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The Woman's Right to Know: A Model Approach to the Informed Consent of Abortion

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I. INTRODUCTION

Historically, physicians have encountered few restraints concerning the manner in which they examined, consulted with, and treated their patients. The hippocratic oath and the AMA Principles of Medical Ethics perhaps have provided the physician's only guidelines. Today, however, a movement aimed at providing the patient with more information and a greater role in determining the proper course of medical treatment is replacing "physician-dominated" medical decision making. Malpractice actions, and in particular actions based on a lack of informed consent, are an important factor driving this movement. Indeed, states have begun legislating specific informed consent requirements for many medical procedures, including sterilization, treatment for breast cancer, and AIDS testing.

Abortion is one procedure for which states have enacted informed consent provisions. The subject of abortion has been swept up in a storm of moral and legal controversy largely unrelated to a woman's need for information that would enable her to make an informed choice concerning medical treatment. The United States Supreme Court generally has rejected state attempts to impose informed consent requirements for abortions. However, the Court's recent decision in *Webster v. Reproductive Health Services*[1] appears

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1. 109 S. Ct. 3040 (1989).

to recognize that states have significant authority to regulate medical standards for abortion practice. *Webster* touched off new state efforts to regulate abortions, including statutes that require the physician to obtain a patient's informed consent prior to performing the abortion.[2]

In light of such efforts, this Article offers a Model Woman's Informed Choices Act[3] (the "Model Act") drafted to address many, if not all, obstacles upon which other similar statutes stumbled in previous court cases. The Model Act is designed to ensure not only the well-being of a pregnant woman, but also that the woman, in deciding whether to have an abortion, does not make her choice without being fully informed of the potential risks and consequences of her decision upon herself and the fetus she carries. The state, this Article will argue, has the right to ensure that this decision, which many view as one involving the taking of human life, is carefully weighed and fully informed.

In addition, the Article will argue that the Supreme Court has been unduly restrictive in evaluating the nature and importance of a woman's interest in the effective administration of informed consent statutes in the abortion context. Specifically, the Article suggests that the Court has placed too little value on a state's right to protect the well-being of women in the health care setting; has failed to affirm the right of legislatures to ensure that fully informed and reasoned decisions are made on health care issues of great importance; has overlooked extensive state regulation of informed consent outside the abortion area; and, in its zeal to protect the right to abortion, has in effect created a right of doctors and their employees to practice medicine free from the state's oversight.

II. Informed Consent in the Supreme Court

A. The Doctrine of Informed Consent

The Supreme Court has long recognized the power of a state to protect the health of its citizens through the exercise of legislative authority, including regulation of the medical profession.[4] This au-

2. *E.g.*, Pa. Cons. Stat. Ann. tit. 18, § 3205(a) (Purdon 1983 & Supp. 1990). In the first quarter of 1991, North Dakota and Mississippi enacted statutes similar to the Model Act. Act of April 1, 1991, 1991 N.D. Laws — (available on WESTLAW, ND-LEGIS library, formerly H.B. 1579); Act of March 28, 1991, Pub. Ch. 439, 1991 Miss. Laws — (available on WESTLAW, MS-LEGIS library, formerly H.B. 982).

3. The text of the Model Woman's Informed Choices Act appears in the Appendix to this Article.

4. Watson v. Maryland, 218 U.S. 173, 176 (1910) (affirming conviction for practice of

thority derives from the state's right to provide for the general welfare of its residents.[5] The common law in most states requires physicians or health care providers to obtain a patient's informed consent prior to treatment, and many states have enacted informed consent statutes for medical procedures.[6] Although the informed consent requirement is not one of long standing,[7] it is now firmly rooted.[8] Additionally, the right to be informed should not be

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medicine without state registration), *quoted in* Jipping, *Informed Consent to Abortion: A Refinement*, 38 CASE W. RES. L. REV. 329, 352 (1988).

5. Dent v. West Virginia, 129 U.S. 114, 122 (1889), *quoted in* Jipping, *supra* note 4, at 352. That right, in turn, derives from the state's police powers. Jipping, *supra* note 4, at 352.

6. *See, e.g.*, ALASKA STAT. § 09.55.556 (1983); ARIZ. REV. STAT. ANN. § 12-563 (1982); ARK. STAT. ANN. § 16-114-206 (1987); CAL. PENAL CODE §§ 2670.5-2674 (West 1982 & Supp. 1990) (prisoners' right to give informed consent to organic therapy); COLO. REV. STAT. §§ 13-20-401 to -402 (1989) (written informed consent needed for electroconvulsive treatments); DEL. CODE ANN. tit. 18, § 6852 (1989); FLA. STAT. § 766.103 (1990); GA. CODE ANN. § 31-9-6.1 (1985); HAW. REV. STAT. § 671-3 (1985); IDAHO CODE §§ 39-4301-4306 (1985 & Supp. 1990); IOWA CODE § 147.137 (Supp. 1989); KY. REV. STAT. ANN. § 304.40-320 (Baldwin 1987); LA. REV. STAT. ANN. § 40:1299.40 (West 1977 & Supp. 1990); ME. REV. STAT. ANN. tit. 24, §§ 2905 to 2905-A (1990); MASS. GEN. LAWS ANN. ch. 111, § 70E (West 1983) (health care patients "have the right . . . to informed consent to the extent provided by law"); MICH. COMP. LAWS ANN. § 333.20201 (West 1980 & Supp. 1990) (health care patients' right to give informed consent to treatment); MINN. STAT. ANN. § 144.651 (West 1989 & Supp. 1990) (health care patients' right to give informed consent to treatment); MO. ANN. STAT. § 198.088 (Vernon 1983) (nursing home patients' right to give informed consent to experimental treatment); NEB. REV. STAT. § 44-2816 (1988); NEV. REV. STAT. § 41A.110 (1987); NEV. REV. STAT. § 449.710 (1987) (health care patients' right to give informed consent to treatment); N.H. REV. STAT. ANN. §§ 507-C:1 to C:2 (1989); N.Y. PUB. HEALTH LAW §§ 2440-2446 (McKinney 1985) (right to give informed consent to experimental research); N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1985 & Supp. 1990); N.C. GEN. STAT. § 90-21.13 (1985); OHIO REV. CODE ANN. § 2317.54 (Anderson 1981 & Supp. 1989); OR. REV. STAT. § 441.605 (1989) (nursing home patients' right to give informed consent to treatment); OR. REV. STAT. § 677.097 (1989); PA. CONS. STAT. ANN. tit. 40, § 1301.103 (Purdon Supp. 1990); TENN. CODE ANN. § 29-26-118 (1980); TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.01-.07 (Vernon Supp. 1991); UTAH CODE ANN. § 78-14-5 (1987); VT. STAT. ANN. tit. 12, § 1909 (Supp. 1990); VA. CODE ANN. §§ 37.1-234 to -235 (1984 & Supp. 1990) (informed consent must be obtained in order to conduct human research); WASH. REV. CODE ANN. §§ 7.70.050-.060 (Supp. 1990).

7. Although one frequently-cited early case is Schloendorff v. Society of New York Hosps., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"), arguably, the tort did not become "mainstream" until 1972, when Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), was decided. For the informed consent doctrine's history preceding *Canterbury*, see R. FADEN & T. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 116-33 (1986); *see also* F. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE §§ 1.2-.3 (1990); Andrews, *Informed Consent Statutes and the Decision-Making Process*, 5 J. LEGAL MED. 163, 175-78 (1984); Jipping, *supra* note 4, at 356-63.

8. *See* F. ROZOVSKY, *supra* note 7, § 1.1, at 4 (what "informed consent" means in various settings).

viewed as unique to medicine, but rather as a natural extension of this century's consumer rights movement.[9]

The concept of informed consent espoused in this Article is straightforward. To ensure a patient's informed consent to medical treatment, the doctor, or a qualified employee, should fully inform the patient of the probable outcome of the treatment, the risks and benefits of the treatment, and the risks and benefits of any alternative forms of treatment, including nontreatment.[10]

Basically, two competing informed consent disclosure standards exist.[11] The older one, known as the "medical community" standard, is tailored to the needs of the physician.[12] Under that standard, the doctor decides how much to tell the patient and remains free from liability if the doctor imparts the amount of information reasonable for that area or locality.[13] To prevail in a civil suit, a wronged patient must persuade another doctor from that community to testify as an expert witness against the alleged malpracticing peer.[14] Commentators criticize this standard for its outdated "paternalistic belief that doctor knows best."[15]

In contrast, the other, more recent, standard, known as the "patient autonomy" standard, derives from the patient's right of self-determination.[16] This standard was first detailed in *Canterbury v. Spence*,[17] in which the court rejected the argument that a physician should be able to withhold relevant information, stating that the physician has a duty to divulge "all risks potentially affecting the decision."[18] This standard also drops the expert witness requirement because in some instances the community custom may be "to maintain silence and refuse to testify," thereby unjustly thwarting the adjudication of valid rights of action.[19] The trend appears to be

9. Dobson, *Achieving Better Medical Outcomes and Reducing Litigation Through the Healthcare Consumer's Right to Make Decisions*, 15 J. CONTEMP. L. 175, 196-201 (1989).

10. F. ROZOVSKY, *supra* note 7, § 1.12.1, at 45-47; Andrews, *supra* note 7, at 178; Campenella, *Breast Cancer: Staging, Treatment, and the Duty to Inform*, 35 MED. TRIAL TECH. Q. 17, 29-30 (1989).

11. F. ROZOVSKY, *supra* note 7, §§ 1.13.1-.2; Jipping, *supra* note 4, at 356-60.

12. *See, e.g.*, Karp v. Cooley, 493 F.2d 408, 419 (5th Cir. 1974); Natanson v. Kline, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960).

13. F. ROZOVSKY, *supra* note 7, § 1.13.1; Jipping, *supra* note 4, at 357; Trichter, *Informed Consent: The Patient as an Individual*, 15 FORUM 455, 457 (1979-80).

14. F. ROZOVSKY, *supra* note 7, § 1.18; Jipping, *supra* note 4, at 357; Trichter, *supra* note 13, at 457.

15. Trichter, *supra* note 13, at 459.

16. Canterbury v. Spence, 464 F.2d 772, 784, 786 (D.C. Cir. 1972).

17. 464 F.2d 772 (D.C. Cir. 1972).

18. *Id.* at 787.

