

THE IRRATIONAL WOMAN: INFORMED CONSENT AND ABORTION DECISION-MAKING

MAYA MANIAN*

It must be admitted that women have but little sense of justice We say also of women that their social interests are weaker than those of men, and that their capacity for the sublimation of their instincts is less.¹

Respect for human life finds an ultimate expression in the bond of love the mother has for her child While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.²

I. INTRODUCTION	224
II. A BRIEF HISTORY OF “PARTIAL-BIRTH” ABORTION BANS	228
III. THE PHYSICIAN & PATIENT: INFORMED CONSENT, AUTONOMY & ABORTION LAW.....	235
A. Informed Consent in the Healthcare Context.....	235
B. “Informed Consent” to Abortion from <i>Roe</i> to <i>Casey</i>	242
C. “Informed Consent” and Abortion Decision-Making After <i>Carhart</i> ...	254
IV. THE STATE AND THE PATIENT: SOME EXCEPTIONS TO PATIENT AUTONOMY	262
A. Exceptions to Patient Autonomy “For the Common Good”	266
1. Compulsory Vaccination.....	266
2. Controlled Substances	269
B. Exceptions to Patient Autonomy “For the Patient’s Own Good”	274

* Copyright © 2009 by Maya Manian. Associate Professor, University of San Francisco School of Law. B.A., 1995, University of Michigan; J.D., 1998, Harvard Law School. For their helpful comments on prior drafts, I am grateful to Kerry Abrams, Susan Frelich Appleton, Caroline Davidson, Josh Davis, Susan Freiwald, Jessie Hill, Lisa Ikemoto, Julie Nice, Reginald Oh, Bruce Price, and Steve Shatz. I also thank my colleagues at USF for providing valuable feedback at our faculty scholarship workshops. This article also benefited from feedback from participants at the UCSF Abortion Seminar; the Consent, Capacity, and Liability: Women and Legal Regulation session at the 2008 Law & Society Annual Meeting; and the LatCrit XIII Works-in-Progress session. Many thanks to Amy Wright for her outstanding services as Research Librarian. For able research assistance, I thank Erin Bennett, Caroline Burnett, Jennie Griffiths, Aliya Karmali, and Alexandria Walden. Thanks to Roy Sehgal for thoughtful comments on early drafts.

1. SIGMUND FREUD, *Three Essays on the Theory of Sexuality*, in THE COMPLETE PSYCHOLOGICAL WORKS vol. 7, 183 (1953).

2. *Gonzales v. Carhart*, 550 U.S. 124, 128 (2007).

1. Experimental Drugs	274
2. Physician Assisted Suicide	283
IV. CONCLUSION	289

I. INTRODUCTION

This article explores the law's failure to treat pregnant women as capable of making their own decisions concerning whether to have an abortion. The Supreme Court's decision in *Gonzales v. Carhart*,³ which upheld a federal ban on a type of second-trimester abortion that many physicians believe is safer for their patients, brought the question of women's capacity for healthcare decision-making to the forefront of public legal consciousness. In *Carhart*, the Court abandoned its previous deference and respect for a woman's right to be her own decision-maker with regard to abortion and instead determined that a pregnant woman lacks capacity to make her own decisions and to give informed consent to abortion-related medical treatment. According to the Court, the government may make the final decision regarding a pregnant woman's healthcare to ensure that she realizes her "ultimate" role as a mother.

Carhart marks the Supreme Court's first refusal to require a health exception to an abortion restriction since *Roe v. Wade* and its first use of the anti-abortion movement's woman-protective rationale to uphold an abortion ban.⁴ The woman-protective rationale claims that banning abortion promotes women's mental health.⁵ *Carhart's* woman-protective anti-abortion reasoning casts the federal "partial-birth" abortion ban as a public health measure that serves to protect women from "regret" and depression. Contrary to this claim, the *Carhart* decision not only endangers women's health, but also may encourage courts and legislatures to approve other similar measures under the guise of "protecting" women. The woman-protective rationale also obscures the underlying constitutional question at issue in challenges to "partial-birth" abortion bans—may the government jeopardize women's health for the sake of the government's "ethical and moral" interests in the fetus?⁶

3. *Id.*

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

5. See Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of "Woman-Protective" Abortion Restrictions*, U. ILL. L. REV. 991, 991-94 (2007) (describing development of the claim that women regret their abortions and labeling this claim the "woman-protective" anti-abortion argument) [hereinafter Siegel, *The New Politics of Abortion*].

6. See *Carhart*, 550 U.S. 124, 158 (2007). See also Rebecca Dresser, *Protecting Women from their Abortion Choices*, The Hastings Center Report 13 (2007) (arguing that the "woman-protective" rationale relied upon by *Carhart* is contrary to bioethical principles and confuses substantive issues). In addition to the government's "moral" interest in the manner in which the fetus is killed, Justice Kennedy opined that the federal ban could potentially reduce second-trimester abortions, but failed to explain how "partial-birth" abortion bans would achieve this goal. See *Carhart*, 550 U.S. at 160. As Justice Ginsburg noted in her dissent, the federal "partial-birth" abortion ban in fact "saves not a single fetus from destruction, for it targets only a *method* of performing abortion." *Id.* at 181 (Ginsburg, J., dissenting).

Carhart's portrayal of women evokes a century-old societal view of femininity.⁷ The *Carhart* Court's cabined view of women's decision-making capacity reflects a gender-stereotyped view of women's nature.⁸ The Court also exposed its discriminatory view of women as decision-makers by articulating a new paradigm of "informed consent" in the abortion context that controverts well-established rules of patients' right to informed consent in healthcare law. This article focuses on *Carhart's* disturbing reasoning—that competent adult women lack the capacity to determine for themselves what is best for their own health—and evaluates its implications in the abortion context and in other areas of medical treatment related to pregnancy. This article criticizes the woman-protective anti-abortion claim from the perspective of healthcare law by comparing the treatment of women's healthcare decision-making under abortion law to patient decision-making under more general law. A close examination of the law on healthcare decision-making yields the conclusion that, compared to how the law treats all other competent adult patient decision-making, abortion law treats pregnant women unequally. This article argues that the denial of pregnant women's capacity to make abortion decisions unjustifiably diverges from the law's treatment of patient decision-making in both the private law doctrine of informed consent and in public law constitutional cases governing medical decision-making. In no other area of healthcare does the State override a competent adult's right to consent to a medical procedure that falls within the bounds of proven and accepted medical practice, and in fact may be *physically* safer for the patient, based on the State's unsubstantiated view that the treatment will be *psychologically* harmful to the patient. The law only subjects the gender-specific abortion decision to this kind of doubt about patient decision-making capacity, therefore denying that women have the same ability as men to make informed healthcare decisions.⁹ The law's unequal treatment of women as decision-makers further bolsters the argument articulated by feminist legal scholars that restrictions on abortion are manifestations of sex discrimination.¹⁰

7. See, e.g., *Bradwell v. Illinois*, 83 U.S. 130 (1873) (permitting states to deny women admission to the Bar). In his concurrence, Justice Bradley famously declared: "The paramount destiny and mission of woman are to fulfill the noble and benign offices of wife and mother." *Id.* at 141.

8. See, e.g., Siegel, *The New Politics of Abortion*, *supra* note 5, at 1029–50 (arguing that the use of informed consent discourse to justify restrictions on abortion rests on sex-based stereotypes about women's roles and women's agency, therefore violating equal protection).

9. The Supreme Court infamously concluded that discrimination based on pregnancy does not on its face amount to sex discrimination because the discrimination is not between men and women, but between "pregnant women and nonpregnant persons." *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974). See also *General Electric Co. v. Gilbert*, 429 U.S. 125, 140 (1976) (concluding for similar reasons that Title VII does not protect against discrimination based on pregnancy). *Geduldig* has been heavily criticized by feminist legal scholars. Furthermore, Congress rejected the Supreme Court's reasoning when it enacted the Pregnancy Discrimination Act of 1978, which recognizes that pregnancy-related discrimination is a form of sex discrimination in the employment context. See, e.g., Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983 (1984) (noting that criticizing *Geduldig's* reasoning became "a cottage industry" among scholars); Wendy W. Williams, *Equality's Riddle: Pregnancy and the Equal Treatment/Special Treatment Debate*, 13 N.Y.U. REV. L. & SOC. CHANGE 325 (1984/85) (arguing that discrimination related to pregnancy is sex discrimination).

10. See, e.g., Susan Frelich Appleton, *Unraveling the "Seamless Garment": Loose Threads in Pro-Life Progressivism*, 2 U. ST. THOMAS L.J. 294, 296–300 (2005); David H. Gans, *Stereotyping and Difference:*

This article begins by examining the tort law doctrine of informed consent. Informed consent law serves primarily to respect patient self-determination and autonomy. The article then contrasts the tort doctrine of informed consent with abortion law's approach to informed consent. It seeks to disentangle "informed consent" as used in abortion law from informed consent law generally. A growing disrespect for women's decision-making capabilities has been underway for some time in the abortion context, which the Court's approval of abortion-specific "informed consent" regulations particularly reveals. Abortion law invokes and then misuses "informed consent" terminology. These so-called "informed consent" to abortion regulations belie a deep suspicion of women as medical (and moral) decision-makers. This article traces the history of the Supreme Court's acceptance of abortion-specific "informed consent" legislation, starting with its decision in *Planned Parenthood v. Casey*.¹¹ The *Casey* opinion characterized women as incapable decision-makers in need of the State's "protection" provided through biased information disguised as "informed consent" legislation.¹² Abortion law's divergence from traditional informed consent law culminated in *Carhart*, which turned established informed consent doctrine on its head by completely denying women's capacity to give consent to treatment. *Carhart*'s stark departure from informed consent law properly understood exposes abortion law's sex discriminatory treatment of women as healthcare decision-makers.

In order to further flesh out the law's approach to medical decision-making, this article next considers how constitutional law treats patient decision-making capacity. In tort law, the rule of informed consent firmly respects a patient's ability to make her own medical decisions, at least in principle.¹³ Although its basic principle of respect for patient autonomy has at times guided the Supreme Court's interpretation of the Due Process Clause as applied to individuals' right to healthcare decision-making, informed consent doctrine primarily governs the physician-patient relationship, not the relationship of the State to the patient.¹⁴ With respect to the State-patient

Planned Parenthood v. Casey and the Future of Sex Discrimination Law, 104 YALE L.J. 1875, (1995); Elizabeth M. Schneider, *The Synergy of Equality and Privacy in Women's Rights*, 2002 U. CHI. LEGAL F. 137; Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992).

