommendation.<sup>282</sup> Third, the patient is asked to give feedback by summarizing her understanding of the disclosures and asking any questions she may have.<sup>283</sup> At the end of this process, the physician formally requests the patient's consent to the recommended treatment.<sup>284</sup> Wear recognizes the traditional exceptions to physicians' obligation to obtain informed consent to treatment: patient incompetence, emergencies, patient waiver, and the therapeutic privilege.<sup>285</sup>

Wear's model does not allow the physician to make a recommendation where the choice involves subjective, value-laden judgments.<sup>286</sup> This can come about when there are multiple options available that are equally reasonable from a medical point of view. Wear expressly includes abortion in the category of decisions on which the physician should not make a recommendation because "the values at stake are so profound and personal that only the patient can speak to them."<sup>287</sup> It is an implication of this feature of the model that ideological or moral statements without medical content should not be a part of the informed consent event.

Physicians should "give an accurate rendition of the risk and complication profile of a given intervention."<sup>288</sup> One of the goals of the informed consent event is to develop trust between physician and patient,<sup>289</sup> which requires that the physician not lead the patient astray. At

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281. *Id.* at 101.

282. *Id.* at 116–22.

283. *Id.* at 122–24.

284. *Id.* at 124.

285. *Id.* at 156. However, Wear is so skeptical of therapeutic privilege that it may be accurate to say that it is not a valid exception on his model. *See id.* at 169. As is the case with other accounts of informed consent, the presence of an emergency exception highlights an ethical problem for laws that do not include such exceptions for emergencies. *See, e.g.,* MISS. CODE ANN. § 41-41-34 (2011) (requiring that the pre-abortion ultrasound be performed and the patient be afforded the chance to view it and listen to embryonic or fetal heart tones, without exception for medical emergencies). Furthermore, Wear holds that the question of whether there is an emergency should be left "to objective medical judgment." WEAR, *supra* note 244, at 170. This casts doubt on the ethical validity of laws that have narrowly crafted exceptions. *See, e.g.,* N.D. CENT. CODE 14-02.1-02(9) (2011).

286. WEAR, *supra* note 244, at 115; *see also id.* at 163 (recommending against allowing patients to waive informed consent and decision making in such situations); *cf. id.* at 121 (discussing the effect of a profound and personal choice at the core disclosure stage).

287. *Id.* at 71 (listing elective abortion as a "clear example").

288. *Id.* at 107–08.

289. *Id.* at 101

the comprehensive disclosure stage, risks should be identified along with their likelihood of occurrence.<sup>290</sup> Major risks with a high magnitude (for example, death or paralysis) and high percentage of occurrence should be emphasized.<sup>291</sup> Risks should be discussed in the context of counterbalancing benefits and a comparison of the risks of other options, including non-treatment.<sup>292</sup> This discussion should be narrowed to major risks at the core disclosure stage.<sup>293</sup>

Although Wear recognizes the legitimacy of the principle, “when in doubt, mention it,”<sup>294</sup> at the comprehensive disclosure stage, his model never sanctions making inaccurate statements about risks. It holds that “[a] false understanding of the essential facts . . . renders the incorporating decision-making process invalid.”<sup>295</sup> Wear requires that percentages of occurrence of risks be mentioned and requires balancing risk disclosures in the context of benefits and the risk profiles of alternatives.<sup>296</sup> Some states’ abortion counseling laws fail to satisfy this model. They require physicians to make inaccurate statements about risks, as demonstrated above. They mention risks of abortion without explaining their likelihood and offer one-sided information about risks, focusing on negative risks of abortion without mentioning the benefits of abortion or, in some cases, the risks of childbirth. Counseling materials make warnings about high-magnitude risks like breast cancer and infertility without offering information about the low percentage of occurrence of those risks or the fact that abortion does not increase them.<sup>297</sup>

According to Wear’s model, detailed actual understanding on the part of the patient is not necessarily a goal of informed consent; some patients may benefit from it, others may not.<sup>298</sup> Indeed, Wear thinks that “we should be willing to respect the patient’s autonomy . . . in the sense that he does not want very much detail and is willing to rely on the physician’s judgment.”<sup>299</sup> The model accommodates different levels of

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290. *Id.* at 108 (recommending that major risks be mentioned individually “with attendant statistics”).

291. *Id.* at 109–10.

292. *Id.* at 111.

293. *Id.* at 121.

294. *Id.* at 109.

295. *Id.* at 151.