19. *Id.* at 784.

toward the patient autonomy standard.[20]

The patient autonomy standard is preferable to the medical community standard for several reasons. First, a broader disclosure process results in better treatment for the patient.[21] Patient participation in the treatment process may lessen pretreatment or preoperative worry, encourage cooperation in determining the treatment plan (if any), and speed postprocedure recovery.[22] A detailed explanation of the procedure and its aftermath can lead to an understanding not achieved with a cursory description.[23] Second, patient autonomy is a logical continuation of the emerging movement to protect consumers from harmful and inferior goods and services.[24] Arguably, the medical community should be held not only to this newer level of responsibility, but to an even higher standard because of the often irreversible nature of treatment rendered. Third, a broader disclosure process protects the physician from the patient's anger (and litigation) if treatment fails.[25] Knowledge about alternatives also reduces the probability that the patient will later have "second thoughts" about the treatment.[26]

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20. Jipping, *supra* note 4, at 360-61.

21. Trichter, *supra* note 13, at 464.

22. *See* Andrews, *supra* note 7, at 165-68; *see also* NATIONAL ABORTION FED'N, STANDARDS FOR ABORTION CARE 4 (1987) (objectives of informed consent). In contrast, Justice Blackmun, writing for the majority in Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986), although citing no supporting scientific or medical authority, alleged that disclosures of risks "compound the problem of medical attendance [and] increase the patient's anxiety," thereby rendering such disclosure "the antithesis of informed consent." *Id.* at 764. Justice White, in his *Thornburgh* dissent, disagreed:

> It is in the very nature of informed-consent provisions that they may produce some anxiety in the patient and influence her in her choice. This is in fact their reason for existence . . . . If information may reasonably affect the patient's choice, the patient should have that information; and, as one authority has observed, "the greater the likelihood that particular information will influence [the patient's] decision, the more essential the information arguably becomes for securing her informed consent." That the result of the provision of information may be that some women will forego abortions by no means suggests that providing the information is unconstitutional, for the ostensible objective of *Roe v. Wade* is not maximizing the number of abortions, but maximizing choice.

Id. at 801 (White, J., dissenting) (quoting Appleton, *Doctors, Patients, and the Constitution*, 63 WASH. U.L.Q. 183, 211 (1985)).

23. *See* Andrews, *supra* note 7, at 165; *cf. id.* at 199 (breast cancer patients had better recall and understanding of information presented when allowed to take material home).

24. Dobson, *supra* note 9, at 197 n.165; *see also* U.C.C. §§ 2-314 to -316.

25. Campenella, *supra* note 10, at 32-33; Dobson, *supra* note 9, at 200, 201.

26. Dobson, *supra* note 9, at 200; *see also, e.g., Abortion: A Special Report*, USA Today, Apr. 26, 1989, Special Advertising Insert at 2, col. 1 [hereinafter *Special Report*] (quoting one Sandra D. Walton: "[i]f only someone had been there to give me the facts about the child inside me . . . I could have been spared the haunting grief and guilt").

The patient, because she bears the consequences of the medical treatment, becomes the ultimate decision maker.[27]

As part of the trend toward greater patient autonomy and regulation of medical providers, a number of states and localities have attempted to enact informed consent statutes for abortion. State regulation of informed consent for abortion is particularly appropriate. Not only is abortion elective, it is also irreversible. Partially informed decisions to abort may lead to subsequent harm, both physical and emotional, for the woman.[28] Additionally, the Supreme Court recognizes the uniqueness of the abortion decision: "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life."[29] All of these reasons, but especially the fact that the procedure results in what many people believe is the taking of a human life, mandate full and complete discussion of the facts, risks, and benefits of the procedure and its alternatives before a woman makes a decision to proceed with an abortion.

Indeed, several publications written for abortion providers stress the importance of obtaining the woman's informed consent prior to the procedure. The National Abortion Federation (NAF), "an organization specifically committed to the provision and accessibility of high quality abortion services," encourages exploration of all possible outcomes.[30] The NAF urges discussion of the procedure and its concomitant risks and benefits to provide "the woman with accurate information."[31]

This advice is echoed in what has become the standard handbook for physicians who perform abortions.[32] The recommended consent form contained therein details some specific risks of the procedure.[33] Further, the American College of Obstetricians and

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27. Trichter, *supra* note 13, at 461 (*"[i]n actuality, it is the patient who bears the risk in all medical procedures"*) (emphasis in original).

28. For examples, see *Special Report*, *supra* note 26:

> Karen Cross: "I didn't realize the impact [that my abortions] would have on my life, and the nightmares that would come."
>
> Sandra D. Walton: "Those few minutes scarred me for the rest of my life."
>
> Teresa L. Fangman: "I'm not sure the tears will ever stop. I've been waiting almost 11 years now and they never seem to cease."

See also D. REARDON, ABORTED WOMEN: SILENT NO MORE 89-160 (1987).

29. Harris v. McRae, 448 U.S. 297, 325 (1980).

30. NATIONAL ABORTION FED'N, *supra* note 22, Foreword.

31. *Id.* at 4.

32. W. HERN, ABORTION PRACTICE (1984).

33. *Id.* at 270-71.

Gynecologists (ACOG) recommends "options" counseling.[34] Such counseling includes a full disclosure of the procedure, including the nature of the treatment, its risks and benefits, alternatives to abortion, and an opportunity for the woman to ask questions.[35] The ACOG asserts that the woman should also "be allowed sufficient time for reflection prior to making an informed decision."[36] The Model Act provides a vehicle whereby a state and the woman herself may ensure that consent to an abortion is truly informed.

B. General Framework of Supreme Court Decisions on Informed Consent for Abortion

In its earliest review of an informed consent for abortion statute, *Planned Parenthood v. Danforth*,[37] the Court established a state's right to require written consent to the abortion procedure, even when the state requires such consent for few or no other medical procedures.[38] The Court justified this holding on the grounds of the "imperative" need for full knowledge of the nature and consequences of abortion due to the stressful nature of the decision to abort.[39] The Court appeared to rely upon a rational basis analysis, further noting that a state can require written consent for procedures that involve significant risk to the patient (e.g., intracardiac procedure or whenever the surgical risk is elevated above a specified mortality rate).[40]

In its next major review of an informed consent for abortion law, the Court appeared to apply an intermediate level of scrutiny. In *City of Akron v. Akron Center for Reproductive Health, Inc.*,[41] the Court reaffirmed its *Danforth* decision, noting the importance of written consent in furthering important health-related state

34. AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES 63 (6th ed. 1985).

35. *Id.* at 84.

36. *Id.*

37. 428 U.S. 52 (1976).

38. *Id.* at 66-67.

39. *Id.* at 67. In fact, Planned Parenthood coined the phrase "options counseling" in an attempt to ensure that abortion counseling and referral services are provided to women dealing with problem pregnancies. Planned Parenthood Ass'n v. Kempiners, 700 F.2d 1115 (7th Cir.), *on remand*, 568 F. Supp. 1490 (N.D. Ill. 1983). But when the situation has been reversed and opponents of abortion have sought to include childbirth and adoption information in the "options counseling" given to women at abortion clinics, Planned Parenthood has litigated to block the dissemination of such information. *See infra* notes 41-59 and accompanying text.

40. *Danforth*, 428 U.S. at 67.

41. 462 U.S. 416 (1983).

concerns.[42]

However, the *Akron* Court struck down a city ordinance that set forth, in detail, the information that the attending physician was required to convey to the woman.[43] The ordinance required the physician to tell the woman that her unborn child is a human life from the moment of conception. Further, the preamble to the ordinance stated that the City Council of Akron had found that "there is no point in time between the union of the sperm and egg, or at least the blastocyst stage and the birth of the infant at which point we can say the unborn child is not a human life."[44] The Court held that this language was designed "not to inform the woman's consent but rather to persuade her to withhold it altogether."[45]

The Court also believed that the required dissemination of information intruded upon the "discretion of the pregnant woman's physician."[46] The *Akron* Court reiterated prior holdings stating that (1) "because abortion is a medical procedure, . . . the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment,' "[47] and (2) "[t]he physician's exercise of this medical judgment encompasses both assisting the woman in the

42. *Id.* at 430. The *Danforth* decision did not appear to impose a heightened burden on the state. The *Akron* Court further noted, however, that during the second trimester, the state's regulation need only be "legitimately" or "reasonably" related to its health objective. *Id.* at 430-31.

43. *Id.* at 444-45. The ordinance required the attending physician to disclose to the patient: (1) that she is pregnant; (2) the number of weeks elapsed from the probable time of conception, based upon the number of weeks since her last menstrual period or upon a history, physical examination, and appropriate laboratory tests; (3) that the unborn child is a human life from the moment of conception, along with a description of the anatomical and physiological characteristics of the unborn child at that particular gestational point, including appearance, mobility, tactile sensitivity (pain, perception, or response), brain and heart function, presence of internal organs, and presence of external members; (4) that the unborn child may be capable of surviving outside the womb in those instances when the physician determines gestational age to be more than 22 weeks and, therefore, the physician has a legal obligation to take all reasonable steps to preserve the life and health of the unborn child during the abortion; (5) that abortion is a major surgical procedure that can result in serious complications and may leave unaffected or worsen any existing psychological problems, or result in severe emotional disturbances; (6) that numerous public and private agencies and services are available to provide birth control information, a list of which the physician will provide upon request; and (7) that numerous public and private agencies and services are available to assist during the woman's pregnancy and after the birth of the child, a list of which the physician will provide upon request. *Id.* at 423 n.5.

44. *Id.* at 421 n.1.

45. *Id.* at 444.

46. *Id.* at 445.

47. *Id.* at 427 (quoting Doe v. Bolton, 410 U.S. 179, 192 (1983)).

decisionmaking process and implementing her decision should she choose abortion."[48]

Three years later, the Supreme Court decided another major case involving an informed consent statute in *Thornburgh v. American College of Obstetricians and Gynecologists*.[49] A Pennsylvania informed consent statute required physicians and others to provide certain information to a woman at least twenty-four hours prior to her giving consent.[50] The Court struck down this provision, relying upon the *Akron* Court's determination that such a provision is intended to dissuade a woman from having an abortion, and that it also intrudes upon physician-patient relationships.[51]

In his dissent, Chief Justice Burger, who had joined the *Roe v. Wade*[52] majority thirteen years earlier, expressed dismay at the Court's expansion of the abortion right and the striking of informed consent statutes:

> Can anyone doubt that the State could impose a similar requirement with respect to other medical procedures? Can anyone

48. *Id.* (citing Colautti v. Franklin, 439 U.S. 379, 387 (1979)).

49. 476 U.S. 747 (1986).