11. 505 U.S. 833 (1992). *Casey* upheld the right to abortion, but established a new, less protective test for abortion rights than the strict scrutiny applied in *Roe v. Wade*. See *id.* at 876-77. Under *Casey*, an abortion regulation is invalid if it amounts to an "undue burden." *Id.* at 876-77. A finding of an undue burden "is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877.

12. See *id.* at 882 (discussing need for abortion-specific "informed consent" legislation in order to protect women from psychological harm).

13. There is a rich literature on informed consent law, which includes extensive criticism of the doctrine as applied in clinical practice and by the courts. See, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994). A full discussion of whether informed consent law achieves its goal of furthering patient autonomy in the clinical setting is beyond the scope of this article.

14. See, e.g., *Cruzan v. Director, Missouri Dep't. of Health*, 497 U.S. 261 (1990) (acknowledging common law and constitutional right to refuse medical treatment based in part on law of informed consent). See *infra* Part IV.B.2 (discussing *Cruzan*).

relationship, the picture of patient decision-making is more complex. Although under private law we clearly allocate decision-making power to the patient rather than the physician, under constitutional law—public law—we sometimes allocate decision-making power to the government rather than the patient for the sake of protecting public health.¹⁵ The Supreme Court has permitted government to impose some limits on individuals' healthcare decision-making. These limits act as exceptions to the general rule of patient informed consent. Nevertheless, public health restrictions on patient choice do not undermine the notion that the law generally should respect the decision-making abilities of competent adult patients. Even under precedents that allow government limits on patient choice, the State cannot endanger patient health in order to paternalistically protect patients from unproven risks of psychological harm that may result from their own supposedly poor medical decision-making. Therefore, not only does *Carhart* eviscerate the longstanding principle of respect for patients' decision-making capacity enshrined in the doctrine of informed consent, it also finds no support in precedent related to healthcare decision-making in the field of constitutional law.

In sum, only in the abortion context does the law deny a competent adult's capacity to determine which healthcare choice they will least regret. By denying women's capacity for sound medical decision-making, the Court justifies the government's denial of women's autonomy and excuses the imposition of the State's substitute judgment on pregnant women. In addition, *Carhart*'s characterization of women as incompetent decision-makers may resonate with courts and legislatures since it reflects "ancient notions about women's place in the family and under the Constitution."¹⁶ The woman-protective rationale for restricting abortion has dangerous implications for women's equality and liberty, and not only within abortion law. The *Carhart* Court's inversion of informed consent principles could lead to much more extensive regulation of pregnancy in the larger context of "maternal-fetal conflicts."¹⁷

This article proceeds in three parts. Part II provides a brief overview of "partial-birth" abortion bans in the United States, like that upheld in *Gonzales v. Carhart*. In particular, this review will trace the history of state "partial-birth" abortion bans and the federal "partial-birth" abortion ban, as well as the prior Supreme Court decision, *Stenberg v. Carhart*,¹⁸ which struck down a state "partial-birth" abortion statute. Part II then summarizes the Supreme Court's reversal of course in *Gonzales v. Carhart*.

15. See Jessie B. Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 281–83 (2007) [hereinafter Hill, *A Tale of Two Doctrines*]. Hill describes constitutional law precedents related to medical treatment as falling into two models, an "Autonomy Model" and a "Public Health Model." These models emphasize individual autonomy in decision making or focus on the police power of the state over individual rights, respectively. See *id.* at 294–95. Hill argues that in *Carhart* the Court attempted to justify the federal "partial-birth" abortion ban as a public health type of restriction. See *id.* at 320.

16. *Gonzales v. Carhart*, 550 U.S. 124, 185 (2007) (Ginsburg, J., dissenting).

17. See *infra* Part V. See also Judith Resnik, *Courts and Democracy: The Production and Reproduction of Constitutional Conflict*, THE FOUNDATION FOR LAW, JUSTICE AND SOCIETY 5 (2008) (arguing that *Carhart*'s reasoning could lead to broader government regulation of pregnant women).

18. *Stenberg v. Carhart*, 530 U.S. 914 (2000).

Part III demonstrates that abortion law, although invoking “informed consent” as a reason for abortion restrictions, has diverged far from the law of informed consent. It briefly reviews the development of the tort law doctrine of informed consent in the United States and describes the basic principles underlying informed consent in the healthcare context. Prior to the *Carhart* decision, abortion law had already diverged from the general law of informed consent by doubting women’s equal capacity to make healthcare decisions. Part III traces this shifting analysis of so-called “informed consent” statutes specific to abortion, critically examines *Carhart*’s reasoning regarding women’s capacity to consent to abortion-related medical treatment, and examines the impact of the Court’s validation of the woman-protective anti-abortion claim.

Finally, Part IV argues that contrary to Justice Kennedy’s suggestion, *Carhart*’s woman-protective reasoning finds no support in precedent governing the State’s limited ability to override patient decision-making under the Constitution. In particular, the Supreme Court has permitted the government to mandate vaccination, ban certain controlled substances, restrict access to experimental medications, and ban physician assisted suicide. Yet, the State does not endanger patients’ physical health in any of these healthcare situations based on the State’s unsubstantiated belief that the treatment will be psychologically detrimental to the patient.

This article concludes that the woman-protective rationale adopted in *Carhart* is likely to continue to undermine the equal treatment of women as healthcare decision-makers in the abortion context and beyond.

II. A BRIEF HISTORY OF “PARTIAL-BIRTH” ABORTION BANS

More than one million elective abortions are performed each year in the United States, making it one of the nation’s most common surgical procedures.¹⁹ The vast majority of these abortions occur in the first trimester, with second trimester abortions occurring only in approximately 12% of all abortions.²⁰ Nevertheless, this leaves over 100,000 women per year seeking abortions in the second trimester. Second-trimester procedures “are potentially more morbid because of the increased size of fetal and placental tissue, increased blood volumes and a distended uterus with decreased resistance.”²¹ Furthermore, women seeking second trimester abortions are medically “a very important group, including virtually all patients who have antenatal diagnosis of congenital anomalies, many women with serious illness, and a disproportionate share of very young women.”²² In other words, second trimester abortion patients represent the most vulnerable group of women, including the very sick, the very young and the very poor.²³

19. Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 PERSPECTIVES IN SEXUAL AND REPRODUCTIVE HEALTH 6, 8 (2003).

20. David K. Turok et al., *Second Trimester Termination of Pregnancy: A Review By Site and Procedure Type*, 77 CONTRACEPTION 155, 155 (2008).

21. *Id.*

22. Phillip G. Stubblefield et al., *Methods for Induced Abortion*, 104 OBSTETRICS & GYNECOLOGY (ACOG) 174, 179 (July 2004).

23. See Diana G. Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, 77 CONTRACEPTION 289, 291-93 (2008).

The abortion regulation at issue in *Gonzales v. Carhart* purports to ban a method of second trimester abortion called “partial-birth” abortion by its opponents. “Partial-birth” abortion is not a medical term, but a political one.²⁴ In a 1992 National Abortion Federation meeting, an Ohio physician presented a paper entitled “Dilation and Extraction for Late Second Trimester Abortion,” describing the procedure also known as “partial-birth abortion.”²⁵ Anti-abortion groups obtained information about the procedure, invented the term “partial-birth” abortion and took their plan of action to the states.²⁶ Since 1995, thirty-one states have enacted “partial-birth” abortion bans,²⁷ not including new bans proposed in several states since the *Carhart* decision.²⁸

The safest and most commonly used procedure for terminating a pregnancy in the second-trimester is Dilation and Evacuation (“D&E”).²⁹ In a D&E procedure, the physician dilates the cervix and evacuates the fetus and placenta using forceps.³⁰ Physicians may also choose to use a variation of the D&E procedure, which is known as “intact” D&E.³¹ In an intact D&E procedure, the physician dilates the cervix and evacuates the fetus, but accomplishes the evacuation with the fetus largely intact.³² Proponents of “partial-birth” abortion bans argue that the term “partial-birth” abortion only applies to the intact D&E procedure, and not to the more commonly used non-intact version of D&E. Proponents of these bans also claim that the intact D&E method is never medically necessary.³³ However, physicians experienced in second trimester abortion procedures have consistently stated that the intact version of D&E is

24. Cynthia Gorney, *Gambling with Abortion: Why Both Sides Think They Have Everything to Lose*, HARPER'S MAG., Nov. 2004 at 33–34.

25. *Id.* at 34, 38.

26. *See id.* at 38 (describing the strategically deceptive language created by anti-choice advocates to advance so-called “partial-birth” abortion bans).

27. *See* Guttmacher Institute, State Policies in Brief, *Bans on “Partial-Birth” Abortion*, August 1, 2008.

28. *See id.* As of April 2009, the following 31 states have enacted bans on “partial-birth” abortion since *Carhart*: Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin. *See* http://www.guttmacher.org/statecenter/spibs/spib_BPBA.pdf.

29. Stephen T. Chasen et al., *Dilation and Evacuation at ≥ 20 Weeks: Comparison of Operative Techniques*, 190 AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY 1180, 1180 (2004) (“Dilation and evacuation is the most common method used for second trimester abortion and is considered the safest abortion technique in the second trimester.”).

30. Stubblefield, *supra* note 22, at 179. *See also* *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 852–99 (D. Neb. 2004), *aff'd sub nom Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev'd*, 550 U.S. 124 (2007) (district court findings of fact describing doctor’s testimony regarding abortion procedures).

31. *Gonzales v. Carhart* held that the federal abortion ban criminalizes the intentional use of only one method of second-trimester abortion, “intact D&E,” but the medical literature labels this same procedure with various names: “intact D&E,” “intact D&X,” or “D&X.” *See* *Gonzales v. Carhart*, 550 U.S. 124, 136–37 (2007). This paper will refer to the procedure as “intact D&E.”

32. *See* Stubblefield, *supra* note 22; *Stenberg v. Carhart*, 530 U.S. 914, 925–28 (2000) (describing various abortion procedures).