296. See *supra* text accompanying notes 290–292.

297. See *supra* Part II.A.

298. WEAR, *supra* note 244, at 173.

299. *Id.* at 124 (emphasis omitted) say (discussing the third stage of the informed consent event and supporting broad disclosures at the first stage); *id.* at 135 (“[P]eople *autonomously* choose to pursue quite varying degrees of understanding, in health care as in all other areas of human endeavor, and [] such choices should generally be honored.”).



disclosure in different circumstances, contrary to the one-size-fits-all mandatory disclosures of many biased counseling laws. Furthermore, Wear's model recognizes the waiver exception, allowing patients to waive the disclosures normally owed them and letting the physician make the decision as to the appropriate intervention.<sup>300</sup> Wear thinks that physicians should not allow patients to use waiver to abdicate personal and profound decisions.<sup>301</sup> But the patient who has made the personal and profound decision to terminate her pregnancy and does not want to be told about the graphic details of the procedure or hear a description of her ultrasound is not attempting a waiver that is problematic in this sense. Rather, she is exercising control over whether she receives information that goes beyond the core disclosures that she needs in order to make a responsible choice about the intervention.

Because a solicitation of patient hesitation and confusion is built into this model,<sup>302</sup> it does not support mandatory waiting periods. The physician has a responsibility to address patient apprehension, which may include recommending that the patient take some time to reflect. But Wear's model gives no reason to think that requiring all patients to wait a given number of hours between the provision of information and the procedure adds anything to the quality of patients' decision making or otherwise benefits patients.

Wear's model does not expressly emphasize that disclosures be limited to information that is relevant to the patient's circumstance, but the notion can be inferred from his discussion of the comprehensive disclosure. He lists the types of information that should be disclosed as "the patient's overall medical condition, the specific problem for which treatment is being recommended, the treatment recommended with its attendant benefits and risks, any alternative modalities, and the prognosis without treatment."<sup>303</sup> Risks of procedures that are not appropriate to the patient's situation, such as abortion procedures used at later gestational stages, do not appear on the list.

#### *D. Consent as Waiver*

In their book *Rethinking Informed Consent in Bioethics*, Neil Manson and Onora O'Neill reject the standard view that informed consent is jus-

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300. *Id.* at 162–66.

301. *Id.* at 163–64.

302. *Id.* at 112 (explaining that one of the goals of the comprehensive disclosure is to rule out "hesitancy and ambivalence on the patient's part").

303. *Id.* at 102.

tified by respect for autonomy. Instead, their account is deontological in that it focuses on rights and obligations. It is centered on the insight that informed consent changes the character of an action from a violation of a norm, right, or obligation into an ethically or legally acceptable action.<sup>304</sup> For example, if A stabs B with a needle, A commits battery and violates B's right to bodily integrity. However, if A stabs B with a needle because A is taking a sample of B's blood with B's consent, then A has not wronged B thereby.<sup>305</sup> Informed consent in medicine is justified not by a need to protect autonomy, but by the need to waive important norms in order for treatment to be possible.<sup>306</sup> Manson and O'Neill describe informed consent as more than mere disclosure, but rather a communicative transaction that is "governed and constrained by a rich normative framework,"<sup>307</sup> including norms of "intelligibility, relevance, accuracy and honesty."<sup>308</sup> A transaction that satisfies these communicative norms can waive specific rights, such as the right not to be battered.<sup>309</sup>

Manson and O'Neill describe the standard view regarding informed consent as one that strives to make consent more explicit and specific because it is conceived as the disclosure of information needed for autonomous decision making.<sup>310</sup> They argue that this effort has resulted in standards that are overly formalistic and impossible to satisfy in practice.<sup>311</sup> They also question the "general agreement that informed consent is required for the sake of autonomy, and that autonomy is a basic ethical value."<sup>312</sup> They are skeptical about this supposed agreement because they diagnose substantive disagreement within the field of medical ethics regarding how to conceive of autonomy, its importance to the field, and its connection to informed consent.<sup>313</sup>

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304. MANSON & O'NEILL, *supra* note 167, at 72–73.

305. See Neil C. Manson, *Consent and Informed Consent*, in PRINCIPLES OF HEALTH CARE ETHICS 297, 297–98 (Richard E. Ashcroft et. al. eds., 2d ed. 2007).

306. See MANSON & O'NEILL, *supra* note 167, at 72–77, 94–96, 188. Beauchamp has questioned whether Manson and O'Neill have really replaced autonomy as the justification for informed consent or whether their preferred justification is itself supported by respect for autonomy. Tom L. Beauchamp, *Autonomy and Consent*, in THE ETHICS OF CONSENT, *supra* note 167, at 55, 60.

307. MANSON & O'NEILL, *supra* note 167, at ix.

308. *Id.* at xi.

309. *Cf. id.* at 72–73.

310. *Id.* at 6–11, 32–33.