50. The Pennsylvania act required that the woman be told the following:

> (a) the name of the physician who will perform the abortion, (b) the "fact that there may be detrimental physical and psychological effects which are not accurately foreseeable," (c) the "particular medical risks associated with the particular abortion procedure to be employed," (d) the probable gestational age, . . . (e) the "medical risks associated with carrying her child to term" . . . (f) the "fact that medical assistance benefits may be available for prenatal care, childbirth and neonatal care," and (g) the "fact that the father is liable to assist" in the child's support, "even in instances where the father has offered to pay for the abortion."

Id. at 760-61. The first five of these had to be disclosed by a physician. *Id.* at 760. The statute also mandated that the woman be informed of, and be provided upon request, materials describing the fetus and listing the agencies offering alternatives to abortion. *Id.* at 761.

51. *Id.* at 762-65. The procedural aspects surrounding the Court's review of the Pennsylvania Act were circumspect. *See* Grant, *Abortion and the Constitution: The Impact of* Thornburgh *on the Strategy to Reverse* Roe v. Wade, in ABORTION AND THE CONSTITUTION: REVERSING *Roe v. Wade* THROUGH THE COURTS 251-52 (1987). The parties hurriedly prepared for a preliminary injunction hearing before the district court over a two-week period that included Thanksgiving. After the trial court entered a preliminary injunction, the court of appeals took the highly unusual step of permanently enjoining the statute.

Justice O'Connor sharply disagreed with the Court's judgment in addressing the merits of the case. She argued that the proper course would have been to remand the case to the district court, allow for a trial on the merits, and then review if necessary. *Thornburgh*, 476 U.S. at 815 (O'Connor, J., dissenting). Justice O'Connor concluded that if the case had not concerned state regulation of abortion, "it may be doubted that the Court would entertain, let alone adopt, such a departure from its precedents." *Id.* at 826 (O'Connor, J., dissenting).

52. 410 U.S. 113 (1973).

> doubt that doctors routinely give similar information concerning risks in countless procedures having far less impact on life and health, both physical and emotional than an abortion, and risk a malpractice lawsuit if they fail to do so?
>
> Yet the Court concludes that the State cannot impose this simple information-dispensing requirement in the abortion context where the decision is fraught with serious physical, psychological, and moral concerns of the highest order. Can it possibly be that the Court is saying that the Constitution *forbids* the communication of such critical information to a woman?[53]

Justices White and Rehnquist also dissented in *Thornburgh*. They dismissed the majority's argument that the information was unconstitutional because it might "increase the woman's 'anxiety' about the procedure and even 'influence' her in her choice."[54] According to Justices White and Rehnquist, such information serves a valuable role.[55]

More recently, in *Webster v. Reproductive Health Services*,[56] a plurality of the Court abandoned the *Roe* framework and stated that a woman's decision whether or not to abort her child is not a "fundamental right," as the Court described it in *Akron*, but rather a liberty interest protected by the due process clause.[57] The plurality argued that a court must weigh this liberty interest against the state's compelling interest in protecting potential human life, an interest present not only at the point of viability, but throughout the pregnancy.[58]

Under the *Webster* analysis, many if not all of the informed consent provisions in *Akron* and *Thornburgh* would have survived.[59] Indeed, the plurality cited with approval the dissents in *Thorn-*

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53. *Thornburgh*, 476 U.S. at 783 (Burger, C.J., dissenting) (emphasis in original) (footnote omitted).

54. *Id.* at 801 (White, J., dissenting).

55. See quotation from Justice White's *Thornburgh* dissent, *supra* note 22.

56. 109 S. Ct. 3040 (1989).

57. *Id.* at 3058.

58. *Id.* at 3056-58.

59. *See* Wardle, *Time Enough:* Webster v. Reproductive Health Services *and the Prudent Pace of Justice*, 41 FLA. L. REV. 881, 914-16 (1990). The Court is now more receptive to the state's interpretation of challenged statutes. It has "repudiated the 'bad intent' principle applied in *Thornburgh* and *Akron*. . . . The likelihood that otherwise valid state legislation is intended to deter or will deter some women from choosing abortion is no longer an acceptable reason for courts to strike down abortion legislation." *Id.* at 914-15. Further, three of the present Justices (O'Connor, White, and Rehnquist) dissented in *Akron* and *Thornburgh*. A fourth, Justice Scalia, would overrule *Roe* itself, while Justice Kennedy, and recently Justice Souter, have voted to uphold reasonable regulation of abortion rights.

burgh.[60] The following sections of this Article will argue that under such a balancing test, requirements such as fetal description, a short waiting period, and mandatory disclosure of certain risks further the legitimate state interest in preserving potential human life by ensuring that any abortion decision is carefully weighed, while minimally burdening the abortion right.

III. Analysis of the Model Woman's Informed Choices Act

A. Section 2—Legislative Purposes and Findings

As a general proposition, legislative statements of "findings and purposes" do not, by their own terms, regulate the conduct of the persons affected by the remaining statute.[61] Nonetheless, such "findings and purposes" serve a valuable role for the public, and any court that reviews the legislation, as an expression of the state interests intended to be protected.[62]

In *Webster*, the Court refused to invalidate a legislative finding that human life begins at conception.[63] The Court recognized that a preamble might be used to interpret state statutes or regulations. However, when the preamble is not used in a manner prohibited by the Constitution, the Court determined that review of the preamble is not a ripe issue.[64]

Sections 2(A) and (B) of the Model Act focus principally on a woman's right to receive accurate, truthful information prior to the decision to abort. This right to information is consistent with the Court's conclusion that the decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences."[65]

60. *See Webster*, 109 S. Ct. at 3057. Two of the three Justices in the *Webster* plurality were dissenters in the earlier informed consent cases.

61. *See id.* at 3050; *see also* L. Tribe, American Constitutional Law 302-03 & n.9 (2d ed. 1988).

62. Justice Stevens, writing for the majority in Hodgson v. Minnesota, 110 S. Ct. 2426 (1990), noted the confusion surrounding the Minnesota statute because it did not contain a statement of its purposes. Justice Stevens pointed out that the Minnesota Attorney General had advised the Court that the purposes were apparent from the statutory text. The district court, however, found the purposes to be different from those set forth by the Attorney General. *Id.* at 2933.

63. *Webster*, 109 S. Ct. at 3049-50. In addition to its determination that the preamble did not raise a ripe constitutional issue, the Court reiterated that a state has authority to " 'make a value judgment favoring childbirth over abortion.' " *Id.* at 3050 (quoting Maher v. Roe, 432 U.S. 464, 474 (1977)).

64. *Id.* at 3050.

65. Planned Parenthood v. Danforth, 428 U.S. 52, 67 (1976).

Consistent with Section 2(C) of the Model Act, the Court has also recognized that consideration of a woman's psychological and physical well-being is a valid concern in the context of abortion:

> The decision to have an abortion has "implications far broader than those associated with most other kinds of medical treatment," and thus the State legitimately may seek to ensure that it has been made "in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient."[66]

Section 2(D) makes findings concerning the nonexistence of the physician-patient relationship in the context of abortion. Approximately eighty percent of abortions are performed in free-standing clinics.[67] Other than pregnancy testing, the primary business of such clinics is to perform abortions.[68] Normally, women who undergo an abortion at a free-standing abortion clinic do not return to the clinic for follow-up care, nor do they continue a physician-patient relationship with the physician who performed the abortion.[69] As Justice O'Connor pointed out in her *Akron* dissent, "the record in this case shows that the [physician-patient] relationship is nonexistent."[70] In fact, the woman's first encounter with the phy-

66. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 443 (1983) (citations omitted).

67. Torres & Forrest, *Why Do Women Have Abortions?*, 20 FAM. PLAN. PERSP. 169, n.* (1988) (nonhospital facilities that performed 400 or more abortions in a year—only 26% of all abortion providers—accounted for 81% of the procedures).

68. " 'Look,' said hot-line operator Valerie McCullough, 'no matter how you put it, we're in the business of selling abortions. . . . Use a positive approach. It's not, "*Do* you want a termination, but *when*?" ' " Zekman & Warrick, *The Abortion Profiteers*, Chicago Sun-Times, Nov. 12, 1978, at 4, col. 3. "To keep his business booming, [one clinic owner] pays his employees $5 cash bonuses for every abortion they sell over the phones." Zekman & Warrick, *Meet the Profiteers*, Chicago Sun-Times, Nov. 13, 1978, at 5, col. 3.

69. Iffy, *Second Trimester Abortions*, 249 J. A.M.A. 588 (1983) (letter to the editor).

70. *Akron*, 462 U.S. at 473 (O'Connor, J., dissenting). The Court's reliance, from *Roe* onward, on the physician's judgment to deter or encourage abortions (depending on the individual patient) is not only misplaced, but also wrong. There is no incentive for an abortion clinic physician to turn away a woman seeking an abortion. The only limitation that can be brought upon the abortionist must come from the state, and most states, notwithstanding *Webster*, are hesitant or do not have the resources to monitor the clinics. *Cf.* Sontag, *Do Not Enter*, Miami Herald, Sept. 17, 1989, Tropic, at 8, col. 1 (continued existence of a dangerously unhealthy clinic despite numerous injuries, malpractice suits, and even deaths). Furthermore, to make the physician the responsible party severely undermines the ability of the patient to choose the best treatment for her unwanted pregnancy. *See* Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 55 (1983). *See generally* Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U.L.Q. 183 (1985); Appleton, *More Thoughts on the Physician's Constitutional Role in Abortion and Related Choices*, 66 WASH. U.L.Q. 499 (1988).

sician who performs the abortion in the free-standing clinic often occurs when she is gowned and on the operating table, after she already has made the decision to have the abortion.[71] This lack of a physician-patient relationship is further supported by the testimony of persons formerly associated with the abortion industry and women who have had abortions.[72]

Section 2(E) is the legislature's acknowledgment of its interest in protecting unborn life throughout a woman's pregnancy. Justice O'Connor, in her *Akron* dissent, which she reaffirmed in her opinions in *Thornburgh* and *Webster*, stated that "the State's interest in protecting potential human life exists throughout the pregnancy."[73] Furthermore, the Supreme Court consistently has held that a state has authority to "make value judgments favoring childbirth over abortion."[74] By requiring that a woman receive sufficient factual information regarding the developmental characteristics of her unborn child, section 2(F) is consistent with the state's legitimate right to insure that any decision against childbirth is a fully informed one.[75]

Section 2(G) is a prelude to the substantive provisions of the Model Act. Under the standards announced in the Court's abortion decisions, these provisions "must be 'legitimately related to the objectives that the state seeks to accomplish' "[76] and may not interfere unreasonably with the woman's right to choose an abortion.[77]

As noted earlier, legislative purposes and findings serve to educate other members of the legislature, as well as the public at large,

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71. *Danforth*, 428 U.S. at 91 n.2. "A 25-year-old rape victim waited [six hours] for her abortion .... When she finally saw the doctor, it was just for four minutes—the time he took to perform the abortion." Zeckman & Warrick, *The Abortion Profiteers*, Chicago Sun-Times, Nov. 12, 1978, at 6, col. 2.