33. *See* *Stenberg*, 530 U.S. at 931–32 (summarizing Nebraska’s argument that intact D&E is never medically necessary).

safer for some patients.³⁴ Nevertheless, in 2003 Congress enacted the first federal abortion regulation, a ban on “partial-birth” abortion which did not contain an exception to protect women’s health.

The federal ban defines “partial-birth” abortion as follows:

[T]he term “partial-birth abortion” means an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus³⁵

The statute subjects physicians who violate the ban to criminal punishment, including imprisonment for up to two years, and to civil liability.³⁶ In addition to the federal ban, a number of states have enacted their own “partial-birth” abortion bans, each of which may define the term differently.³⁷ Whether the federal ban and various state bans will in fact apply only to the “intact” D&E method of abortion is a matter of ongoing contention.³⁸

Before *Gonzales v. Carhart*, in *Stenberg v. Carhart*,³⁹ a bare 5-4 majority of the Supreme Court struck down Nebraska’s ban on “partial-birth” abortion.⁴⁰ The Court concluded that the ban violated a woman’s constitutional right to seek an abortion for two separate reasons. First, the Nebraska law lacked any exception for cases when the procedure was needed to preserve the woman’s health.⁴¹ Second, the ban amounted to an undue burden on the right to seek pre-viability abortions because the law as written was so vague it could be applied to ban non-intact D&E, the most commonly used method of second-trimester abortion.⁴²

34. See *Carhart*, 331 F. Supp. 2d at 1012–27 (summarizing testimony of physicians and district court findings of fact that intact D&E is medically necessary for some women). See also *Planned Parenthood v. Ashcroft*, 320 F. Supp. 2d 957, 1032–35 (N.D. Cal. 2004); *Nat’l Abortion Fed’n v. Ashcroft*, 330 F. Supp. 2d 436, 480–82 (S.D.N.Y. 2004).

35. 18 U.S.C. § 1531(b)(1)(A) (2003).

36. 18 U.S.C. § 1531(a) (2003).

37. See Nancy Kubasek & Daniel Tagliarina, *Failed Lessons of History: The Predictable Shortcomings of the Partial-Birth Abortion Ban Act*, 6 U. MD. L. J. RACE, RELIGION, GENDER & CLASS 159, 163–96 (2006). See also *Richmond Med. Ctr. v. Herring*, 527 F.3d 128 (4th Cir. 2008), *rev’d*, 2009 WL 1783515 (4th Cir. 2009) (en banc) (striking down Virginia’s “partial-birth” abortion ban because worded sufficiently differently than federal ban such that it violated Due Process).

38. Because of the ways in which statutes are worded, these laws could apply to physicians performing non-intact D&E procedures as well. See *Planned Parenthood Fed’n of Am. v. Gonzales*, 435 F.3d 1163, 1181–82 (9th Cir. 2006), *rev’d*, 550 U.S. 124 (2007) (holding that the federal “partial-birth” abortion ban was unconstitutionally vague because it did not clearly define the prohibited medical procedures, therefore, physicians were deprived of fair notice and enforcement would be arbitrary).

39. 530 U.S. 914 (2000).

40. *Id.*

41. *Id.* at 938.

42. *Id.* at 941–46. Similarly to *Stenberg*, and prior to the *Carhart* decision, lower federal courts had struck down state “partial-birth” abortion bans for three reasons: (1) violation of women’s right to privacy because the ban constituted an “undue burden” on the woman’s right to choose abortion pre-viability; (2) vagueness in the language of the statute; and (3) the failure to include a health

In reaction to *Stenberg*, anti-abortion groups sought to have the U.S. Congress pass a federal “partial-birth” abortion ban, but President Clinton twice vetoed proposed legislation.⁴³ Subsequent Congresses considered similar bans, until finally on November 5, 2003, George W. Bush signed the Partial-Birth Abortion Ban Act of 2003 (“the Act”).⁴⁴ The Act was immediately challenged in three federal courts. All six courts that reviewed the Act—three district courts and three appellate courts—found the Act unconstitutional.⁴⁵

Despite the lack of a circuit split, the Supreme Court granted review of decisions from both the Eighth and Ninth Circuits. Previously in *Stenberg*, Justice O’Connor had provided the crucial fifth vote to strike down Nebraska’s “partial-birth” abortion ban,⁴⁶ but given the changed composition of the Court commentators speculated that the new conservative majority would overrule *Stenberg* outright.⁴⁷ In fact, the *Carhart* Court took the approach of surreptitiously overruling precedent.⁴⁸ The majority opinion claimed to uphold *Stenberg* by distinguishing the terms of the statutes at issue in the two cases, but instead gutted *Stenberg*’s main principles as well as reversed longstanding precedent requiring a health exception in abortion regulations.⁴⁹

exception. An abortion regulation is unconstitutional if it amounts to an “undue burden,” which *Planned Parenthood of Southeastern Pa. v. Casey* defined as a “substantial obstacle” placed in the path of the woman seeking an abortion. See *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 869 (1992). Some “partial-birth” abortion bans were also overturned because of unconstitutional spousal consent or parental consent requirements. See Kubasek & Tagliarina, *supra* note 37, at 159–65 (noting that eighteen of these statutes had been challenged in court, seventeen had been overturned and finding four general reasons why state “partial-birth” abortion bans were struck down: “(1) vagueness in the language of the statute; (2) a specific reference to a violation of a woman’s right to privacy due to a consent provision; (3) a more general violation of a woman’s right to privacy by placing an undue burden on the woman by making it more difficult to obtain safe abortions; and (4) failing to include an exception to protect the mother’s health or her life.”).

43. Kubasek & Tagliarina, *supra* note 37, at 186–88.

44. See 18 U.S.C. § 1531 (2003).

45. See *Carhart v. Gonzales*, 413 F.3d 791, 803 (8th Cir. 2005), *rev’d*, 550 U.S. 124 (2007); *Planned Parenthood Fed’n of Am. v. Gonzales*, 435 F.3d 1163, 1175–76 (9th Cir. 2006); *Nat’l Abortion Fed’n v. Gonzales*, 437 F.3d 278, 285 (2d Cir. 2006); *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1024–27 (D. Neb. 2004); *Nat’l Abortion Fed’n v. Ashcroft*, 330 F. Supp. 2d 436, 480–82 (S.D.N.Y. 2004); *Planned Parenthood Fed’n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1000–02 (N.D. Cal. 2004). The Second and Eighth Circuits struck down the Act solely on the ground that it did not contain a health exception. *Nat’l Abortion Fed’n v. Gonzales*, 437 F.3d 278, 290 (2d Cir. 2006); *Carhart*, 413 F.3d at 803–04. The Eighth Circuit concluded that *Stenberg* requires a health exception whenever “substantial medical authority” supports the medical necessity of a banned procedure, and found that such authority existed with respect to intact D&E. *Carhart*, 413 F.3d at 796. The Ninth Circuit similarly struck down the Act, but on three separate grounds: (1) the Act places an undue burden on women’s ability to obtain pre-viability abortions; (2) the Act is unconstitutionally vague; and (3) the Act fails to include a health exception. *Planned Parenthood Fed’n of Am. v. Gonzales*, 435 F.3d 1163, 1171–72 (9th Cir. 2006).

46. *Stenberg*, 530 U.S. 914, 947–49 (2000) (O’Connor, J., concurring).

47. See Michael C. Dorf, *Nineteenth Annual Supreme Court Review: Abortion Rights*, 23 *TOURO L. REV.* 815, 820–21 (2008) (discussing speculation that the Court would overrule *Stenberg*).

48. *Id.* (arguing that *Carhart* claimed to merely distinguish *Stenberg* although in fact it contradicted prior holdings); David Franklin, *Looking Through Both Ends of the Telescope: Facial Challenges and the Roberts Court*, 36 *HASTINGS CONST. L.Q.* 689 (2009) (arguing that *Carhart* is impossible to reconcile with *Stenberg*).

49. See Maya Manian, *Rights, Remedies and Facial Challenges*, 36 *HAST. CON. L.Q.* 611 (2009).

In the 5-4 decision written by Justice Kennedy, *Carhart* upheld the constitutionality of the Act. The Court concluded that the Act does not restrict first-trimester abortions.⁵⁰ The Court also decided that the Act does not prohibit what Justice Kennedy termed a “standard” D&E, but only prohibits intact D&E.⁵¹

In upholding the Act, the Court rejected three constitutional claims put forth by the physicians challenging its provisions. First, the physicians argued that the Act places an undue burden on women’s right to choose abortion pre-viability because its operative language is so vague that it also bans non-intact D&E, the safest and most commonly used method of second-trimester abortion.⁵² With respect to the undue burden argument, the Court interpreted the Act to apply only when a physician “intends” to perform an intact D&E. The plaintiff physicians had presented evidence that any D&E has the potential to violate the Act, because doctors cannot predict beforehand how much the cervix will dilate. Either variation of the D&E requires that physicians dilate the cervix in order to evacuate the fetus and placenta. If the cervix dilates to a sufficient degree, the fetus may inadvertently be removed intact and thus subject physicians to criminal punishment under the Act. Although the Court acknowledged that a D&E procedure could “accidentally” result in the removal of an intact fetus,⁵³ the Court opined that the Act’s intent requirement would “preclude liability from attaching to an accidental intact D&E.”⁵⁴ The Court also claimed that “an intact delivery is almost always a conscious choice rather than a happenstance,” because physicians may alter the techniques of the procedure in a manner that decreases the likelihood of an intact D&E.⁵⁵

Second, the Court rejected the physicians’ claim that the Act is unconstitutionally vague because it imposes criminal liability without providing sufficient notice to physicians of what procedures are banned and encourages arbitrary and discriminatory enforcement.⁵⁶ The Court concluded that the “anatomical landmarks” laid out in the Act, plus the requirement of an “overt

50. *Gonzales v. Carhart*, 550 U.S. 124, 128 (2007).

51. *Id.* The Court attempted to differentiate between “standard” D&E and “intact” D&E as defined in the Act. However, the implications of the Act’s precise restrictions for pregnant women seeking abortions in the second-trimester are far from clear. *See* ACLU Memo (unprivileged), *Provider Compliance With The Federal Abortion Ban*, 18 U.S.C. § 1531, April 19, 2007 (on file with author).