311. *Id.* at 11, 15–16.

312. *Id.* at 17.

313. *Id.* at 17–22. Beauchamp has noted that, while there are problems with the literature on autonomy, there are similar problems with the literature regarding the concepts

Part of the motivation of Manson and O'Neill's account is their view of the deficiencies present in common ways of thinking about the communication of information: the container and conduit metaphors. Information is commonly thought of as material that is contained somewhere—it is possessed by people or stored in written texts, for example.<sup>314</sup> A related view is that the act of communication is the conveyance or transfer of information through some conduit, such as speech.<sup>315</sup> Manson and O'Neill point out that this way of thinking obscures the crucial importance of context, communicative norms, and background expectations.<sup>316</sup>

Among the norms governing communication are epistemic norms—norms concerning knowledge. Speakers<sup>317</sup> who make assertions—that is, statements that represent the world if they are true—have an epistemic responsibility to communicate the way the world actually is to others.<sup>318</sup> Speakers have a responsibility to their listeners not to do things that are likely to mislead them, including apparently asserting a fact when actually doing something else. A pair of examples of the importance of context to communication will illustrate the point. The actor on stage does not mislead the audience when she shouts, “The building is on fire Aunt Matilda, everybody leave!”<sup>319</sup> But the person who shouts the same thing in a crowded train station is likely to lead people to have mistaken beliefs that will affect their behavior. In addition to this responsibility not to engage in communicative acts that would lead the audience to believe things the speaker does not believe to be true, speakers have a responsibility to their audiences not to make assertions that they sincerely believe but for which they do not have sufficient evidence.<sup>320</sup> For this reason, listeners are entitled to engage speakers in a “two-way exchange” and ask for the grounds for their assertions.<sup>321</sup> Thus, statements in abortion counseling materials that are not well supported by scientific evidence, such as claims about an increased

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that Manson and O'Neill's account depends on. Tom L. Beauchamp, *Autonomy and Consent*, in *THE ETHICS OF CONSENT*, *supra* note 167, at 55, 60.

314. MANSON & O'NEILL, *supra* note 167, at 36.

315. *Id.* at 35.

316. *Id.* at 38–41, 48–49.

317. For stylistic reasons, I primarily use the language of speaking and listening here, although I am discussing all communication. Nothing in Manson and O'Neill's account hinges on differences between speaking and other forms of communication.

318. MANSON & O'NEILL, *supra* note 167, at 59–60.

319. *Id.* at 59.

320. *Id.* at 61.

321. *Id.* at 62.

risk of breast cancer or the likelihood of fetal pain, violate epistemic norms.

Another communicative norm is that of relevance to the audience's interests and practical commitments. For example, the assertion that "nickel melts at 1,455 degrees [Celsius]" satisfies various communicative norms; it is true, epistemically justified, comprehensible, and so on.<sup>322</sup> But if a speaker utters that statement when called on to give a lifeguard training, or when the listener's house is on fire, the speaker has failed to satisfy the norm of relevance to the audience's interests. "Good communicative practice therefore always involves *withholding* information—comprehensible, true, grounded information—that could have been conveyed."<sup>323</sup> This norm highlights a problem with the standard view's urge for greater specificity in informed consent disclosures: too much specificity may harm the ethical adequacy of a communicative transaction.<sup>324</sup> It also shows the ethical problem with biased counseling laws that require the description of graphic details of abortion procedures, especially those that the patient will not undergo, or descriptions of patients' ultrasounds. Because such disclosures are not relevant to patients' interests, providing them violates the norms of communicative transactions.

As I have explained, Manson and O'Neill hold that the ethical justification of informed consent is that it constitutes a waiver of ethical and legal requirements.<sup>325</sup> Their position entails that the scope of informed consent requirements is not determined by the prerequisites for autonomy, but by the ethical and legal norms that are at play in a given circumstance.<sup>326</sup> For the same reason, the authors are skeptical of attempts to impose uniform standards on informed consent practices, such as lists of mandated disclosures.<sup>327</sup> They argue that, for a routine intervention like taking a blood sample, a patient's rolling up her sleeve and extending her arm is sufficient implied consent, and that an explanation of the procedure from the nurse is not necessary.<sup>328</sup> In diagnosing and

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322. *Id.* at 63.

323. *Id.*

324. *Id.* at 67. ("It is not always necessary—and it may even be wrong—to inluct full details about a medical intervention upon a patient.")

325. Cf. John Kleinig, *The Nature of Consent*, in *THE ETHICS OF CONSENT*, *supra* note 167, at 3, 4, 10 (describing consent as a communicative transaction that can transform moral relations between agents).