72. *The Right to Privacy and Reproductive Freedom: Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 101st Cong., 2d Sess. (1990) (statement of Carol Everett) (on a busy day, a doctor could perform 10 to 12 first-trimester abortions in an hour).

73. Webster v. Reproductive Health Servs., 109 S. Ct. 3040, 3063 (1989) (O'Connor, J., concurring); Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 828 (1986) (O'Connor, J., dissenting); *Akron*, 462 U.S. at 461 (O'Connor, J., dissenting).

74. Rust v. Sullivan, Nos. 89-1391, 89-1392 (May 23, 1991) (WESTLAW, SCT library). *Webster*, 109 S. Ct. at 3050; Maher v. Roe, 432 U.S. 464, 474 (1977).

75. *Cf.* Smolin, *Abortion Legislation After* Webster v. Reproductive Health Services: *Model Statutes and Commentaries*, 20 CUMB. L. REV. 71, 141-42 (1989) (abortion clinics will provide this information only if required by law).

76. *E.g.*, *Akron*, 462 U.S. at 431 (quoting Doe v. Bolton, 410 U.S. 179, 195 (1973)).

77. *Id.* at 430-31.

regarding the actual need for such legislation.[78] In addition to the legislative purposes and findings in the Model Act, legislatures should feel free to add additional purposes if appropriate.

This Article next analyzes the Model Act's operative provisions and demonstrates that each is legitimately related to the state's valid interest in protecting the life and health of the pregnant woman and her unborn child. It also examines whether the substantive provisions of the Model Act present any unreasonable obstacles to obtaining an abortion.

B. Section 3—Definitions

Section 3(A)'s definition of abortion is substantially similar to standard definitions that have withstood attacks for vagueness.[79] The phrase "known to be pregnant" is intended to avoid prohibition of existing or potential contraceptives, such as the "morning-after pill."[80]

The Supreme Court upheld the definition of viability as used in Section 3(C). In *Danforth*, the Court approved a Missouri provision defining viability as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems."[81] The Court noted that the statute's language placed viability (i.e., life continued indefinitely) at, perhaps, a later stage in the pregnancy than had *Roe*, in which viability was defined as the point at which the fetus is " 'potentially able to live outside the mother's womb.' "[82] The Model Act chooses the *Roe* definition.

Section 3(E), which allows a "qualified person assisting the physician" to counsel the woman, is needed because the Court recognized in *Akron* that the performance of certain functions relating to informed consent may not constitutionally be limited to physi-

78. *See supra* note 62 and accompanying text.

79. *See, e.g.*, Charles v. Carey, 627 F.2d 772, 787-89 (7th Cir. 1980).

80. The Model Act's definition of abortion would, however, extend to the abortifacient RU486 (mifepristone). RU486 breaks down the uterine lining and causes it to be expelled, usually carrying the fertilized egg, or embryo (depending on when the drug was given), with it. Cherfas, *Stopping the Process of Pregnancy*, 245 SCI. 1320 (1989). In France, the only country in which RU486 is legally sold, the drug can be taken through the seventh week of pregnancy. Ulmann, Teutsch, & Philibert, *RU 486*, 262 SCI. AM. 42, 48 (1990). RU486 has also been mentioned as a possible improved method of aborting third-trimester pregnancies. *Id.* at 47; Cherfas & Palca, *Hormone Antagonist with Broad Potential*, 245 SCI. 1322 (1989).

81. Planned Parenthood v. Danforth, 428 U.S. 52, 63 (1976).

82. *Id.* at 64 (quoting Roe v. Wade, 410 U.S. 113, 160 (1973)).

cians.[83] The Court held that the state "may establish reasonable minimum qualifications for those people who perform the primary counseling function."[84] Section 3(E) establishes these qualifications.

C. *Section 4—Voluntary and Informed Choice*

The Supreme Court consistently recognizes the significance of the act of abortion and the often stressful circumstances under which the decision is made:

> The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with the full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent.[85]

1. Risks from Abortion

Abortion counseling about possible risks makes good medical sense. Approximately twenty percent of all abortion patients suffer psychologically from the abortion experience,[86] and as many as five percent more suffer physically from the procedure.[87] Physical complications increase with the number of prior induced abortions.[88] Counseling helps the patient not only to readjust after the procedure, but also helps her prepare for it.[89] Inadequate counseling injures women by not informing them of all the risks and benefits of the treatment.[90] Unfortunately, as one recent commentary on abortion and informed consent stated, between ten and twenty-five percent of all abortion patients do not receive pre-abortion

83. *Akron*, 462 U.S. at 445 n.37.

84. *Id.* at 449.

85. Planned Parenthood v. Danforth, 428 U.S. 52, 67 (1976). The Supreme Court has previously upheld the constitutionality of informing the patient of the following facts, which are included in the Model Act: (1) that she is pregnant (Section 4(B)(i)); (2) that the patient is free to withhold or withdraw her consent (Section 4(B)(iii)); (3) the number of weeks elapsed from conception (Section 4(B)(v)); and (4) the availability of adoption as an alternative (Section 4(B)(x)). *See Akron*, 462 U.S. at 445 n.37.

86. Note, *Abortion Counseling: To Benefit Maternal Health*, 15 AM. J.L. & MED. 483, 487 (1989).

87. *See infra* notes 92-104 and accompanying text.

88. *See infra* note 98. About 43% of all abortions are repeat procedures. Brotman, *Repeat Abortions Open Complex Issue*, Chicago Tribune, Feb. 25, 1990, § 2, at 1, col. 5.

89. Note, *supra* note 86, at 492.

90. *Id.* at 493.

counseling.[91] Thus, the state has a clear interest in protecting by statute against an ill-informed decision.

Section 4(B)(iv) of the Model Act provides for the disclosure of specific risks to the patient. This section requires that the woman be told:

> That abortion is a medical procedure with certain foreseeable physical and psychological risks, including
>
> (a) retained tissue of conception;[92]
>
> (b) damage to the cervix;[93]
>
> (c) hemorrhage;[94]
>
> (d) infection;[95]
>
> (e) perforation of the uterus;[96]
>
> (f) sterility;[97]

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91. *Id.* at 487. Using the standard figure of 1.5 million abortions per year in the United States, *id.* at 483, this represents 150,000 to 425,000 women.

92. W. HERN, *supra* note 32, at 180-81, 270; Chung, Smith, Steinhoff & Mi, *Induced Abortion and Ectopic Pregnancies in Subsequent Pregnancies*, 115 AM. J. EPIDEMIOLOGY 879, 885 (1982) (retained tissue elevates risk of future ectopic pregnancy). "Incomplete abortions are the most common complication, occurring in one-half to one percent of all abortions. . . . Generally, only small pieces of tissue are left behind, causing a patient to bleed excessively afterward." Sontag, *supra* note 70, at 12, col. 1.

93. Schulz, Grimes & Cates, *Measures to Prevent Cervical Injuries During Suction Curettage Abortion*, LANCET, May 28, 1983, at 1182-83 (approximately one percent of 15,438 women in study required suturing of cervical injuries from abortion procedure).

94. W. HERN, *supra* note 32, at 175, 270 (if hemorrhage is not controlled, patient can quickly go into shock); Grimes, Kafrissen, O'Reilly & Binkin, *Fatal Hemorrhage from Legal Abortion in the United States*, 157 SURGERY, GYN. & OB. 461 (1983) (hemorrhage is third most frequent cause of death from legal abortion).

95. W. HERN, *supra* note 32, at 270; Darj, Stralin & Nilsson, *The Prophylactic Effect of Doxycycline on Postoperative Infection After First Trimester Abortion*, 70 OB. & GYN. 755 (1987) ("postoperative infection is a common and serious complication of induced abortion"); *Genital Tract Infection*, 20 OB. GYN. NEWS 42 (1985); Jerve & Fylling, *Therapeutic Abortion*, 57 ACTA OBSTETRICA ET GYNECOLOGICA SCANDINAVICA 237 (1978) (pelvic inflammatory disease is a major complication after therapeutic abortion); Moberg, Eneroth, Harlin, Ljung & Nord, *Postoperative Cervical Microbial Flora and Post-Abortion Infection*, 57 ACTA OBSTETRICA ET GYNECOLOGICA SCANDINAVICA 415 (1978) (probability of contracting a pelvic infection varies from 0.3% to 14%); Quivstag, Skarg, Jerve, Vik & Ulstrup, *Therapeutic Abortion and Chlamydia Trachomatis Infection*, 58 BRIT. J. VENEREAL DISEASES 182 (1982) (patients harboring chlamydia trachomatis in the cervix at termination of pregnancy are at high risk of developing postoperative infections).

96. W. HERN, *supra* note 32 at 175, 270; Nathanson, *The Management of Uterine Perforation Suffered at Elective Abortion*, 114 AM. J. OB. & GYN. 1054, 1055 (1972) (24 perforated uteruses out of 30,000 abortions performed); Sontag, *supra* note 70.

97. Adler, Belsey & O'Connor, *Morbidity Associated with Pelvic Inflammatory Disease*, 58 BRIT. J. VENEREAL DISEASES 151-57 (1982) ("sterility is the most serious and best documented complication of [pelvic inflammatory disease]"); March & Israel, *Intrauterine Adhesions Secondary to Elective Abortion*, 48 OB. & GYN. 422 (1976) (sterility following elective abortion is a significant complication).

(g) complication of future pregnancies;[98]

(h) death;[99]

(i) posttraumatic stress disorder [also known as postabortion syndrome];[100]

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98. Harlap, *Prospective Study of Spontaneous Fetal Losses After Induced Abortions*, 301 NEW ENG. J. MED. 677 (1979) (risk of spontaneous abortion increased with number of induced abortions); Houge, Cates & Tietze, *Impact of Vacuum Aspiration Abortion on Future Childbearing: A Review*, 15 FAM. PLAN. PERSP. 119, 123 (1983) (women whose first pregnancies were terminated were 3.4 times more likely to have a midtrimester miscarraige during their second pregnancy); Levin, *Association of Induced Abortion with Subsequent Pregnancy Loss*, 243 J. A.M.A. 495 (1980) (women who had two or more prior induced abortions had a twofold to threefold increase in first-trimester miscarraige); Levin, *Ectopic Pregnancy and Prior Induced Abortion*, 72 AM. J. PUB. HEALTH 253 (1982) [hereinafter Levin, *Ectopic Pregnancy*] (after more than one abortion, proportional relationship between the number of prior induced abortions and a subsequent ectopic pregnancy); *Repeated Abortions Increase Risk of Miscarriage, Premature Births and Low Birth Weight Babies*, 11 FAM. PLAN. PERSP. 39 (1979) (repeat abortions are associated with a two- to two-and-a-half-fold increase in low birth weight and premature delivery in subsequent pregnancies); Slater, Davies & Horlap, *The Effect of Abortion Method on the Outcome of Subsequent Pregnancy*, 26 J. REPRODUCTIVE MED. 123 (1981) (greater percentages of infants born following a previous dilatation and curettage (D & C) abortion have low birth weight); Turner, *Ectopic Pregnancy Case Study*, PERSP. & PROBS. IN OB/GYN, Jan. 1985, at 9, 10-11 (after a single ectopic pregnancy a woman has only a 30% chance of producing a live child; the risk of suffering an ectopic pregnancy increases with the number of prior induced abortions).