52. *Carhart*, 550 U.S. at 150–51.

53. *Id.* at 155 (“A fetus is only delivered largely intact in a small fraction of the overall number of D&E abortions.” (citing *Planned Parenthood v. Ashcroft*, 320 F. Supp. 2d 957, 965 (N.D. Cal. 2004))).

54. *Id.*

55. *See id.* at 155–56 (“Doctors, for example, may remove the fetus in a manner that will increase the chances of an intact delivery. . . . And intact D&E is usually described as involving some manner of serial dilation Doctors who do not seek to obtain this serial dilation perform an intact D&E on far fewer occasions.”). This statement may not be medically accurate. *See* Tracy A. Weitz & Susan Yanow, *Implications of the Federal Abortion Ban for Women’s Health in the United States*, 16 REPRODUCTIVE HEALTH MATTERS 99, 103 (2008) (noting that medical experts have stated that adequate dilation is “a critical factor in the safety of any D&E” and the Court’s emphasis on dilation as proof of intent “may lead some providers not to dilate adequately for fear of appearing to induce an intact D&E”).

56. *Carhart*, 550 U.S. at 148–50.

act” killing the fetus after delivery to an anatomical landmark, made sufficiently clear to physicians the conduct banned by the Act.⁵⁷ However, as the evidence admittedly showed, the non-intact D&E procedure could result in a fetus being accidentally delivered to the anatomical landmark. Again, the Court emphasized that the “scienter requirement” alleviated vagueness concerns, because “[i]f a living fetus is delivered past the critical point by accident or inadvertence, the Act is inapplicable.”⁵⁸

Third and most striking, the Court rejected the argument that the Act fails constitutional scrutiny because it lacks a health exception. Previously, in *Planned Parenthood v. Casey*, the Court had reaffirmed *Roe v. Wade*'s⁵⁹ holding that abortion regulations must have an exception to protect women's health, even after viability.⁶⁰ In *Stenberg*, the Court reaffirmed the requirement for a health exception whenever “substantial medical authority” supports the medical necessity of the banned procedure.⁶¹ Thus, even where there is a lack of consensus in the medical community, *Stenberg* mandated that legislatures err on the side of protecting women's health.⁶² *Carhart* found exactly the opposite, holding that legislatures could choose to err on the side of risking women's health: “Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends.”⁶³ The physicians challenging the Act had presented substantial evidence, accepted by six different federal courts, that the intact D&E procedure is medically necessary in some cases, especially for women with certain medical conditions.⁶⁴ Although the Act permits physicians to perform an intact D&E if the physician first causes fetal demise, the evidence also showed that the methods for causing fetal demise presented health risks to patients.⁶⁵ The majority in *Carhart* acknowledged that the requirements of the Act may in fact endanger women's health, but nevertheless concluded that legislatures could impose those risks on women.⁶⁶

In discussing the health exception, the Court also suggested that it would not be as amenable to facial challenges to abortion regulations—the typical manner of challenging abortion restrictions.⁶⁷ Instead, the Court held that physicians must seek individual exemptions using as-applied challenges in order to obtain health exceptions for patients burdened by the Act.⁶⁸

57. See *id.* at 147–48 (identifying the “anatomical landmarks” as the points when “either the fetal head or the fetal trunk past the navel is outside the body of the mother”).

58. *Id.* at 148. The Court dismissed the physicians' argument that the Act would encourage arbitrary and discriminatory enforcement. *Id.*

59. 410 U.S. 113 (1973).

60. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 879 (1992).

61. *Stenberg v. Carhart*, 530 U.S. 914, 937–38 (2000).

62. *Id.*

63. *Carhart*, 530 U.S. at 166.

64. See *id.* at 176–78 (Ginsburg, J., dissenting) (summarizing district court findings of fact).

65. *Id.*

66. *Id.* at 164.

67. *Id.* at 167–68 (stating that the as-applied challenge in a discrete case “is the proper manner to protect the health of the woman”).

68. *Id.* at 168. See also Caitlin Borgmann, *Holding Legislatures Constitutionally Accountable Through Facial Challenges*, 36 HAST. CON. L.Q. 563 (2009) (arguing that *Carhart*'s promise of future as-applied

In a sharply worded dissent, Justice Ginsburg condemned the Court's retreat from protecting women's health. She emphasized that the Court's precedents had always mandated exceptions to abortion restrictions for women's health "at any stage of pregnancy."⁶⁹ She further noted that *Stenberg* had expressly rejected a ban on intact D&E due to its lack of a health exception.⁷⁰ Criticizing Congress' inaccurate findings of fact, Ginsburg reviewed in detail the factual findings of three district courts that "the safety advantages of intact D&E are marked for women with certain medical conditions . . ."⁷¹ Ginsburg found the Court's claim that the Act can survive in the face of medical uncertainty "bewildering"⁷² and repeatedly stressed that the Court "def[ie]d [its] longstanding precedent affirming the necessity of a health exception, with no carve-out for circumstances of medical uncertainty."⁷³

Moreover, Ginsburg argued that the Court's justifications for upholding the Act were "flimsy and transparent," since "the law saves not a single fetus from destruction, for it targets only a *method* of performing abortion . . . and surely the statute was not designed to protect the lives or health of pregnant women."⁷⁴ In this regard, Ginsburg remarked on the peculiarities of the Court's rhetoric throughout the opinion: "[T]he opinion refers to obstetrician-gynecologists and surgeons who perform abortions not by the titles of their medical specialties, but by the pejorative label 'abortion doctor' A fetus is described as an 'unborn child' and as a 'baby'; second-trimester, pre-viability abortions are referred to as 'late-term'; and the reasoned medical judgments of highly trained doctors are dismissed as 'preferences' motivated by 'mere convenience.'"⁷⁵ Ultimately, Ginsburg concluded that the Act is "irrational" since it does not further any legitimate government interest. She asserted that the Act's true purpose, as well as the purpose of the Court's defense of the Act, was to "chip away at a right declared again and again by this Court—and with increasing comprehension of its centrality to women's lives."⁷⁶

challenges to protect women's health is illusory); Manian, *supra* note 49, at 618–23 (discussing implications of *Carhart*'s dismissal of facial challenges in the abortion context).

69. *Carhart*, 550 U.S. at 172 (Ginsburg, J., dissenting).

70. *Id.*

71. *Id.* at 177 (citing *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 923–28, 1025 (D. Neb. 2004); *Planned Parenthood v. Ashcroft*, 320 F. Supp. 2d 957, 982, 1001 (N.D. Cal. 2004); *Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp. 2d 436, 471 (S.D.N.Y. 2004)).

72. *Id.*

73. *Id.* at 179. Ginsburg also noted that alternatives to intact D&E, such as an injection to kill the fetus prior to performing the banned procedure or medical induction of labor, is "considered less safe for many women, and impermissible for others" by medical experts. *Id.* at 180 n.6.

74. *Id.* at 181 (emphasis in original).

75. *Id.* at 186–87.

76. *Id.* at 191. Ginsburg also criticized the Court's holding as to whether and when facial challenges are permitted to abortion restrictions: "It makes no sense to conclude that this facial challenge fails because respondents have not shown that a health exception is necessary for a large fraction of second-trimester abortions, including those for which a health exception is necessary: the very purpose of a health *exception* is to protect women in *exceptional* cases." *Id.* at 189.

III. THE PHYSICIAN & PATIENT: INFORMED CONSENT, AUTONOMY & ABORTION LAW

Informed consent law establishes the legal rules regarding patient medical decision-making, and therefore provides a useful lens through which to critique abortion law's treatment of women as healthcare decision-makers. By now a well-established principle in healthcare law, the common law rule of informed consent rejects a paternalistic model of patient decision-making in which the physician makes treatment decisions for the patient and instead embodies a model recognizing that competent adult patients have the capacity to make their own medical treatment decisions. The Supreme Court has at times relied on the private law doctrine of informed consent as a guide in interpreting patients' rights related to medical treatment under the Due Process Clause.⁷⁷ If we applied this same model of patient decision-making to abortion law, we would see some very different results. This section sets forth the basic principles underlying the law of informed consent in the physician-patient relationship. It then compares "informed consent" terminology as used in abortion law. This comparison exposes abortion law's treatment of women as less capable decision-makers than other patients.

A. Informed Consent in the Healthcare Context

An extensive literature has developed on informed consent law.⁷⁸ This section provides a brief sketch of the rules and debates surrounding the law of informed consent. It emphasizes informed consent's underlying principle of respect for patient autonomy, which is of special relevance to the question of the law's treatment of patient capacity for medical decision-making.

Informed consent doctrine was originally established through the common law, and has since been codified in all states. Commentators attribute the first definitive statement of the concept of the informed consent doctrine to Justice Cardozo's oft-quoted pronouncement in *Schloendorff v. Society of New York Hospitals*: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits assault."⁷⁹ The subsequent development of informed consent doctrine has largely reflected the *Schloendorff* court's concern with a patient's right to bodily integrity and self-determination in medical treatment.⁸⁰

77. See, e.g., *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) (relying on informed consent law in acknowledging a substantive due process right to refuse medical treatment).

78. See, e.g., Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 437-45 (2006). See also Dayna Bowen Matthew, *Race, Religion, and Informed Consent—Lessons from Social Science*, 36 J.L. MED. & ETHICS 150, 154 (Spring 2008).

79. 105 N.E. 92, 93 (1914).

80. See Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 420 (stating that the "purpose of requiring the patient's consent to treatment is to protect his physical and psychic integrity against unwanted invasions, and to permit the patient to act as an autonomous, self-determining human being" (rationale articulated in *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906))) [hereinafter Meisel, *The "Exceptions" to the Informed Consent Doctrine*].

The term “informed consent” was later used for the first time in the watershed case of *Salgo v. Leland Stanford Jr. University Board of Trustees*.⁸¹ *Salgo* discussed the obligation of physicians to disclose “any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”⁸² The *Salgo* court opined that rigid rules regarding the specific content of the disclosure would not be appropriate, recognizing:

[T]hat each patient presents a separate problem, that the patient’s mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.⁸³

In many ways, informed consent law today generally still follows *Salgo*’s vision.