326. MANSON & O'NEILL, *supra* note 167, at 78–79, 83, 189.

327. *Id.* at 80.

328. *Id.* at 81. However, if the patient expressed a refusal or the nurse deceived the patient about the procedure or used force to obtain a sample, the ethical character of the nurse's act would of course change. *Id.*

proposing a treatment, a physician's use of "simplified language that omits much detail" may be ethically appropriate as long as the physician "does not deceive or manipulate the patient, and the subsequent treatment does not force or coerce."<sup>329</sup> In addition, rare and minor risks can ethically be left unmentioned, since there is a limit to how much can be disclosed.<sup>330</sup> Biased counseling laws' long lists of low-frequency risks are therefore not supported by this model.

On the other hand, where the treatment is complex or unfamiliar or comes with high risks or significant side effects, informed consent standards demand greater specificity and explicitness.<sup>331</sup> Most fundamentally, "[c]onsent is a way of ensuring that those subjected to invasive interventions are not abused, manipulated or undermined, or wronged in comparably serious ways. . . . [W]hat matters will vary depending on the case at hand; and more is not always better."<sup>332</sup> Nevertheless, the authors acknowledge that "[a]ny request for consent will include some account of a proposed action or intervention, and of the effects—including risks and benefits—that are thought likely."<sup>333</sup>

Manson and O'Neill hold that the disclosures made in the informed consent process must be intelligible, relevant to patients, and "adequately accurate" given "each party's background knowledge and inferential competencies."<sup>334</sup> The epistemic norms that govern communication also demand that communication is not dishonest, which rules out the use of "exaggeration, omission of important qualifications and mere confusion,"<sup>335</sup> as well as communications that "mislead or manipulate."<sup>336</sup> Furthermore, patients "do not offer genuine consent or refusal when . . . they . . . base consent or refusal on their misunderstandings" of proposed interventions.<sup>337</sup> As is the case with other ethical accounts of informed consent, this view condemns misleading statements and those that omit qualifications, such as fetal pain statements and statements about psychological consequences of abortion.

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329. *Id.* at 81; *see also id.* at 66 ("[B]eing truthful, relevant and responsive to the intended audience's interests[] may in some contexts be sufficient for ethically sound informed consent practices.").

330. *Id.* at 190.

331. *Id.* at 81–82.

332. *Id.* at 82.

333. *Id.* at 87.

334. *Id.* at 88. The notion of adequate accuracy is contrasted with the goals of full specificity and explicitness, which the authors reject. *See id.* at 90.

335. *Id.* at 86.

336. *Id.* at 185.

337. *Id.* at 93.

A key aspect of their view is that Manson and O'Neill recognize the ability of patients to make judgments of reliability and trustworthiness about health care professionals.<sup>338</sup> This is one of the facts that justifies a patient's decision to not try to learn everything about a given intervention prior to consenting. After all, patients hire professionals precisely because they have expertise that patients do not, and trusting the recommendation of a professional without insisting on being informed of every detail can be entirely rational.<sup>339</sup>

Carefully applying Manson and O'Neill's account to abortion-specific counseling laws requires examining the norms that would be violated by the termination of a pregnancy in the absence of patient consent. Before discussing the laws themselves, it is important to clarify what Manson and O'Neill's account ethically requires of informed consent to abortion. There is widespread agreement that the destruction of a wanted pregnancy would be a serious moral wrong, resulting in tort and criminal consequences in many states.<sup>340</sup> These norms protect prospective mothers' interests in the continuation of their pregnancies, and for many people they express the value of the pregnancy, whether its metaphysical status is seen as potential life or as a person. Informed consent to abortion, therefore, must be sufficient to ensure that the patient waives these norms. This requires making certain that the patient understands that an abortion is the destruction of the pregnancy and is irreversible, as well as making certain that the patient wants to end her pregnancy. This much would be required by the generally applicable informed consent laws that exist in every state. Assuming that the norms surrounding the termination of pregnancy differ depending on the stage of the pregnancy—that is, many would find that the gestational age of the pregnancy is relevant to the moral significance of its destruction—Manson and O'Neill's account would presumably counsel a disclosure of the gestational age and information about the developmental features of the pregnancy. Given their emphasis on relevance and two-way communication, Manson and O'Neill would surely require that the provider elicit from the patient what she finds important and answer any of her questions.

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338. *Id.* at 154–67, 192.

339. *Cf. id.* at 192.