99. *Legal Abortion Mortality*, 156 AM. J. OB. & GYN. 611 (1987) (63 reported legal abortion deaths from 1974-78); *cf.* Atrash, *Ectopic Pregnancy in the United States, 1970-1983*, 35 MORBIDITY & MORTALITY WEEKLY REP. 225 (1986) (nearly 70,000 ectopic pregnancies in 1983 causing 63 maternal deaths, an increase from 17,800 ectopic pregnancies in 1970). The risk of suffering an ectopic pregnancy increases with the number of prior induced abortions. *See* Levin, *Ectopic Pregnancy*, *supra* note 98, at 253.

100. Posttraumatic stress disorder results from "an event that is outside the range of usual human experience," for example, serious threat or harm to one's child or witnessing a violently inflicted injury or death. Speckhard & Rue, *Post Abortion Syndrome: An Emerging Public Health Concern*, 47 J. SOC. ISSUES — (1991) (quoting AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL III—REVISED § 309.89 (1990); *see also* David, Rasmussen & Holst, *Postpartum & Postabortion Psychotic Reactions*, 13 FAM. PLAN. PERSP. 88 (1981) (comparison of admissions to psychiatric hospitals of women delivering babies and women obtaining abortions); Dunlop, *Counseling of Patients Requesting an Abortion*, 220 PRACTITIONER 847, 850 (1978) (immature teenagers especially susceptible to the disorder); Gould, *Post Abortion Depressive Reactions in College Women*, 28 J. AM. C. HEALTH A. 316-20 (1980); Liebman & Zimmer, *The Psychological Sequelae of Abortion: Fact and Fallacy*, in THE PSYCHOLOGICAL ASPECTS OF ABORTION 127-38 (1979) (reporting 24 immediate and long-term reactions to abortion); Mattinson, *The Effects of Abortion on a Marriage*, in ABORTION: MEDICAL PROGRESS AND SOCIAL IMPLICATIONS 115, 165-77 (1985) (couples show a delayed grief reaction to the abortion, with many still troubled years after the abortion); Mester, *Induced Abortion and Psychotherapy*, 30 PSYCHOTHERAPY & PSYCHOSOMATICS 98, 99 (1978) (induced abortion is a stressing experience, and women may unconsciously ignore or minimize emotional pain); Note, *supra* note 86, at 487 (about 20% of abortion patients suffer from postabortion syndrome). For one professional's perspective, see McCarthy, Wash. Post, Feb. 14, 1989, at F2, col. 1 (conversation with abortionist-psychiatrist about postabortion syndrome):

(j) severe depression;[101]
(k) anniversary syndrome;[102]
(l) sexual dysfunction;[103] and
(m) interference with personal relationships . . . .[104]

Additionally, the Model Act requires that the woman be informed of any other risks that "the physician deems relevant" and "the degree of risk faced by the woman as to each of the [specified foreseeable injuries]." Unlike *Thornburgh*, the Model Act does not require disclosure of all risks. Nor does it overstate the risks from abortion by providing a list of possible adverse consequences without identifying the probability of each occurring, something the Court in *Akron* described as a "parade of horribles."[105] Nor does

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> There is no question . . . about the emotional grief and mourning following an abortion. It shows up in various forms. I've had patients who had abortions two years ago—women who did the best thing at the time for themselves—but it still bothers them. Many burst out crying. . . . There is no question in my mind that we are disturbing a life process. . . . A psychological price is paid. . . . Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist.

101. Dunlop, *supra* note 100, at 850; Kent, Greenwood, Loeken & Nicholls, *Emotional Sequelae of Elective Abortion*, 20 B.C. MED. J. 118-19 (1978) (abortion was a major precipitant in seeking psychotherapy); Lloyd & Laurence, *Sequelae and Support After Termination of Pregnancy for Fetal Malformation*, 290 BRIT. MED. J. 907, 908 (1985); Tishler, *Adolescent Suicide Attempts Following Elective Abortion: A Special Case of Anniversary Reaction*, 68 PEDIATRICS 670, 671 (1981) (case studies of suicide attempts due to anniversary syndrome).

102. Cavenar, Maltbie & Sullivan, *Aftermath of Abortion: Anniversary Depression and Abdominal Pain*, 42 BULL. MENNINGER CLINIC 433, 434 (1978) ("many psychogenic reactions to abortion are anniversary phenomena, motivated by incomplete or abnormal grieving over the loss of the fetus"); Gould, *supra* note 100, at 316-20; Spaulding & Cavenar, *Psychoses Following Therapeutic Abortion*, 135 AM. J. PSYCHIATRY 364, 365 (1978); Tishler, *supra* note 101, at 670.

103. Gerrard, *Sex Guilt in Abortion Patients*, 45 J. CONSULTING & CLINICAL PSYCHOLOGY 708 (1977) (unmarried pregnant women planning to have abortions have more sex guilt); *cf.* Parker, *Motivation of Surrogate Mothers: Initial Findings*, 140 AM. J. PSYCHIATRY 117, 118 (1983) (those applying to be surrogate mothers include a substantial number of women with unresolved psychological problems from a prior induced abortion).

104. Dunlop, *supra* note 100, at 850 (immature teens especially vulnerable to withdrawing from their peers and isolating themselves); Freeman, Rickels, Huggins, Garcia & Polin, *Emotional Distress Patterns Among Women Having First or Repeat Abortions*, 55 OB. & GYN. 630, 636 (1980) (repeat aborters continue to have significantly higher emotional distress scores in interpersonal relationships); Friedlander, Kaul & Stimel, *Abortion: Predicting the Complexity of the Decision-Making Process*, 9 WOMEN & HEALTH, 1986, at 43, 53 ("many women apparently experience difficulties in decision-making which exceed the immediate concern and may include . . . problems in relationships"); Rue, *Abortion in Relationship Context*, INT'L REV. NAT. FAM. PLAN., Summer 1985, at 95, 121 (abortion reinforces defective problem solving); Weiner & Weiner, *The Aborted Sibling Factor: A Case Study*, 12 CLINICAL SOC. WORK J. 209-15 (1984).

105. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 445 (1983).

the Act preclude the physician from independently exercising his judgment. Rather, the Model Act requires that the physician exercise his professional judgment to inform the woman of the particular threat to her of encountering certain specified risks from an abortion, as well as any other risks that the physician believes are relevant. In *Akron*, the Court upheld a similar provision requiring that the woman be informed of the particular risks to her from an abortion.[106]

Further, when one moves outside the abortion context, these types of restrictions are commonplace and noncontroversial. Increasingly, states legislate specific informed consent requirements that include the disclosure of certain specified risks for medical procedures, such as breast cancer treatment,[107] hysterectomies,[108] sterilizations,[109] and HIV testing.[110]

For example, California's statute regarding blood transfusions directs the State Department of Health Services "to develop and annually review . . . a *standardized written summary* which explains the advantages, disadvantages, risks, and descriptions of autologous blood, and directed and nondirected homologous

106. *Id.* at 446. It is true that some of the risks specified in the Model Act may not apply to all patients. However, there is surely no reason why it is unconstitutional to require that the woman be informed that certain risks are not present in her case.

107. CAL. HEALTH & SAFETY CODE § 1704.5 (West Supp. 1990); FLA. STAT. ANN. §§ 458.324(2), 459.0125(2) (West Supp. 1990); GA. CODE ANN. § 84-902(g) (1985 & Supp. 1989); HAW. REV. STAT. § 671-3(c) (1985); KY. REV. STAT. ANN. § 311.935 (Baldwin 1987); MICH. COMP. LAWS ANN. § 333.17013 (West Supp. 1990); MINN. STAT. ANN. § 144.651(9) (West 1989); N.J. STAT. ANN. § 45:9-22.2 (West Supp. 1990); N.Y. PUB. HEALTH LAW § 2404 (McKinney Supp. 1990); PA. STAT. ANN. tit. 35, § 5641 (Purdon Supp. 1990); VA. CODE ANN. § 54.1-2971 (1988).

108. CAL. HEALTH & SAFETY CODE §§ 1690-1691 (West Supp. 1990); MD. HEALTH-GEN. CODE ANN. § 19-348 (1990) (hospital inpatients' opportunity to receive papanicolaou smear); OHIO REV. CODE ANN. § 3701.60 (Anderson 1988) (hospital inpatients' opportunity to receive uterine cytologic examination); 42 C.F.R. §§ 441.250-.259.

109. CAL. WELF. & INST. CODE §§ 14191-14192 (West 1980); CONN. GEN. STAT. ANN. § 45-78q (West 1981); KY. REV. STAT. ANN. § 212.345 (Baldwin 1982); ME. REV. STAT. ANN. tit. 34-B, §§ 7003-7004 (1988); OR. REV. STAT. §§ 436.225-.325 (1989); UTAH CODE ANN. § 62A-6-102 (1989); VA. CODE ANN. § 54.1-2974 (1988); 42 C.F.R. §§ 441.250-.259 (1989).