The early case law permitting recovery for failure to obtain informed consent sounded in battery. When the physician performed a procedure without obtaining the patient’s consent, either because the physician misled the patient about the nature of the procedure or because the physician exceeded the bounds of the consent obtained, courts treated the physician’s actions as nonconsensual contact amounting to a battery.⁸⁴ For example, in *Mohr v. Williams*,⁸⁵ the patient brought a claim for battery on the ground that the physician operated on her left ear when she had only consented to an operation on her right ear.⁸⁶ The court noted that the operation was performed without negligence, but nevertheless held that a claim for battery could lie merely upon proof that the operation was performed without the patient’s consent.⁸⁷ *Mohr* emphasized the value of bodily integrity in allowing liability without proof of bad intent or negligence:

It cannot be doubted that the patient must be consulted, and his consent given, before a physician may operate upon him Under a free government, the free citizen’s first and greatest right, which underlies all others—the right to the inviolability of his person; in other words, the right to himself—is the subject of universal acquiescence. . . .⁸⁸

The court’s recognition that medical treatment without consent constituted a battery “was a critical step in establishing patients’ unequivocal right to

81. 154 Cal. App. 2d 560, 578 (Cal. Ct. App. 1957). See also Matthew, *supra* note 78, at 154.

82. *Salgo*, 154 Cal. App. 2d at 578.

83. *Id.* *Salgo*’s rejection of rigid rules of disclosure stands in sharp contrast to today’s abortion “informed consent” legislation. See *infra* Part III.C.

84. See, e.g., *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (stating that the wrong complained of is “not merely negligence,” but trespass of the body); *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905) (holding that physician was liable for battery because consent to an operation on the patient’s right ear did not authorize surgery on the left ear); *Cobbs v. Grant*, 502 P.2d 1, 7 (Cal. 1972) (“Where a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery.”). See also Note, *Abortion Regulation: The Circumscription of State Intervention by the Doctrine of Informed Consent*, 15 GA. L. REV. 681, 694 (1980–1981) [hereinafter Note, *Abortion Regulation*].

85. 104 N.W. 12 (Minn. 1905).

86. *Id.* at 13.

87. *Id.* at 15–16.

88. *Id.* at 14 (internal quotations omitted).

control access to their bodies."⁸⁹ The Supreme Court later relied on informed consent law's emphasis on protecting bodily integrity to recognize a patient's constitutional right to refuse medical treatment under the Due Process Clause.⁹⁰

Despite the common law requirement of consent to treatment, physicians could easily evade a battery claim with a generic consent form that in practice provided patients little opportunity for meaningful consent.⁹¹ Courts and commentators later concluded that patients who are unaware of the risks, benefits and alternatives to a particular treatment cannot effectively render their consent to treatment.⁹² Consent to medical treatment means more than mere consent to bodily contact; it means respect for patient capacity for self-determination given accurate, unbiased information. Thus, the notion of informed consent also encompasses a duty of the physician to make adequate disclosures to the patient. Courts have considered failure to provide sufficient information a breach of the physician's duty to meet the appropriate standard of care.⁹³ Hence, informed consent malpractice actions based on lack of adequate disclosures have sounded in negligence theory rather than battery.

The leading case on the negligence theory of informed consent, *Natanson v. Kline*,⁹⁴ explained that "the relation between the physician and his patient is a fiduciary one, and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness."⁹⁵ The court noted that the physician may be acting "in relatively good faith for the benefit of the patient" but nevertheless is liable for failure to disclose.⁹⁶ *Natanson* affirmed that the corollary principle to protection of a patient's bodily integrity is protection of a patient's right of decision-making. In particular, *Natanson* emphasized that "a doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception."⁹⁷ Other jurisdictions followed *Natanson*, expanding liability for failure to obtain a patient's consent from a battery to a negligence theory based on a lack of full disclosure and broadly establishing a patient's right to self-determination.⁹⁸

89. Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 465 (2000).

90. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990) (discussed *infra* Part IV.B.2). Furthermore, both the private law and constitutional right to refuse medical treatment are at issue in cases involving forced treatment of pregnant women. See *infra* Part V.

91. See Oberman, *supra* note 89, at 465 (describing reasons for the move from battery claims to negligence claims for lack of informed consent).

92. See *id.* at 465 n.57 (citing decisions giving rise to a patient's right informed consent to treatment).

93. See *id.* at 465; Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 77–81 (1994).

94. 350 P.2d 1093 (Kan. 1960).

95. *Id.* at 1101–02.

96. *Id.* at 1100.

97. *Id.* at 1104.

98. See, e.g., *Mitchell v. Robinson*, 334 S.W. 2d 11 (Mo. 1960) (holding that "doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards" of shock therapy and insulin treatment for mental illness and that they could be liable in negligence for failure to inform). While there is still ongoing debate on whether and when informed consent claims should sound in battery as opposed to negligence, the general trend has

The development of informed consent common law continued in *Canterbury v. Spence*,⁹⁹ one of the leading cases articulating the parameters of informed consent law.¹⁰⁰ There, the court explored the “first principles” of the doctrine in detail and placed great emphasis on respect for patient decision-making capacity.¹⁰¹ *Canterbury* notably declared: “To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.”¹⁰² The court reasoned that informed consent liability should rest on a patient-based standard of disclosure, because “[r]espect for the patient’s right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.”¹⁰³ Furthermore, *Canterbury* held that

been to treat cases of failure to disclose as an issue of negligence. See *Rubino v. DeFretias*, 638 F. Supp. 182, 185 (D. Ariz. 1986) (discussing the distinction between an informed consent claim sounding in battery versus negligence); *Logan v. Greenwich Hosp. Assoc.* 465 A.2d 294, 298–99 (Conn. 1983) (explaining the difference between battery theories and negligence theories of informed consent); *Cobbs v. Grant*, 502 P.2d 1, 8 (Cal. 1972) (discussing cases and scholarship on debate between battery and negligence theories of informed consent and noting that “the trend appears to be towards categorizing failure to obtain informed consent as negligence” while reserving the battery theory “for those circumstances when a doctor performs an operation to which the patient has not consented”); *Wilkinson v. Vesey*, 295 A.2d 676, 685–86 (R.I. 1972) (noting that there “is no unanimity as to the theory of recovery” for failure of a physician to adequately disclose but the “prevailing view” is to apply a negligence as opposed to a battery frame). See also RESTATEMENT (SECOND), TORTS § 892B, cmt. i (1979) (noting that failure to make a sufficient disclosure is regarded by most courts as presenting the question, not whether there was such a lack of consent as to amount to a battery, but whether the physician had fulfilled his duty of care by informing the patient under the appropriate standard).

99. 464 F.2d 772, 781 (D.C. Cir. 1972). The negligence theory generated an ongoing debate in informed consent law regarding the appropriate scope of physician disclosure necessary to avoid liability. *Natanson* held that whether the physician provided full disclosure should be judged on a physician-based standard, stating that the “duty of the physician to disclose. . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.” *Natanson*, 350 P.2d at 1106. The court opined that how the duty of disclosure may best be discharged to any particular patient “involves primarily a question of medical judgment” and therefore should be left to the medical profession. *Id.* Later cases rejected this approach as insufficient for protecting patient autonomy and instead adopted a patient-based standard. *Canterbury* is the leading case on the patient-based approach. See *Canterbury*, 464 F.2d at 784. A minority of U.S. jurisdictions follow *Canterbury*’s patient-centered perspective. See *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (adopting patient-based approach to informed consent and stating: “Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected”); See also *Wilkinson v. Vesey*, 295 A.2d 676, 687 (R.I. 1972) (“Since the patient’s right to make his decision in light of his own individual value judgment is the very essence of his freedom of choice . . . it should not be left entirely to the medical profession to determine what the patient should be told.”). A slight majority of states have adopted the physician-based approach to informed consent, as articulated in *Natanson*. See *Matthew*, *supra* note 78, at 152. See also *Natanson v. Klein*, 350 P.2d 1093 (Kan. 1960).

100. *Canterbury*, 464 F.2d. at 781.

101. *Id.*

102. *Id.*

103. *Id.* at 784. “Any definition of scope in terms purely of a professional standard is at odds with the patient’s prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient’s right to know and the physician’s

the disclosure must include unbiased information on all “material” risks, defining material risk as when “a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk in deciding whether or not to forego the proposed therapy.”¹⁰⁴

Legal liability for failure to provide information necessary to informed consent ultimately hinges on proof that the patient would have decided upon a different course of treatment or no treatment at all had there been full disclosure. Most significantly, informed consent law compels the disclosure only of accurate medical information consistent with the expert knowledge of the medical community.¹⁰⁵ Although debate continues as to the appropriate standards for determining the scope of information to be provided to patients, the law of informed consent consistently “reflects the notion of patient control and self-determination.”¹⁰⁶

A corollary to the right of informed consent is the patient’s right to refuse medical treatment. In fact, the term informed “consent” is a bit misleading, because patients have the right not only to make the ultimate decision whether to accept treatment (consent), but also to refuse treatment entirely.¹⁰⁷ Under the common law, the right to refuse medical treatment grew out of the doctrines of trespass and battery, which were applied to unauthorized contact by a physician.¹⁰⁸ Thus, just as courts applied a claim of battery where physicians failed to obtain consent to a procedure or performed a different procedure than the one to which the patient consented, forced medical treatment amounted to a battery. Courts eventually recognized a claim of battery for forced medical treatment even in cases where the patient refused life-saving medical treatment. As one court stated, “[there is] a well-established rule of general law . . . that it is the patient, not the physician, who ultimately decides if treatment—any

correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.” *Id.* at 786.

104. *Id.* at 787. Courts have also held that physicians must disclose “personal interests unrelated to the patient’s health” that may affect their medical judgment, such as financial and research interests in the patient’s treatment. See *Moore v. Regents of the University of California*, 793 P.2d 479 (Cal. 1990).

105. See Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 969–70 (2007).

106. Matthew, *supra* note 78, at 156; Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 347 (1974) (stating that *Natanson v. Kline* and its progeny “carried the law beyond merely giving body to ‘the wish on the part of the individual to be his own master . . . to be a subject, not an object,’ to include the rational processes involved in the desire”); Oberman, *supra* note 89, at 465 (stating that the law on “the right to make an informed consent establishes with utter certainty the principle that doctors may not impose medical treatment upon their patients, even if they believe such treatment to be in the patient’s best interests, unless and until the patient permits the doctor to do so”).