340. *See, e.g.,* *Wiersma v. Maple Leaf Farms*, 543 N.W.2d 787 (S.D. 1996) (interpreting the South Dakota wrongful death statute to authorize a cause of action for the death of a fetus, surveying other jurisdictions); *Dunn v. Rose Way, Inc.*, 333 N.W.2d 830, 832 (Iowa 1983) (holding that a pregnant woman could recover for loss of consortium in a case of fetal death); ME. REV. STAT. tit. 17-A, § 208-C (2011) (providing that causing the termination of a pregnancy without consent of the pregnant woman is “elevated aggravated assault”).

Biased counseling laws go further than the requirements just mentioned, however. They include exaggerated and misleading information about risks of serious outcomes like infertility and psychological problems. Such statements violate communicative norms requiring adequate accuracy and the inclusion of qualifying statements. For example, Michigan requires that patients be told that “as the result of an abortion, some women may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger.”<sup>341</sup> This statement is literally true, but it omits relevant qualifications. Most women who get abortions do not experience significant problems like those mentioned, and most women who do have negative psychological outcomes after abortions experienced other stressors prior to and distinct from their abortions.<sup>342</sup> The statement is calculated to mislead patients into thinking the risk is greater than it really is, which makes it a violation of the epistemic norms that govern informed consent transactions. Note that the strength of the norms that are waived by consent to abortion does nothing to justify misleading statements about risk. Those norms condemn the termination of a wanted pregnancy. Tricking a woman into continuing to carry an unwanted pregnancy by telling her she will be harmed by the abortion procedure does not serve norms against the destruction of wanted pregnancies.

As we have seen, Manson and O’Neill’s maxim that a speaker should make her statements relevant to the listener’s interests shows that irrelevant information does not enhance informed consent. For the same reason, patients should not be forced to hear information that they affirmatively state they do not want to hear. This counsels against mandatory statements generally, and certainly rules out requirements to listen to a description of an ultrasound or the embryonic or fetal heart-beat. Those women who feel that viewing or listening to a description of an ultrasound, or listening to heart tones, is relevant to their decision are free to request the information; other women should not have it forced upon them. Statements about the moral or metaphysical status of the embryo or fetus do not fare any better. A woman who wants this kind of information is able to seek it out, whether from a health care professional or an authority on such matters. As before, the norms that protect wanted pregnancies from destruction provide no justification for imposing information on a woman who is seeking to terminate her pregnancy.

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341. MICH. COMP. LAWS § 333.17015(11)(b)(iii) (2011). As another example, Missouri includes “possible adverse psychological effects associated with the abortion” in its list of risks that must be disclosed. MO. REV. STAT. § 188.027(1)(1)(b)(b) (2011).

342. See *supra* Part II.A.2.

Finally, mandatory waiting periods are not supported by Manson and O'Neill's approach to informed consent. The authors are opposed to uniform consent procedures generally,<sup>343</sup> and therefore would not favor the idea that every patient ought to wait a standard amount of time, even if some patients ought to be given time to consider their options. Their model calls for a two-way communicative transaction in which the patient knowingly waives norms that would otherwise forbid the termination of her pregnancy, not a mandatory time out.<sup>344</sup>

### *E. Consent as a Fair Transaction*

Franklin Miller and Alan Wertheimer argue against the standard autonomous authorization theory propounded by Faden and Beauchamp and offer in its place a "fair transaction" model of consent,<sup>345</sup> on which consent serves the values of both autonomy and well-being.<sup>346</sup> For these authors, the central ethical question is whether a consent transaction is "morally transformative and, in particular, whether a consent transaction renders it permissible for [the person seeking consent] to proceed."<sup>347</sup> Their model recognizes the bilateral nature of consent transactions and holds that "A is morally permitted to proceed on the basis of a consent transaction if A has treated B fairly and responds in a reasonable manner to B's token or expression of consent or what A reasonably believes is B's token or expression of consent."<sup>348</sup>

Miller and Wertheimer's model generates different results about morally effective consent than the autonomous authorization model because it holds that valid consent is neither necessary nor sufficient for moral transformation.<sup>349</sup> For example, they describe the following case: A, a department chair, says, "I'm going to appoint C to our new position unless anyone objects." B is daydreaming, and says nothing. A assumes that B has authorized him to appoint C.<sup>350</sup> B has not given valid consent because she is not aware of the proposal and does not authorize it, so B would not be permitted to proceed on the autonomous authorization model. However, A is reasonable in believing that B has

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343. MANSON & O'NEILL, *supra* note 167, at 190–91.

344. *See supra* text accompanying notes 307–08.

345. Miller & Wertheimer, *supra* note 167, at 79, 81.

346. *Id.* at 83.

347. *Id.* at 79.

348. *Id.* at 81; *see also id.* at 94.

349. *Id.* at 99–101.