110. CAL. HEALTH & SAFETY CODE §§ 1603.1(a), 1603.3 (West Supp. 1990); DEL. CODE ANN. tit. 16, §§ 1201-1202 (Supp. 1988); FLA. STAT. § 381.609 (1990); HAW. REV. STAT. § 325-16 (Supp. 1989); ILL. REV. STAT. ch. 111 1/2, paras. 7303-7309 (1989); ME. REV. STAT. ANN. tit. 5, § 19203-A (1989); MD. HEALTH-GEN. CODE ANN. § 18-336 (1990); MICH. COMP. LAWS ANN. § 333.5133(2) (West Supp. 1990); MONT. CODE ANN. § 50-16-1007 (1989); N.Y. INS. LAW § 2611 (McKinney Supp. 1990); N.Y. PUB. HEALTH LAW § 2781 (McKinney Supp. 1990); OR. REV. STAT. § 433.045 (1989); R.I. GEN. LAWS §§ 23-6-12 to -14 (1989); W. VA. CODE § 16-3C-2 (Supp. 1990); WIS. STAT. ANN. § 146.025 (West 1989).

blood."[111] The physician must provide this summary to the patient.[112] Similarly, with respect to breast cancer treatment, the California Department of Health Services is required to develop a standardized written summary to be given by the physician to the patient informing her of the "advantages, disadvantages, risks and descriptions of the procedures with regard to medically viable and efficacious alternative methods of treatment."[113]. Finally, Massachusetts requires that maternity patients receive:

> complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian sections, . . . annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery . . . rooms, . . . annual percentage which were continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinals, epidurals and general anesthesia, and its annual percentage of women breast-feeding upon discharge from said hospital.[114]

Thus, states can and do require a physician to provide a patient with certain statistical information and a standardized description and written summary of the risks for medical procedures involving fundamental rights other than abortion.[115] Similarly, the abortion procedure should not be exempt from state regulation in this regard.

Further, the Court's past refusal to countenance state regulation of the abortion provider is misplaced. Since *Roe v. Wade*,[116] a woman's right to an abortion could perhaps be better characterized as a physician's constitutional right to treat his patient as he sees fit without interference from the state.[117] In *Roe*, the Court declared that "for the period of pregnancy prior to this 'compelling' point [the end of the first trimester], the attending physician, in consultation with his patient, is free to determine, without regulation by the

111. CAL. HEALTH & SAFETY CODE § 1645(e) (West Supp. 1991) (emphasis added).
112. *Id.* § 1645(f).
113. *Id.* § 1704.5 (West 1990). California is not alone with respect to informed consent for breast cancer. *See* MICH. COMP. LAWS ANN. §§ 333.17013, 333.17513 (West Supp. 1990).
114. MASS. GEN. L. ch. 111, § 70E (Supp. 1990).
115. CAL. WELF. & INST. CODE § 14191 (West 1980); OR. REV. STAT. § 436.225(1) (1989); 42 C.F.R. § 441.255(c)(1) (1989).
116. 410 U.S. 113 (1973).
117. Asaro, *supra* note 70, at 59.

state, that, in his medical judgment, the patient's pregnancy should be terminated."[118] This view of the abortion right laid the foundation for the Court to strike down informed consent abortion statutes because they " 'straitjacket' " physicians in the exercise of their professional judgment.[119] The *Akron* Court went further, actually linking the woman's right to an abortion with her physician's ability to exercise discretion: "because abortion is a medical procedure, . . . full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment.' "[120]

As difficult as it is to find a woman's right to an abortion within the penumbra of the Constitution, it is astonishing to find that the same document has been used to protect a physician from state-established standards for disclosing information relevant to a patient contemplating an abortion. Not surprisingly, despite such an alleged "physician's right," states routinely regulate the activities of professionals, including physicians.[121] In the end, abortion is more than a mere "medical procedure." It is an act that raises profound moral and sociological questions. Just as other medical issues, such as terminating life support, genetic research, and disclosure of positive HIV results to others, are not made solely within the physician-patient relationship, but rather within parameters dictated by the state, so the state permissibly may intrude upon that relationship over the issue of abortion.

Heretofore, the Court's view of the physician's role has been outdated, harkening back to an era of the family physician who sought only his own counsel in deciding upon treatment but also drew upon a years-long professional relationship with the patient. Those times are past, and new settings for care now predominate.[122]

Governments and patients now play a far greater role in deciding upon a course of treatment.[123] The large majority of abortions are performed in clinics whose primary, if not sole, function is to

118. *Roe*, 410 U.S. at 163.

119. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 445 (1983) (quoting Planned Parenthood v. Danforth, 428 U.S. 52, 67 n.8 (1976)).

120. *Id.* at 427 (quoting Doe v. Bolton, 410 U.S. 179, 192 (1973)). The Court assumes that the physician actually makes a medical judgment, rather than simply acts as a technician. One commentator noted that a careful reading of the abortion decisions are as much vindications of the rights of physicians to practice medicine as they are feminist "pro-choice" victories, if not more so. Asaro, *supra* note 70, at 59.

121. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 802 (1986) (White, J., dissenting).

122. *See* F. ROZOVSKY, *supra* note 7, § 1.1.2.

123. *Id.*

perform abortions;[124] the woman is unlikely to meet the operating physician before the procedure or see the physician again, unless it is for another abortion.[125] Thus, the physician is unlikely to know much more about the woman's individual circumstances than would any member of the state legislature.

In addition, a clinic's economic survival depends upon women choosing abortions. There is a strong economic incentive for such clinics to encourage abortions,[126] unlike the traditional hospital or physician with a more diverse practice, whose goal is to heal the patient. Healing is not the goal of an abortion clinic unless an abortion is the only rational way to deal with an unwanted pregnancy. Further, physicians who provide abortions are likely to be isolated from their professional peers and to feel ostracized and defensive about their work.[127] Such individuals may well lack the objectivity necessary to see that the patient makes a fully informed choice. If a state is concerned about a physician's or clinic's objectivity, then regulation is a reasonable and permissible way to protect its citizens.

Finally, a woman is free to sue a physician after she has an abortion for failure to inform her of particular risks or to provide a fetal description.[128] A court might even adopt a general rule that failure to provide certain information to a pregnant woman is malpractice per se. What the Supreme Court has done is to fashion, without explanation, a constitutional doctrine that permits, in effect, the physician's judgment to be second guessed by the state after, but not before, an abortion. This doctrine is completely without support in the Constitution.

2. Private Counseling

Section 4(C) of the Model Act requires that:

> The information contained herein shall be disclosed to the wo-

124. *See supra* notes 67-72 and accompanying text.

125. *See supra* notes 69-72 and accompanying text.

126. "Would you please remember that abortion is not about right, abortion is not about choices, abortion is . . . about money. . . . Abortion is a skillfully marketed product sold to a woman when she needs help. They don't give her help. The only choice they have is abortion." Myers, *Senate to Debate Abortion Bill*, Baton Rouge Morning Advocate, June 21, 1990, at 1A, col. 2 (comments of Carol Everett, a pro-life activist, who at one time operated a lucrative abortion clinic in Dallas).

127. *Abortion Providers Meet to Honor Peers*, Wash. Post, May 9, 1990, at 6, col. 4; Kolata, *Under Pressures and Stigma, More Doctors Shun Abortion*, N.Y. Times, Jan. 8, 1990, at 1, col. 1.

128. *See* Annotation, *Medical Malpractice in Performance of Legal Abortion*, 69 A.L.R.4TH 875, 885 (1989).

> man in private to protect her privacy and maintain the confidentiality of the woman's decision, and to ensure that the information she receives focuses on her individual circumstances.

Although the Supreme Court has not yet addressed this type of provision, it is quite consistent with the Court's repeated admonitions that the information a woman receives must, as a constitutional matter, be tailored to her individual circumstances, and that abortion is a personal decision, to be made between the woman and her physician or counselor.[129] Presumably, the provision will add an additional minimal cost to the abortion procedure. However, the Supreme Court sustained a Missouri statute that required a pathology report for each abortion performed, resulting in an approximate $19.40 increase in cost to the woman, on the basis that it furthered important health-related concerns.[130] Accordingly, this provision is consistent with existing Court precedent.

3. One-Day Waiting Period

Section 4(D) of the Model Act mandates a minimum overnight waiting period for an abortion after the information has been given, except in certain emergency situations. In *Akron*, the Court struck down a twenty-four-hour waiting period because it encroached upon the physician's exercise of judgment as to whether and for how long an individual patient should postpone the abortion procedure.[131]

As noted earlier, however, the Court now seems more amenable to state regulation of abortion, including a waiting period.[132] Further, as argued above, the Court's deference to the physician is entirely misplaced. For example, California's informed consent sterilization statute requires a thirty-day waiting period.[133] If a state may impose upon a physician its view of the appropriate waiting period for sterilization, why is it any different legally when it seeks to do so for abortion? Because most abortions are performed

129. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 762-63 (1986); City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 442-49 (1983); Colautti v. Franklin, 439 U.S. 379, 387 (1979); Planned Parenthood v. Danforth, 428 U.S. 52, 67 & n.8 (1976); Doe v. Bolton, 410 U.S. 179, 192 (1973).

130. Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476, 487 (1983).

131. *Akron*, 462 U.S. at 450-51.

132. Indeed, the Court, by a six-to-three margin, recently upheld a 24-hour waiting period and a 48-hour waiting period for parental notice statutes. Ohio v. Akron Center for Reproductive Health, 110 S. Ct. 2972 (1990); Hodgson v. Minnesota, 110 S. Ct. 2926 (1990).

133. CAL. ADMIN. CODE tit. 22, § 70707.1(a)(4) (1986); *see also* KY. REV. STAT. ANN. § 212.347 (Baldwin 1982).

in clinics,[134] where the physician-patient relationship may be tenuous if not nonexistent, state regulation of abortion is likely to be less intrusive than for procedures such as breast cancer treatment and sterilization, for which the physician-patient relationship is usually much more developed.

4. Description of the Fetus

Section 4(B)(vi) of the Model Act requires the physician to inform the woman:

> In language designed to be understood by the pregnant woman given her age, level of maturity, and intellectual capability, the probable anatomical and physiological characteristics of the fetus she is carrying, based upon information available to the physician concerning the gestational age and physical development of the woman's fetus.

The Act further requires in Section 4(B)(vii):

> The availability, for the woman's review if she so chooses, of a fetal model or depiction of a fetus with the probable anatomical and physiological characteristics as determined pursuant to Subsections (B)(v) and (vi) herein.

Unlike the *Akron* statute, the Model Act requires only that the fetus be described; it does not enumerate specific characteristics.[135] Thus, the physician need not speculate about certain unknowable characteristics. Further, because the details of the fetal description are left to the discretion of the physician, intrusion into the physician-patient relationship is limited. The only determination made by the state under these provisions of the Model Act is that a description of the fetus is relevant to a woman's decision whether to abort. Both proponents and opponents of the abortion right have pointed to physiological characteristics of the fetus to support their

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134. *See supra* note 67 and accompanying text.