107. *Natanson v. Kline* discussed the importance of the right to informed refusal of treatment: “Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment.” *Natanson v. Klein*, 350 P.2d 1093, 1104 (Kan. 1960).

108. See *Mills v. Rogers*, 457 U.S. 291, 294 n.4 (1982) (stating that “the right to refuse any medical treatment emerged from the doctrines of trespass and battery, which were applied to unauthorized touchings by a physician”).

treatment—is to be given at all The rule has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it.”¹⁰⁹

In sum, battery cases focus on the patient’s consent to the specific treatment or right to refuse treatment in order to respect the patient’s bodily integrity, while negligence cases focus on the physician’s duty to inform in order to respect the patient’s right to make his or her own healthcare decisions. These twin values of bodily integrity and self-determination reflect the key underlying principle of informed consent doctrine: respect for patient autonomy.¹¹⁰ Although a number of different rationales have been proposed in support of informed consent rules, informed consent law primarily serves to “protect patient dignity and autonomy.”¹¹¹ As Peter Schuck argues,

The most fundamental normative argument in favor of requiring health care providers to obtain patients’ informed consent to medical treatments proceeds from the principle of autonomy—the notion that each mature individual has a right to make the basic choices that affect her life prospects.¹¹²

Numerous scholars have noted that the doctrine operates primarily to respect the capacity of competent adults to make autonomous decisions.¹¹³

109. *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 (D.D.C. 1985). *See also Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974) (“The rationale of this rule lies in the fact that every competent adult has the right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be to others.”).

110. *See King & Moulton, supra* note 78, at 437 (stating that informed consent “was originally derived from the ethical principle of personal autonomy and its subsets: self-determination and bodily integrity”); Note, *The Abortion Alternative and the Patient’s Right to Know*, WASH. U.L.Q. 167, 175 (1978) (“The modern doctrine of ‘informed consent’ . . . is a merger of two fundamental principles of Anglo-American jurisprudence: the fiduciary relationship of the doctor to his patient and the basic right of self-determination articulated in the early consent cases.”). *See also* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 120–181 (4th ed. 1994) (describing importance of autonomy principle in legal and ethical rules of informed consent).

111. *Matthew, supra* note 78, at 152–53. Matthew argues that informed consent law should also reflect the ethical principles of beneficence and non-maleficence, and not simply patient autonomy.

112. Schuck, *supra* note 13, at 924. *See also* Matthew, *supra* note 78, at 155 (demonstrating that the principal justification of informed consent has shifted from a reflection of the three ethical principles of physician beneficence, non-maleficence, and autonomy, to a sole emphasis on autonomy).

113. *See, e.g., Alan Meisel et al., Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285, 286 (1977) (“The doctrine of informed consent both reflects and enforces the ancient concern of Anglo-American law with the individual’s right to be free from the conduct of others that affronts bodily integrity, privacy, and individual autonomy.”) [hereinafter Meisel, *Toward a Model*]; Post, *supra* note 105, at 969–70 (noting that basic purpose of informed consent doctrine is to respect patient’s right to choose her treatment and to ensure that patient obtains necessary information from the physician in order to do so). Case law has also emphasized that informed consent protects patient autonomy both by preserving patients’ bodily integrity and by respecting patients’ capacity for decision-making. *See, e.g., Arato v. Avedon*, 858 P.2d 598, 605–06 (Cal. 1993) (describing informed consent doctrine as “the legal recognition of the medical patient’s protectable interest in autonomous decision-making”); *Truman v. Thomas*, 611 P.2d 902, 906 (Cal. 1980) (stating that the “duty to disclose was imposed . . . so that patients might meaningfully exercise their right to make decisions about their own bodies.”); *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (“The weighing of these [medical] risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.”). Similarly, a government study concluded that the ethical notion of informed consent “rests on three closely interrelated elements”: (1) capacity to make decisions about their care; (2) voluntary participation in

Although there continues to be much debate about whether informed consent functions to its ideal in clinical practice,¹¹⁴ in principle at least, informed consent law reinforces the notion that competent adults have the capacity to make their own healthcare decisions.¹¹⁵ There are some limited exceptions to the doctrine of informed consent; however, none of these exceptions undermine the fundamental principle that the law should protect competent adult patients' decision-making authority.¹¹⁶ Informed consent law "does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs," because "that attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself."¹¹⁷

The twin values of bodily integrity and self-determination, protected by informed consent, also underlie the "right to privacy" line of cases that support

these decisions; (3) adequate, appropriate information to make the decisions. See THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH REPORT (1982).

114. See, e.g., Matthew, *supra* note 78, at 150–51 (describing critiques of informed consent law).

115. The American Medical Association's Code of Ethics reflects and reinforces the legal doctrine. *American Medical Association, Medical Code of Ethics*, 2006, <http://www.ama-assn.org/ama/pub/category/2512.html>.

116. There are four exceptions to the doctrine of informed consent: (1) emergencies; (2) incompetent patients (mentally disabled and minors); (3) patient waiver; and (4) therapeutic privilege. Meisel, *The "Exceptions" to the Informed Consent Doctrine*, *supra* note 80, at 433 (discussing all four exceptions). The emergency exception and incompetency exception are closely related, as "emergency" situations often involve cases in which the patient is unable to give consent. *Id.* at 438–39. Thus, neither involves competent adult patients. The waiver exception "is completely in keeping with the values sought to be promoted by informed consent," since it respects the patient as ultimate decision-maker even if the decision is to refuse information. *Id.* at 459. The therapeutic exception is the most controversial. The therapeutic exception permits physicians to withhold information in specific cases if the information will do more harm than good for the patient. This is a highly criticized exception and generally not cited in the case law as a defense to failure to obtain informed consent. Any application of the exception must be determined on a case-by-case, patient-by-patient basis. *Logan v. Greenwich Hosp. Assoc.*, 465 A.2d 294, 292 (Conn. 1983) (noting that only very limited recognition has been given to the "therapeutic privilege" of a physician to withhold information "where disclosure might jeopardize a course of therapy"). See also *Cobbs*, 502 P.2d at 4410–11 ("A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent In all cases other than the foregoing, the decision whether or not to undertake treatment is vested in the party most directly affected: the patient."). In *Canterbury v. Spence*, the court noted a narrow exception to informed consent "when risk disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view." 464 F.2d 772, 789 (D.C. Cir. 1972). *Canterbury* emphasized that this therapeutic privilege "must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself." *Id.* Furthermore, *Canterbury* stressed that even the therapeutic privilege "does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs." *Id.* Scholars have also criticized the therapeutic exception and proposed its abolition. See Meisel, *The "Exceptions" to the Informed Consent Doctrine*, *supra* note 80, at 460–67 (noting that the therapeutic privilege is much discussed in the literature although "few cases turn on its application" and arguing for its abolition).

117. *Canterbury*, 464 F.2d at 789 (discussing therapeutic exception to informed consent doctrine).

the constitutional right to abortion.¹¹⁸ Yet, comparing the law of informed consent to abortion law reveals a stark difference in how the law views pregnant women as decision-makers. Abortion law ignores the long history of protection for patient decision-making capacity that has been well-established in informed consent law.

B. "Informed Consent" to Abortion from *Roe* to *Casey*

For a period of time, under the rules as established in *Roe v. Wade*,¹¹⁹ the law generally treated women as entitled to autonomy in their abortion decision-making similar to other patients. Both the Supreme Court and lower courts' use of the general law of informed consent to guide the analysis of abortion-specific "informed consent" regulations reflected this equal treatment of women. In part because the courts viewed female patients seeking abortion as equally capable decision-makers as other patients, courts conformed the requirements of abortion "informed consent" to informed consent law as applied to all other patients.

However, abortion law's treatment of women as decision-makers has been diverging from informed consent law's treatment of patient decision-making at least since the Supreme Court's decision in *Planned Parenthood v. Casey*.¹²⁰ This section reviews the transformation of the Supreme Court's view of "informed consent" as it relates to abortion from *Roe* to *Casey*. It disentangles "informed

118. See *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 849 (1992); Louis Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1419–22 (1974) ("In its broadest uses, privacy is as old as law, implicated in the concept of the individual and all that is ascribed to the individual."); Meisel, *The "Exceptions" to the Informed Consent Doctrine*, *supra* note 80, at 431 n.70 (noting that the "'presumption of individual self-determination' is the common-law analog of the constitutional right to privacy. If this right is to be curtailed by the assertion of a societal 'health' interest, there is a heavy burden upon the proponent of that interest to demonstrate why it should predominate in a particular case."). For example, the Supreme Court has explicitly relied on informed consent law in acknowledging a substantive due process right to refuse life-saving medical treatment. In *Cruzan v. Director, Missouri Dep't. of Health*, the Court, using informed consent law as a guide to interpreting Due Process Clause protections for patients, stated in dicta that Constitution protects a right to refuse life-saving medical treatment. *Cruzan v. Director, Missouri Dep't. of Health*, 497 U.S. 261, 279 (1990), discussed *infra* Part IV.B.2. *Cruzan* emphasized: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person . . ." *Id.* at 269 (citing *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)). Thus, a competent adult patient's right to refuse even life-saving medical treatment is established both in private law and in public law based on the principle that competent adults are capable of making important healthcare decisions. Michelle Oberman notes that the right of competent adults to refuse medical treatment is so well-established that her research did not unearth a single case after 1972 forcing medical treatment upon a patient solely for her own benefit. Oberman, *supra* note 89, at 467. Interestingly, courts have often tolerated violations of the right to refuse medical treatment only in cases involving women who are mothers of young children. See, e.g., *Winthrop Univ. Hosp. v. Hess*, 490 N.Y.S.2d 996 (Sup. Ct. Nassau Cty. 1985) (court ordered blood transfusion for religious objector because she was the mother of an infant and had explained that her objection was to the signing of the consent, not the transfusion itself); *In re President & Dir. Of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964) (ordering blood transfusion for mother of infant). *But see* *In re Estate of Brooks*, 205 N.E.2d 435, 441–42 (1965) (holding lower court erred in ordered blood transfusion for woman whose children were grown).