350. *Id.* at 85.



consented, and it is morally permissible for A to proceed on the fair transaction model.<sup>351</sup>

The characteristics that allow consent to be morally transformative—voluntariness, information, and competence—are explained by the fair transaction model.<sup>352</sup> In medicine, where there is a dramatic difference in knowledge between the parties, a concern with fairness requires a greater obligation on the more knowledgeable party to volunteer information (as opposed to merely refraining from deception).<sup>353</sup> On the other hand, if a person seeking consent coerces, deceives, or takes advantage of the incapacity of another, she is not morally permitted to proceed because she has not treated the other fairly.<sup>354</sup> Thus, the model gives force to the intuition that the patient who has been given exaggerated risk statements—like those required by some biased counseling laws—when deciding whether to terminate her pregnancy has been wronged. A patient decision based on a deceptive statement is not morally transformative and therefore does not permit the health care professional to proceed.

Franklin and Wertheimer contend that the explicitness of consent in the medical context depends on the nature of the treatment at issue.<sup>355</sup> The patient's assumption that the physician has an obligation to promote her interests is also relevant, since we demand less explicit information when considering the recommendation of someone we trust to act in our interests.<sup>356</sup> Furthermore, the authors believe that patients ought to have control over the information they receive. They describe a case in which a doctor tells her patient that she needs surgery for breast cancer and begins to explain the options, but the patient interrupts, saying, "I trust you; do whatever you think is best."<sup>357</sup> It is permissible for the doctor to proceed with surgery even though the patient's consent is not fully informed because the doctor has treated the patient fairly by attempting to provide material information.<sup>358</sup> To say otherwise would be unfair to the doctor, who has an obligation to treat, as well as to the patient, who wants to be cured but does not want certain information. A patient may have a rational interest in avoiding the expenditure of "time, mental energy, psychic stress, and money" that it takes to acquire

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351. *Id.* at 98, 100–01.

352. *Id.* at 94–95.

353. *Id.* at 95.

354. *Id.* at 94. Some instances of deception are compatible with fair treatment, such as a buyer deceiving a seller in negotiation about the highest price she is willing to pay.

355. *Id.* at 91–92.

356. *Id.*

357. *Id.* at 87.

358. *Id.* at 88.

and understand relevant information, especially where she has “confidence that the authorized intervention is in her interest.”<sup>359</sup> Thus, the mandatory provision of information, including information gleaned from ultrasounds, disrespects patients’ positive autonomy interest in proceeding with the intervention on their terms.<sup>360</sup>

On this model, the fact that biased counseling laws require statements be made to every patient causes ethical problems because it interferes with the patient’s control over what kind of interaction should permit the health care provider to proceed with an intervention. When a legislature attempts to prevent a woman from getting an abortion where she has not been exposed to all the information that lawmakers want her to be, it “compromise[s] the facilitative function of consent transactions by disabling her from entering into transactions and relationships that she seeks.”<sup>361</sup> Ultimately, whether any given counseling statement is ethical depends on its effect on the fairness of the transaction. The demands of fairness are satisfied by offering information that is relevant to the decision at hand, such as risks and benefits. Irrelevant information and moral statements do not improve the fairness of consent transactions. Of course, such information ought to be available to those patients who seek it out. Ultrasound descriptions or auscultations should be offered when an ultrasound is performed, but the patients’ wishes should control. Finally, a mandatory waiting period does nothing to facilitate a fair transaction; on the contrary, the logistical obstacles that waiting periods present only decrease fairness by constraining patient decision making.

#### *F. Professional Associations’ Positions*

The features of biased counseling laws that deviate from the philosophical accounts of medical ethics are also in conflict with the ethics positions, statements, and codes of professional associations in medicine. Physicians often consider professional associations to be authorities regarding the ethical obligations that physicians face. This section discusses the ethical pronouncements of two influential professional associations, the American Medical Association and the American College of Obstetricians and Gynecologists. These pronouncements do not provide support for the problematic features of biased counseling laws.

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359. *Id.* at 93.

360. *Id.* at 84.

361. *Id.*

## 1. The American Medical Association

The American Medical Association (“AMA”) is the nation’s largest professional association of physicians and medical students. It aims to “promote the art and science of medicine and the betterment of public health.”<sup>362</sup> The AMA’s Code of Medical Ethics “establish[es] the core ethical principles of the medical profession.”<sup>363</sup> This code explains that informed consent allows patients to exercise their “right of self-decision.”<sup>364</sup> “The physician’s obligation is to present the medical facts accurately to the patient” in order to assist patients in making choices.<sup>365</sup> The code exhorts physicians to “sensitively and respectfully disclose all relevant medical information,” and recommends that “[t]he quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.”<sup>366</sup> The Code of Medical Ethics appears to reject the therapeutic privilege, stating that “[w]ithholding medical information from patients without their knowledge or consent is ethically unacceptable.”<sup>367</sup> Physicians should avoid conflicts between the obligations to further patient well-being and to respect patient autonomy through truth-telling by proactively learning what patients’ preferences are regarding communication of information.<sup>368</sup> Finally, “physicians should honor patient requests not to be informed of certain medical information.”<sup>369</sup>

There is no doubt that the abortion-specific biased counseling statutes discussed fail the AMA’s ethical standards, especially since the AMA

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362. *About AMA*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/about-ama/our-mission.page> (last visited Mar. 18, 2012).