135. In *Akron*, the Court struck down a statute requiring that the patient be informed "in detail [of] the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members." *Akron*, 462 U.S. at 423 n.5. A majority of the Court struck down the statute because it was "designed not to inform the woman's consent but rather to persuade her to withhold it altogether," and because it required physicians to speculate about some fetal characteristics, such as the unborn child's sensitivity to pain, which are impossible to deterimine. *Id.* at 444 & n.34. Further, the statute "insist[ed] upon recitation of a lengthy and inflexible list of information," without regard to the woman's individual circumstances, thereby acting as an impermissible straitjacket upon the physician. *Id.* at 445.

positions.[136] Indeed, the Supreme Court itself used a physiological characteristic—viability—as one of its tests in *Roe*.[137] Physical appearance is unquestionably important to our definition of "humanity." Without doubt, should an extraterrestrial civilization ever announce itself to us, we would look first to the physical characteristics of the beings to judge their similarity to us. Given all of the above, it is difficult to argue that physical appearance of the fetus is not relevant, or that a state may not determine that it is relevant as a matter of law and policy, to the moral decision that each woman must make in deciding whether to have an abortion.[138]

Providing a woman with a description of the fetus that she is carrying furthers two important state interests. First, information on fetal development insures that a woman has an opportunity to make the abortion decision based upon all available objective medical information. If she is informed about fetal development, she can act according to her own values. She then will have minimized the risk of future potential psychological harm arising from post-operative reflection prompted by obtaining fetal information not made available to her before the abortion.[139] Offering a woman the opportunity to receive a minimum level of objective biological and medical information is necessary to the abortion counseling process.[140]

Second, providing such information furthers the state's interest in protecting unborn life throughout a woman's pregnancy. As noted earlier, providing a woman with medical and biological information, to which she might not otherwise have access, will allow her to act in light of her own values to protect the unborn child.

The Supreme Court, however, has expressed concern that abortion informed consent statutes are motivated by a desire to dissuade women from seeking an abortion.[141] In articulating its

136. *See infra* note 138.

137. Roe v. Wade, 410 U.S. 113, 163-65 (1973).

138. This Article does not separately review the constitutionality of the fetal model. Under *Thornburgh*, this provision would, arguably, be unconstitutional. *See* Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 762 (1986). Inexplicably, the Court never addressed the fact that the *Thornburgh* provision, like that of the Model Act, is voluntary. Under the Model Act, the physician must inform the woman that the model is available for her viewing if she chooses. To forbid the patient from making this choice not only smacks of paternalism, but weakens the holding of *Roe*. Even some supporters of legal abortion prefer that the woman be given this opportunity. *See* Note, *supra* note 86, at 510.

139. *See supra* notes 26, 100-04.

140. *See generally* Rue, *supra* note 104.

141. *See supra* note 135 and accompanying text.

concern, the Court has appeared to rely on a type of "purpose" test. Specifically, the Court has rejected provisions requiring a description of the fetus or making available for view a picture of a fetus of approximately the same age as the patient's, because such requirements are "inflammatory" and designed to discourage a woman from having an abortion.[142]

Abortion involves presently unresolvable debates over theological, moral, and medical questions about the propriety of taking the life of a fetus. No one can seriously dispute the state's right ordinarily to present evidence as to fetal characteristics. Surely it is relevant evidence and the most objective evidence available in the abortion debate.[143] For example, a state constitutionally may fund a massive advertising campaign highlighting the various stages of fetal development.[144] A woman might even view such an advertisement on a bulletin board immediately outside the abortion clinic. Yet when this information is required to be disclosed during the patient consultation, it somehow becomes unconstitutional.

Quite apart from the issue of whether the Court has drawn a valid distinction here, it is simply incorrect to say that such provisions are inherent attempts by the state to discourage abortion. If a state has a statute permitting abortion in given situations, then the state's interest lies in seeing that the abortion decision is a fully informed one. Once balanced and truthful information is presented to the woman, *she must then choose*. It would be a differ-

142. *See Thornburgh*, 476 U.S. at 762-63 & n.10; City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 444-45 (1983). The standard for abortion contains no formal purpose requirement. In fact, the Court has held that the state may legitimately choose childbirth over abortion. *See supra* note 63 and accompanying text. However, the Court has, in the past, utilized a de facto purpose requirement. For example, the Court invalidated portions of the informed consent ordinance in *Akron* in part because the regulation was "designed . . . to persuade [the woman] to withhold [her consent] altogether." *Akron*, 462 U.S. at 444. Similarly, in *Thornburgh*, the Court found that the state legislature's failure to "compel similar disclosure of every possible peril of necessary surgery or of simple vaccination, reveal[ed] the anti-abortion character of the statute and its real purpose." *Thornburgh*, 476 U.S. at 764. The Model Act is designed simply to provide a woman with sufficient truthful information and the necessary time to make an informed choice. Notwithstanding *Thornburgh* and *Akron*, a state legislature that adopts the Model Act, even with the dual intent of protecting the woman and supporting childbirth over abortion, does not infringe on any existing right to abortion.

143. *See, e.g.*, Sagan & Druyan, *Is It Possible to Be Pro-Life and Pro-Choice?*, PARADE MAG., Apr. 22, 1990, at 4, col. 1.

144. North Carolina began the "First Steps" campaign in 1990, with an investment of $10 million, in order to reduce infant mortality. At least two of the campaign's publications refer to the fetus as a "baby" and list the evolving characteristics of the unborn child. MATERNAL & CHILD HEALTH BRANCH, DIV. OF HEALTH SERVS., N.C. DEPT. OF HUMAN RESOURCES, HEALTHY PREGNANCY, HEALTHY BABY: A HANDBOOK FOR EXPECTING MOMS 3-5 (1983); STATE OF N.C., ME AND MY BABY (1990).

ent situation if the state required the physician to provide false information on fetal development or to provide only physiological information tending to support the argument that the fetus should not be aborted.[145] The information to be disclosed under the Model Act is not in and of itself harmful; rather, it is simply factual. If the woman chooses not to have an abortion, it is not because the state has dissuaded her, but rather because she has received complete information on the physiological characteristics of her fetus and has made her own decision. She has perceived her own best interest and acted upon it. It is quite remarkable for the Court to view the truth as a burden on the exercise of a constitutional right.[146] It becomes even more so when the issue is the possible taking of human life and a decision most Americans probably view as immoral, even if not all are willing to make it unlawful.[147] Indeed, if providing relevant, balanced, and truthful information about fetal development to pregnant women dissuades them from having an abortion, does not this only confirm the legitimacy of the state's fear that the fetus is being unnecessarily killed through an uninformed decision?[148]

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145. *See In re* R.M.J., 455 U.S. 191, 200 (1982) (misleading information is subject to restraint).

146. The Court has rejected the argument that it is permissible for a state to withhold information in order to protect its residents. *See* Virginia Pharmacy Bd. v. Virginia Citizens Consumer Council, 425 U.S. 748 (1976). The Court held that the best way to protect the citizens of Virginia was "to open the channels of communication rather than close them." *Id.* at 770.

147. In recent Gallup Poll, commissioned by Americans United for Life, 75% of the respondents said that they believed that abortion involved the taking of human life. *New Gallup Poll Buoys Pro-Lifers*, HUMAN EVENTS, March 9, 1991, at 6. The poll also revealed "public ignorance of the status of abortion law." *Id.* (42% of poll respondents believe that *Roe v. Wade*, 410 U.S. 113 (1973), authorizes abortions only during the first trimester; 16% of all respondents believe that even a first trimester abortion "could be obtained only if the mother's life or health was in danger."). *Cf.* Chapman, *When it Comes to Abortion, the Public Isn't "Pro-Choice"*, Chicago Tribune, March 21, 1991, at 27, col. 1 ("Most Americans approve of abortions in some cases—the extreme ones. A sizeable majority thinks it is acceptable in cases of rape and incest, when there is a danger to the physical or mental health of the mother, and when the baby is likely to be born with a severe defect.").

148. Justice Blackmun's additional concern that a description of the fetus is inflammatory is misplaced. No one seriously disputes the relevance of a description of the fetus to the abortion decision. It may be inflammatory ordinarily to show the jury a picture of the bloody corpse in a murder case because that information is not relevant. *See* G. LILLY, AN INTRODUCTION TO THE LAW OF EVIDENCE 44-45, 513 (2d ed. 1987); *see also* Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 474, 801 (1986) (White, J., dissenting). However, showing the jury a picture of the victim taken before the murder to show that the victim existed would hardly be inflammatory. It is not uncommon for abortion clinic workers to describe vaguely the life within the woman's womb. Sontag, *supra* note 67, at 14, col. 2 (" 'What baby?' [the clinic owner]

In the recent *Cruzan* case concerning the right to die,[149] the Court noted that the life or death impact of the decision being regulated by the state justified "heightened evidentiary requirements" in evaluating the choice to terminate a patient's life.[150] Similarly, the life or death decision being made by the pregnant woman justifies regulation by the state to ensure that this momentous decision is a fully informed one.

Finally, when viewed in light of informed consent statutes outside the abortion context, the Court's purpose inquiry seems unduly restrictive. Presumably, no legislature would take the time to pass an informed consent statute for any medical procedure unless it determined that there is a real probability that patients are too often opting unwittingly for that procedure, for example, choosing mastectomies instead of less radical treatment. Is this legislative favoritism—seeking to reduce the number of particular medical procedures performed—reason enough to declare the statute unconstitutional? Suppose the legislature also requires the physician to describe what a woman looks like after a mastectomy or to make illustrations available; is the statute then unconstitutional?[151]

States could find that some women later regret choosing an ill-informed mastectomy or sterilization procedure and that prior information may alleviate the problem. In addition, a legislature may be concerned about the cost to the state of mastectomies when other procedures are equally effective but less costly. Or a state may be concerned about the growing number of sterilizations and its declining birth rate. Do these concerns, not directly related to patient welfare, render such statutes unconstitutional? One would hardly think so. In short, the Court seems to have imposed a purpose requirement upon abortion informed consent statutes merely because abortion is controversial. Nothing in the Constitution indicates such a result.

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answered. 'There's no baby. There's just two periods there that will be cleaned out.' "); Zekman & Warrick, *Soft Voices, Hard Sells—Twin Swindle*, Chicago Sun-Times, Nov. 17, 1978, at 22, col. 2 ("We got no [counseling] training except in what *not* to say. How not to use words like 'fetus' or 'kill' that might scare the customers away.").

149. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

150. *Id.* at 2852-53.

151. One could argue that in this example the state is trying to dissuade the woman from choosing one form of treatment, not from foregoing the treatment altogether as is the case with abortion. Without conceding that this distinction makes any difference, informed consent statutes for sterilization involve a choice between treatment and no treatment. Yet there appears to be little or no concern that the state is trying to dissuade individuals from seeking sterilization.