119. 410 U.S. 130 (1973).

120. 505 U.S. 833 (1992).

consent” as (mis)used in abortion law from the general law of informed consent and demonstrates that abortion law has been treating women as less capable decision-makers for some time, well prior to *Carhart*.

In the landmark 1973 ruling, *Roe v. Wade*, the Supreme Court held that state bans on access to abortion violated a woman’s constitutional rights under the Due Process Clause of the Fourteenth Amendment.¹²¹ The Court grounded its decision in a line of “privacy” cases, which recognized the right of the individual to make decisions with respect to “marriage, procreation, contraception, family relationships, and child rearing and education.”¹²² The Court concluded that these rights of privacy in family life encompassed the right of a woman to decide whether to carry her pregnancy to term.

Roe provided extensive protection for women’s constitutional right to abortion and declared that the right to abortion is a “fundamental right,” meaning that states could restrict access to abortion only where there is a “compelling State interest.”¹²³ The Court established a strict trimester-based framework for state regulations of abortion, holding that government only has a compelling interest in regulating abortion beginning in the second-trimester. Thus, states could enact almost no restrictions on abortion during the first-trimester; could enact restrictions necessary to protect maternal health in the second-trimester; and could ban abortion entirely in the third trimester but must make exceptions to protect maternal life and health.¹²⁴ The Court defined “health” broadly in terms of the health exception requirement.¹²⁵

Despite this broad protection for the abortion right, *Roe*’s rhetoric unfortunately did not evince much respect for women’s decision-making capacity. Instead, the Court characterized the abortion decision as belonging primarily to the physician rather than the patient.¹²⁶ Nevertheless, under the doctrinal regime laid out by *Roe*, later cases placed much more emphasis on

121. 410 U.S. 130 (1973).

122. *Id.* at 152–53 (citations omitted).

123. *Id.* at 169–71.

124. *Id.* at 163–165 (1973) (explaining the government’s interest in regulating each trimester of a woman’s pregnancy).

125. *Id.* at 163 (providing examples of permissible state regulation to preserve and protect the health of the mother after the first trimester). *See also* *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (defining health broadly to include “all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient”).

126. *Roe*, 410 U.S. at 165–66 (stating that the “decision vindicates the right of the physician to administer medical treatment according to his professional judgment”). The Court’s rhetoric repeatedly placed less emphasis on the woman’s interest in the decision and greater emphasis on the physician’s involvement. *See also id.* at 153 (“All these factors [discussed above] the woman and her responsible physician necessarily will consider in consultation.”). The Court did not address a so-called “informed consent” abortion law, but the Court stressed that abortion law should respect the physician’s medical judgment in making the decision to terminate a pregnancy. *Id.* at 163 (“[T]he attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated.”); *See also id.* at 164 (holding that until the end of the first trimester, “the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician”); *id.* at 165–66 (stating that this “decision vindicates the right of the physician to administer medical treatment according to his professional judgment”).

women's decisional autonomy in the abortion context.¹²⁷ Most tellingly, in a number of cases the Supreme Court struck down abortion-specific "informed consent" laws that deviated from the general law of informed consent. These precedents emphasized that women are equally entitled to make important healthcare choices and, therefore, applied the law of informed consent with equal force to women's abortion decisions.¹²⁸

The Supreme Court addressed abortion-specific "informed consent" legislation in three cases after *Roe*. In each case, the Court used the general law of informed consent as a yardstick to determine the constitutionality of abortion-specific "informed consent" laws. First, in *Planned Parenthood v. Danforth*,¹²⁹ the Court upheld a statute that required, among other restrictions, that a woman certify in writing her consent to an abortion and "that her consent is informed and freely given and is not the result of coercion."¹³⁰ The challenged statute did not define any specific information that the physician must impart to the woman prior to performing the procedure. The Court interpreted the requirement of "informed consent" in the statute as simply following the general rule that the physician should provide information to the patient "as to just what would be done and as to its consequences."¹³¹ Thus, although the Court upheld an abortion-specific informed consent law, the Court interpreted the law to require no more or less information than what physicians should be providing before any medical procedure in accordance with the general principles of informed consent.

Second, in *City of Akron v. Akron Center for Reproductive Health*,¹³² the Court struck down a number of abortion restrictions set forth in a city ordinance, including an "informed consent" provision. The Court emphasized that the validity of an abortion "informed consent" regulation "rest[s] on the State's

127. See, e.g., *Thornburgh v. ACOG*, 476 U.S. 747, 759 (1986).

128. See Note, *Abortion Regulation*, *supra* note 84, at 702–11 (analyzing cases and concluding that courts attempted to conform abortion "informed consent" legislation to the general law of informed consent).

129. 428 U.S. 52 (1976).

130. *Id.* at 65–66 (internal quotations omitted). The physicians challenging the legislation argued that the requirement of written consent violated *Roe* and was unduly vague. The Court rejected these arguments. "We could not say that a requirement imposed by the State that a prior written consent for any surgery would be unconstitutional. As a consequence, we see no constitutional defect in requiring it only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions." *Id.* at 67. The Court noted that the state may have special concerns justifying ensuring that the decision to abort is truly informed and consensual, since the "decision to abort, indeed, 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." *Id.* However, the Court also noted that the only other Missouri statutes dealing with informed consent for general medical care related to persons committed to the Missouri State chest hospital or to mental or correctional institutions. *Id.* at 66 n.6.

131. The Court rejected the physicians' vagueness challenge to the word "informed," stating that "we are content to accept, as the meaning, the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Id.* at n.8.

132. 462 U.S. 416 (1983).

interest in protecting the health of the pregnant woman."¹³³ Although *Danforth* had acknowledged that government has an interest in ensuring that the decision to abort is well-informed, in *Akron* the Court emphasized that government does not have the authority to determine the precise details of the information to be conveyed, for two reasons. Initially, the Court stressed that the content of the information to be provided to obtain consent "remains primarily the responsibility of the physician."¹³⁴ Furthermore, the Court also emphasized that the State's interest in ensuring that consent to abortion is informed does not permit the State to impose regulations "designed to influence the woman's informed choice between abortion and childbirth."¹³⁵

Applying this view, the Court struck down Akron's abortion "informed consent" ordinance, finding that the regulation was "designed not to inform the woman's consent but rather to persuade her to withhold it altogether."¹³⁶ In particular, the Court disapproved of the ordinance's requirement that the physician inform the patient that "the unborn child is a human life from the moment of conception" and that the physician provide a detailed description of "the anatomical and physiological characteristics of the particular unborn child."¹³⁷ In addition, the ordinance required that the physician make a detailed statement about the physical and emotional risks of abortion:

That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.¹³⁸

The Court concluded that the first statement contradicted the holding in *Roe* that a state may not adopt one theory of when life begins.¹³⁹ The second statement would require the physician to speculate too much about the "characteristics of the particular unborn child."¹⁴⁰ Finally, the Court concluded that the last statement "is a 'parade of horrors intended to suggest that abortion is a particularly dangerous procedure."¹⁴¹

133. *Id.* at 443.

134. *Id.* at 443. The Court expressed concern with protecting the prerogatives of the physician: "An additional, and equally decisive, objection to § 1870.06(B) is its intrusion upon the discretion of the pregnant woman's physician. This provision specifies a litany of information that the physician must recite to each woman regardless of whether in his judgment the information is relevant to her personal decision. For example, even if the physician believes that some of the risks outlined in subsection (5) are nonexistent for a particular patient, he remains obligated to describe them to her. In *Danforth*, the Court warned against placing the physician in just such an 'undesired and uncomfortable straitjacket.'" *Id.* at 445.

135. *Id.* at 443-44.

136. *Id.* at 444-45.

137. *Id.*

138. *Id.* at 445, n.36.

139. *Id.* at 444.

140. *Id.* at 445.

141. *Id.* at 444-45. The Court did not object to requirements that the patient be informed of the fact that she is pregnant; the gestational age of the fetus; the availability of information on birth control and adoption; and the availability of assistance during pregnancy and after childbirth. In

In the third case, *Thornburgh v. American College of Obstetricians and Gynecologists*,¹⁴² the Court once again struck down an “informed consent” abortion regulation that mandated delivery of seven specific kinds of information to all abortion patients. The Court found that much of this information would be irrelevant or inappropriate for some patients, such as those with life-threatening pregnancies or pregnancies resulting from rape.¹⁴³ The Court reaffirmed that a law requiring that “the woman give what is truly a voluntary and informed consent, as a general proposition, is, of course, proper and is surely not unconstitutional.”¹⁴⁴ However, the Court reiterated that government may not mandate the conveyance of biased information designed to influence the woman’s choice against abortion.¹⁴⁵ The Court described the statute at issue as “nothing less than an outright attempt to wedge the Commonwealth’s message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician.”¹⁴⁶ The Court opined that the sum of the challenged “informed consent” regulation “is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures—as it obviously was intended to do—the dialogue between the woman and her physician.”¹⁴⁷ *Thornburgh* recognized and rejected the State’s attempt, under “the guise of informed consent,” to advance a coercive agenda contrary to the respect for autonomous decision-making enshrined in informed consent law.¹⁴⁸ As the

fact, the Court stated that such information is probably routinely given to patients where accurate, as part of the routine informed consent process. *Id.* at 444–45. However, the Court nevertheless struck these provisions down on the ground that this information could be given by a non-physician, whereas the statute mandated that only a physician provide the information. *Id.* at 445 n.37. Similarly, the Court had no objection to the requirement that the patient be informed of the particular risks of her pregnancy and the abortion technique to be used, finding that this provision properly left the precise nature of the “informed consent” disclosures “to the physician’s discretion and ‘medical judgment.’” *Id.* at 447. The Court again struck down these requirements because the ordinance mandated that only a physician provide this counseling. The Court held this requirement unreasonable, since other qualified persons could perform the counseling adequately to ensure maternal health. *Id.* at 447–49.

142. 476 U.S. 747 (1986).

143. *Id.* at 763.

144. *Id.* at 760.