363. *Developing AMA Policies*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/developing-ama-policies.page> (last visited Mar. 18, 2012).

364. *AMA Code of Medical Ethics*, AM. MED. ASS’N, at Opinion 8.08 (2006), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. The AMA recognizes patient autonomy as a key value. *See id.* at Opinion 5.059 (2001), Opinion 10.02 (2001).

365. *Id.* at Opinion 8.08 (2006).

366. *Id.*

367. *Id.* at Opinion 8.082.

368. *Id.*

369. *Id.*; *see also* AM. MED. ASS’N, REPORT ON THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, REP. NO. 2-A-06, WITHHOLDING INFORMATION FROM PATIENTS (THERAPEUTIC PRIVILEGE) 3 (2006), *available at* <http://www.ama-assn.org/resources/doc/code-medical-ethics/8082a.pdf> (“To respect patients’ rights of decisional autonomy, physicians must offer all patients the opportunity to receive relevant medical information. This may be accomplished by asking patients to specify the scope of information they wish to receive and their preferred methods for receiving it. Physicians should then honor these preferences to the extent practicable.”).

“opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.”<sup>370</sup> The requirement that physicians present facts accurately disqualifies deceptive and misleading statements. Making statements that the patient does not want to hear is unethical according to the AMA, and the patient’s expressed desire not to be given certain information should be respected. Finally, there is nothing that provides support for forcing patients to be exposed to the results of an ultrasound against their wishes.

## 2. The American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (“ACOG”) is the leading professional association dedicated to educating physicians who provide health care for women.<sup>371</sup> The ACOG Code of Professional Ethics requires that physicians “deal honestly with patients.”<sup>372</sup> In its discussion of informed consent, the code states that the physician must “present to the patient . . . pertinent medical facts and recommendations consistent with good medical practice.”<sup>373</sup> Disclosures should include treatment alternatives, “objectives, risks, benefits, possible complications, and anticipated results of such treatment.”<sup>374</sup>

ACOG’s ethics committee has issued an opinion regarding informed consent. It recognizes that the purposes of informed consent are respect for bodily integrity and patient self-determination.<sup>375</sup> The

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370. AM. MED. ASS’N, POLICY NO. H-320.951, AMA OPPOSITION TO “PROCEDURE-SPECIFIC” INFORMED CONSENT, *available at* <https://ssl3.ama-assn.org/apps/ecom/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-320.951.HTM> (last visited Apr. 3, 2012).

371. ACOG recently split into two legal entities: the American College of Obstetricians and Gynecologists continues the group’s educational mission and produces practice guidelines, and the American Congress of Obstetricians and Gynecologists engages in various forms of advocacy and professional discipline.

372. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, CODE OF PROFESSIONAL ETHICS 1 (2011), *available at* <http://www.acog.org/-/media/About%20ACOG/acogcode.pdf?dmc=1&ts=20120404T0133267795>.

373. *Id.* at 2.

374. *Id.*

375. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON ETHICS OPINION NO. 439, INFORMED CONSENT 1, 2–3 (2009), *available at* [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Ethics/Informed\\_Consent](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/Informed_Consent) (follow “PDF Format” hyperlink) [hereinafter ACOG OPINION ON INFORMED CONSENT].

patient's comprehension of her situation and options is necessary, and "free consent is an intentional and voluntary choice that authorizes" a medical intervention.<sup>376</sup> ACOG envisions informed consent as "a dialogue between patient and health care provider in support of respect for patient autonomy."<sup>377</sup> The opinion does not list required disclosures. It sets out "significant categories for disclosure," which are the nature of the patient's medical condition, the nature and risks of the proposed treatment, and alternatives.<sup>378</sup> Physicians determine what should be disclosed within each of these categories by considering professional practice, the expectations of ordinary patients, and the unique needs of the individual patient.<sup>379</sup> The opinion endorses physicians making recommendations and trying to persuade patients to follow them, as long as physicians avoid deception, manipulation, and coercion.<sup>380</sup>