5. Duty to Preserve Live Birth Fetus

Section 4(B)C(viii) requires the physician to inform the woman:

> That if the woman's fetus has reached the stage of viability, and if the abortion procedure results in the premature birth of the live child, the attending physician has the legal obligation to take all steps necessary to maintain the life and health of the child. The disclosure required in this Subsection need not be given when the attending physician has determined, with reasonable medical certainty, that the fetus has not reached the stage of viability.

The Supreme Court has never addressed the constitutionality of a provision such as this one. Nevertheless, it is the type of accurate and nonobjectionable information accepted by the Court in *Akron*,[152] particularly considering the state's compelling interest in protecting a postviable child.

IV. CONCLUSION

In its decisions on abortion informed consent statutes, the Supreme Court has struggled with what it views as the often competing interests of the woman's right to choose an abortion, the state's interest in protecting unborn life, and the physician's right to an unregulated practice. The Model Woman's Informed Choices Act discussed in this Article is constructed in accord with the balance struck by the Court in this area.

More importantly, this Article has suggested that the Court incorrectly views these interests as competing. Abortion informed consent statutes serve to insure that the woman exercises her right to choose whether to have an abortion in a knowing and fully informed manner. The information necessary to that decision includes not only the medical and emotional risks inherent in the abortion procedure, but also the physiological characteristics of the life that is within her. The abortion decision is both medical and moral and cannot be made knowingly without consideration of the life of the fetus; for if there is one thing on which both pro-life and pro-choice advocates agree, it is that the fetus represents at least a potential human life. It would be a strange result indeed if the state could not constitutionally require the woman to consider objective information relevant to that life as part of her abortion decision.

Nor is the physician hamstrung by such a statute. Gone are the

152. City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 445 n.37 (1983).

days when the physician operated largely outside of governmental regulation. Today, both statutes and common law extensively regulate the informed consent dialogue between physician and patient. Moreover, the physician-patient relationship considered so sacrosanct in earlier abortion decisions is usually non-existent in the abortion context, and the Model Act is drafted to avoid undue interference with that relationship in the rare circumstance where one exists.

In short, the Court previously erected protective walls around its newly found and controversial right to an abortion, often seeming to protect abortion itself rather than the right to choose abortion.[153] Even as it continues to fashion what Justice Scalia has termed an "abortion code,"[154] the Court has begun to tear down those walls.

153. One commentator has observed that the Court's holdings in certain abortion cases seem driven more by anger over continued opposition to *Roe v. Wade* than by the merits of the particular case. *See* Moses, *The Role of the Legislative and Executive Branches in Interpreting the Constitution*, 73 CORNELL L. REV. 380, 382 (1988).

154. Hodgson v. Minnesota, 110 S. Ct. 2926, 2961 (1990) (Scalia, J., concurring in the judgment in part and dissenting in part).

APPENDIX
Model Woman's Informed Choices Act

Section 1. Short Title

This Act shall be known as the "Woman's Informed Choices Act."

Section 2. Legislative Purposes and Findings

A. The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which the woman receives sufficient information to make an informed choice between two alternatives of great consequence: carrying a child to birth or terminating the pregnancy.

B. The purpose of this Act is to ensure that prior to the performance of an abortion, every woman shall be counseled and given a full range of information regarding her available alternatives and that every woman shall give her voluntary, knowledgeable and informed consent to the abortion procedure.

C. This legislature believes it is essential to the psychological and physical well-being of a woman considering an abortion that she receive complete and accurate information on all options available to her in dealing with her pregnancy.

D. Because the vast majority of abortions in this State are performed in clinics devoted solely to providing abortions and family planning services, women who seek abortions at these facilities normally do not (i) have a prior patient-physician relationship with the abortionist; (ii) return to the facility for post-surgical care; and (iii) continue a patient-physician relationship with the abortionist. In most instances, the woman's only actual contact with the abortionist occurs simultaneously with the abortion procedure, with little opportunity to receive counsel concerning her decision. Because of this, the legislature believes that certain safeguards are necessary to protect a woman's right to choose the option best suited to her particular situation.

E. A further purpose of this Act is to acknowledge this State's interest in protecting unborn children from a woman's uninformed decision to terminate her pregnancy.

F. This legislature believes it is essential to the safeguarding of its interest in protecting unborn children that the woman receive factual, medical and biological information about her unborn child. The dissemination of the information set forth herein is imperative because of the significance of the act of abortion and the

often stressful circumstances under which the abortion decision is made.

G. The safeguards that will best protect a woman seeking advice concerning abortion include the following:

(i) Private, individual counseling, including dissemination of certain information, as the woman's individual circumstances dictate, relevant to the decision whether to choose an abortion; and

(ii) A short waiting period between a woman's receiving information designed to assist in making an informed choice and the actual performance of the abortion procedure, if that is the choice that she makes.

The legislature finds that these safeguards advance the woman's interests in the exercise of her decision on whether to choose an abortion and are justified by the objective of this State to protect the health of women and that of unborn children.

Section 3. Definitions

A. "Abortion" means the use of any instrument, medicine, drug, or other substance or device with the intent to cause the death of a live fetus which is existing within the womb of a woman known to be pregnant.

B. "Fetus" means an individual organism of the species homo sapien from conception until live birth.

C. "Viability" and "viable" mean the stage of physical development at which the life of a fetus may potentially be continued separate from the woman, by natural means or with the assistance of artificial life-support systems.

D. "Physician" means any person licensed to practice medicine under the laws of this State.

E. "Qualified person assisting the physician" means a physician, psychologist, licensed social worker, licensed professional counselor, or registered nurse.

Section 4. Voluntary and Informed Consent

A. An abortion otherwise permitted by law shall not be performed or induced except with the informed written consent of the pregnant woman, such consent given freely and without coercion.

B. Pursuant to Subsection (A) of this Section, an abortion shall not be performed or induced upon a pregnant woman unless she has been orally informed by her attending physician, or a qualified person assisting the physician, of the following information, given the opportunity to ask questions she may have, and, based on her

consideration of this information, signed a consent form acknowledging that she has been informed of the following:

(i) That according to the best medical judgment of a physician she is pregnant;

(ii) The name of the physician who will perform the abortion;

(iii) That she is free to withhold or withdraw her consent to the abortion procedure at any time before the abortion without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded benefits to which she might otherwise be entitled;

(iv) That abortion is a medical procedure with certain foreseeable physical and psychological risks, including (a) retained tissue of conception; (b) damage to the cervix; (c) hemorrhage; (d) infection; (e) perforation of the uterus; (f) sterility; (g) complication of future pregnancies; (h) death; (i) posttraumatic stress disorder; (j) severe depression; (k) anniversary syndrome; (l) sexual dysfunction; and (m) interference with personal relationships, and the physician's judgment as to the degree of risk faced by the woman as to each of the above, as well as such other risks as the physician deems relevant to the woman.

(v) The number of weeks elapsed from the probable time of conception of the fetus, based upon (a) information provided by her as to her last menstrual period and/or other reliable information commonly used in determining the point of conception; or (b) appropriate physical and laboratory tests.

(vi) In language designed to be understood by the pregnant woman taking into account her age, level of maturity, and intellectual capability, the probable anatomical and physiological characteristics of the fetus she is carrying, based upon information available to the physician concerning the gestational age and physical development of the woman's fetus.

(vii) The availability, for the woman's review if she so chooses, of a fetal model or depiction of a fetus with the probable anatomical and physiological characteristics as determined by the physician pursuant to Subsections (B)(v) and (vi) herein.

(viii) That if the woman's fetus has reached the stage of viability, and if the abortion procedure results in the premature birth of the live child, the attending physician has the legal obligation to take all steps necessary to maintain the life and health of the child. The disclosure required in this Subsection need not be given when the attending physician has determined, with reasonable medical certainty, that the fetus has not reached the stage of viability.

(ix) An explanation of the medical or surgical method of removing the fetus that will be utilized in performing the abortion.

(x) The availability of services provided by public and private agencies to assist the woman during her pregnancy and after the birth of her child in the event the woman chooses not to abort the fetus, including services relating to adoption, or, if she chooses to abort, names of groups that counsel women who have had abortions. The physician or qualified person assisting the physician shall provide the woman with a list of such agencies upon the woman's request. This list is to be promulgated by the State Department of Health and shall be updated annually, pursuant to rulemaking procedures established by the Department.

(xi) An explanation of what to do and whom to call (including appropriate telephone numbers) should complications arise after the abortion.

C. The information contained herein shall be disclosed to the woman in private to protect her privacy and maintain the confidentiality of the woman's decision, and to ensure that the information she receives focuses on her individual circumstances.

D. No abortion shall be performed earlier than the day following the disclosure of the information as set forth in Subsection (B) herein, unless the attending physician, utilizing his experience, judgment and professional competence, determines that any waiting period would endanger the life of the pregnant woman.

If the physician determines that the life of the pregnant woman is endangered, the abortion may be performed after disclosure of the required information and the signing of the consent form referenced herein. The attending physician shall maintain a written record identifying the medical basis upon which the decision that the abortion is immediately necessary is based.

E. Prior to performing the abortion, the attending physician performing or inducing the abortion shall provide the pregnant woman with a duplicate copy of the consent form signed by her and shall verify that all information required to be given the woman was provided her, unless the attending physician provided such information initially. The attending physician shall also inform the pregnant woman of her right to withdraw her consent, and of his continuing obligation to provide follow-up services should there be any complications after the abortion.

F. A written consent form meeting the requirements set forth in this Section and signed by the pregnant woman shall be presumed valid. Such presumption may be overcome by evidence sufficient to establish that such consent was obtained through fraud, negligence, deception, misrepresentation, coercion, duress, or omission of a material fact.

Section 5. Penalties

A violation of this Act by a physician or qualified person assisting the physician is a Class — Misdemeanor.

Section 6. Civil Remedies

A. Notwithstanding any other provisions of the laws of this State, failure to comply with the requirements of this Act shall provide a basis for a civil malpractice action for damages against the attending physician, the qualified person assisting the physician, or the hospital, clinic, ambulatory surgical treatment center, professional corporation, or partnership with which the attending physician or qualified person assisting the physician is associated, upon a showing of each the following:

(i) The woman suffered harm to her physical, mental, or emotional health as a result of the abortion or the failure to provide information relevant to her informed consent;

(ii) The information concerning the risk or possibility of such harm was not disclosed as required by this Act; and

(iii) The woman would not have consented to the abortion had the requirements of this Act been met.

Section 7. Severability

The provisions of this Act are declared to be severable, and if any provision, word, phrase, or clause of this Act or the application thereof to any person shall be held invalid, such invalidity shall not affect the validity of the remaining portions of this Act.

Section 8. Construction

Nothing in this Act shall be construed as creating or recognizing a right to legal abortion.