The ethics committee also recognizes that patients may waive their right to informed consent by "refusing information necessary to make an informed decision."<sup>381</sup> Respecting a patient's wish not to receive certain information is itself an expression of respect for autonomy, although the ethics committee warns that "waivers should not be accepted complacently without some concern for the causes of the patient's desire not to participate in the management of her care."<sup>382</sup>

With its emphasis on "knowledge about and understanding of all the available options"<sup>383</sup> and the "professional responsibilit[y] to be honest,"<sup>384</sup> ACOG disapproves of false and misleading statements to patients. Similarly, the organization's disapproval of manipulation indicates ethical problems with the disclosure of irrelevant but emotionally charged information like pictures of late-term fetuses. Furthermore, to require women to listen to a verbal description of the ultrasound image or embryonic or fetal heart tones against their wishes violates ACOG's instruction that "[t]he patient should join with the physician in deciding the amount of diagnostic information that is appropriate for making intelligent choices."<sup>385</sup> ACOG's recommendations for the content of dis-

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376. *Id.* at 3. This account hews closely to Faden and Beauchamp's autonomous authorization model of informed consent. *Cf. id.* at 5 n.4, 8 (listing Faden and Beauchamp's book as a reference).

377. *Id.* at 4.

378. *Id.* at 5.

379. *Id.*

380. *Id.*

381. *Id.* at 7.

382. *Id.*

383. *Id.* at 3.

384. *Id.* at 7.

385. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE ON ETHICS OPINION No. 363, PATIENT TESTING: ETHICAL ISSUES IN SELECTION AND COUNSELING

closures do not include moral statements, such as those about the moral status of the embryo or fetus. Nothing in ACOG's ethics guidance provides support for mandatory waiting periods.

ACOG, like other ethics authorities, maintains that patients are able to waive their right to informed consent by refusing material information.<sup>386</sup> This Article does not criticize biased counseling laws for forcing patients to receive information that *is necessary* for informed consent even when the patients do not want that information. Rather, it argues that the statements and information biased counseling laws require patients to receive are not necessary for, and are often harmful to, informed consent. However, there is a logical relationship between the two propositions: if patients have a right to refuse the information necessary for informed consent, then *a fortiori* they have the right to refuse information that is unnecessary for informed consent.

### CONCLUSION

The views of informed consent examined above come from philosophers, physicians, medical researchers, hospital ethics consultants, lawyers, and professional medical associations. They vary in their accounts of the ethical justification of informed consent in the abstract, as well as how it should be executed in real situations. But none of them offers justification for the methods some states use to discourage abortion through biased counseling laws. On the contrary, the worst features of these laws are condemned as unethical on every account of informed consent that I am aware of. Their utter failure to be ethically justified according to a diversity of theories shows how far outside the bounds of medical ethics these laws are.

In arguing against certain mandatory disclosures, I am not contending that anything should be hidden from patients. The professional obligation of informed consent and generally-applicable informed consent laws require that accurate and material information about risks, benefits, and alternatives be disclosed to all patients. For example, because the evidence shows that abortion does not cause psychological problems, such problems should not be mentioned to all abortion patients. However, some patients may present with preexisting risk factors, such as prior mental illness or a history of being victimized by violence.

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2 (2007), available at [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Ethics/Patient\\_Testing\\_Issues\\_in\\_Selection\\_and\\_Counseling](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/Patient_Testing_Issues_in_Selection_and_Counseling) (follow "PDF Format" hyperlink), *reaff'd* in 2009.

386. ACOG OPINION ON INFORMED CONSENT, *supra* note 375.

Such a case may require a warning about negative psychological sequelae, in the judgment of the health care provider. A parallel warning about the psychological consequences of continuing an unwanted pregnancy would presumably also be indicated, as well as discussion of the emotional toll of an unwanted pregnancy itself. Another reason that opposition to mandatory disclosures does not entail keeping patients in the dark is that the general requirement of informed consent gives patients the power to ask questions, which must be answered truthfully and completely. In sum, the goals that biased counseling laws putatively further are already served by generally applicable informed consent requirements, both legal and ethical.

Abortion opponents have attempted to co-opt the doctrine of informed consent to further their political goal of reducing the number of abortions. In doing so, they have tapped into a discriminatory vision of women's decision-making ability, characterizing women as relatively incapable of rational, responsible decision making and in need of special guidance from the state regarding the exercise of their reproductive rights. This vision should be rejected, as should the cynical use of the banner of informed consent to disguise an anti-abortion agenda. As I have shown, there are features of biased counseling laws that cannot be part of ethical informed consent practices because they are designed to make women's choices regarding ending their pregnancies less well-informed and less voluntary, all in the hope of discouraging abortions. ❀