145. *Id.* (quoting *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 443–44 (1983)). The Court also reiterated its objection in *Akron* to the state’s intrusion on the informed consent process, namely that “a rigid requirement that a specific body of information be given in all cases, irrespective of the particular needs of the patient, intrudes upon the discretion of the pregnant woman’s physician” *Id.* at 762. The Pennsylvania statutes at issue in *Thornburgh* prescribed in detail the method for obtaining “informed consent.” For example, the statute required that the patient be told by her physician the “fact that there may be detrimental physical and psychological effects which are not accurately foreseeable.” *Id.* at 760–61

146. *Id.* at 762.

147. *Id.* at 763.

148. *Id.* The Court stated: “The mandated description of fetal characteristics at 2-week intervals, no matter how objective, is plainly overinclusive. This is not medical information that is always relevant to the woman’s decision, and it may serve only to confuse and punish her and to heighten her anxiety, contrary to accepted medical practice. Even the listing of agencies in the printed Pennsylvania form presents serious problems; it contains names of agencies that well may be out of step with the needs of the particular woman and thus places the physician in an awkward position and infringes upon his or her professional responsibilities. Forcing the physician or counselor to

Court aptly stated, “[t]his type of compelled information is the antithesis of informed consent.”¹⁴⁹

Lower federal courts similarly applied the general law of informed consent in addressing abortion-specific “informed consent” regulations. One commentator analyzing lower federal court cases under *Roe* demonstrated that, in reviewing abortion-specific “informed consent” legislation, courts were attempting to “align the informed consent to abortion prerequisite[s] with the law of informed consent in general.”¹⁵⁰ For example, in *Margaret S. v. Edwards*,¹⁵¹ the district court conducted a thorough review of the purposes of informed consent in considering a challenge to a Louisiana “informed consent” to abortion statute.¹⁵² The court concluded that informed consent “is designed to foster patient knowledge about the risks and benefits of a particular procedure.”¹⁵³ The court upheld provisions it deemed consistent with the purposes of informed consent, but struck down the provisions contrary to such purposes, such as the requirement that the physician inform the patient that “the unborn child is a human life from the moment of conception.”¹⁵⁴

In sum, under the *Roe* regime, both the Supreme Court and lower federal courts treated pregnant women as equally capable decision-makers by ensuring that abortion-specific “informed consent” legislation conformed with the law of informed consent as applied to all other patient decisions.¹⁵⁵

As the composition of the Supreme Court shifted to the right, the Court began signaling a more relaxed standard for judicial scrutiny of abortion

present the materials and the list to the woman makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list.” *Id.* Furthermore, the Court explained, “[t]he requirements of § 3205(a)(2)(i) and (ii) that the woman be advised that medical assistance benefits may be available, and that the father is responsible for financial assistance in the support of the child similarly are poorly disguised elements of discouragement for the abortion decision. Much of this would be nonmedical information beyond the physician’s area of expertise and, for many patients, would be irrelevant and inappropriate. For a patient with a life-threatening pregnancy, the ‘information’ in its very rendition may be cruel as well as destructive of the physician-patient relationship. As any experienced social worker or other counselor knows, theoretical financial responsibility often does not equate with fulfillment. And a victim of rape should not have to hear gratuitous advice that an unidentified perpetrator is liable for support if she continues the pregnancy to term.” *Id.*

149. *Id.* at 764.

150. Note, *Abortion Regulation*, *supra* note 84, at 704.

151. 488 F. Supp. 181 (E.D. La. 1980).

152. *Id.*

153. *Id.*

154. *Id.* at 209 (internal quotations omitted). *See also* Note, *Abortion Regulation*, *supra* note 84, at 685 (noting that post *Danforth*, the lower federal courts uniformly struck down detailed abortion “informed consent” statutes and stating that “[a]s with other medical procedures, the desirability of acquiring consent to treatment only after full knowledge of its nature and consequences involves not only the doctor’s fiduciary responsibility to the patient and the state’s interest in high medical standards, but also the patient’s right to choose or refuse the proffered treatment.”).

155. *See, e.g., id.* at 702–11 (analyzing cases and stating that a review of “judicial scrutiny of the informed consent to abortion statutes for invasions of the woman’s privacy right demonstrates that the courts have upheld the requirements which coincide with the general law of informed consent and have invalidated the portions which do not contribute to the goal of autonomous self-determination”).

restrictions, which came to fruition in *Planned Parenthood v. Casey*.¹⁵⁶ *Casey* dramatically changed the landscape of abortion law and set forth the basic test for abortion regulation that is still the law today, although *Carhart* made significant changes to *Casey*'s rules.¹⁵⁷ The *Casey* joint opinion rejected both the trimester framework and the compelling state interest test set forth in *Roe*,¹⁵⁸ instead declaring that the State had an interest from the outset of pregnancy in protecting maternal health and the potential life of the fetus.¹⁵⁹ Rather than restrict the State's ability to regulate abortion in the first two trimesters, *Casey* drew the line at viability, holding that pre-viability abortion restrictions are constitutional unless they amount to an "undue burden" on a woman's right to access abortion.¹⁶⁰ Post-viability, the rule remained the same as in *Roe*—the State is free to ban abortion entirely with exceptions to protect the health and life of the woman.¹⁶¹ *Casey* defined the term "undue burden" as a government regulation that has the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."¹⁶² Under this new and notoriously vague test,¹⁶³ *Casey* upheld all but one of a number of restrictions on abortion.¹⁶⁴ The Court struck down only the spousal notification provision in the challenged statute.¹⁶⁵ Many of the other restrictions at issue were in fact reenactments of similar statutory provisions that the Supreme Court had previously struck down under the rules established in *Roe*.¹⁶⁶ In particular,

156. 505 U.S. 833 (1992). The Court signaled its changing views most notably in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989). The *Webster* decision was significant mainly for its foreshadowing of a major shift in abortion law, which came to fruition in *Planned Parenthood v. Casey*. See Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J.L. & FEMINISM 317, 324–25 (2006).

157. See Casey A. Coyle, Comment, *Gonzales v. Carhart: Justice Kennedy At The Intersection Of Life Interests, Medical Practice And Government Regulations*, 27 TEMP. J. SCI. TECH. & ENVTL. L. 291, 297–307 (2008) (describing the evolution of abortion case law); Christopher Mirakian, Comment, *Gonzales v. Carhart: A New Paradigm For Abortion Legislation*, 77 UMKC L. REV. 197, 201–205 (2008) (analyzing noteworthy Supreme Court cases in the area of abortion regulation).

158. *Casey*, 505 U.S. at 869. The controlling opinion in *Casey* was an unusual joint opinion coauthored by Justices O'Connor, Kennedy, and Souter.

159. *Id.* at 869 ("The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn.").

160. *Id.* at 878–79.

161. Wharton et al., *supra* note 156, at 330–31 (noting that *Casey* "rebalanced the relative interests of the state and the pregnant woman" and provided for significantly less constitutional protection of abortion than *Roe*).

162. *Casey*, 505 U.S. at 877.

163. See Caitlin Borgmann, *Winter Count: Taking Stock of Abortion Rights after Casey and Carhart*, 31 FORDHAM URB. L.J. 675, 682–83 (2004) (discussing undue burden test and noting that joint opinion "offered no method or standards by which to determine what constitutes a 'substantial obstacle'").

164. See Sandra Lynne Tholen & Lisa Baird, *Con Law is as Con Law Does: A Survey of Planned Parenthood v. Casey in the State and Federal Courts*, 28 LOY. L.A. L. REV. 971, 986 (1995) (describing vagueness of undue burden test).

165. *Casey*, 505 U.S. at 893–94.

166. The challenged Pennsylvania statute required that: (1) physicians obtain their patients' "informed consent" by reciting a state written script and then delaying their patients' abortion procedures for twenty-four hours; (2) married women notify their spouses of their decision to terminate their pregnancies; (3) minors obtain parental consent; and (4) clinics maintain and submit detailed reporting information. *Id.* at 877.

Casey upheld the constitutionality of abortion-specific “informed consent” statutes that were identical to the regulations struck down in *Akron* and *Thornburgh*.¹⁶⁷

Despite significantly reducing constitutional protection for abortion, *Casey* claimed to preserve the “core” of *Roe*.¹⁶⁸ It also offered a restatement of the rationale for protecting a right to abortion. *Roe* relied heavily on the family privacy line of cases in supporting the right to abortion and placed less emphasis on the abortion right as an issue of bodily autonomy and gender equality.¹⁶⁹ *Casey* employed a different reasoning, one that still rested on substantive due process, but also stressed the importance of gender equality and bodily autonomy in protecting access to abortion.¹⁷⁰ *Casey*’s doctrinal holdings did not live up to its rhetoric; nevertheless its language concerning the importance of abortion rights to women’s equality presents a striking contrast to *Carhart*, as will be discussed in the next section.

Although *Casey* did not ground the abortion right in the Equal Protection Clause, the opinion made repeated references to the impact of reproductive rights on women and the effect of abortion restrictions on women’s ability to achieve equality in society:

The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman’s role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a

167. *Id.* Contrary to precedents under *Roe*, *Casey* also upheld mandatory twenty-four hour waiting periods, which typically are linked to “informed consent” provisions in abortion regulations. *Id.*

168. *Id.* at 846 (“[T]he essential holding of *Roe v. Wade* should be retained and once again reaffirmed.”).

169. *Roe v. Wade*, 410 U.S. 130, 165–66 (1973).

170. *Casey*, 505 U.S. at 846–47 (grounding the right to abortion in the Due Process Clause, but emphasizing “liberty” as the controlling word from the Clause rather than “privacy”). See also *id.* at 849 (supporting substantive due process right by citing cases based on right to make “most basic decisions about family and parenthood . . . as well as bodily integrity”). In discussing *stare decisis* as a ground for upholding *Roe*, the Court explained that “*Roe* stands at an intersection of two lines of decisions.” *Id.* at 857. First, the *Roe* opinion rested upon the line of decisions relating to privacy in the family and “decisions about whether or not to beget or bear a child,” in particular *Griswold v. Connecticut* and its articulation of a right to access contraception. *Id.* Second, the joint opinion declared that the right to access abortion “may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection.” *Id.* See also *id.* at 896 (striking down spousal notification statute and emphasizing that the “effect of state regulation on a woman’s protected liberty is doubly deserving of scrutiny . . . as the State has touched not only upon the private sphere of the family but upon the very bodily integrity of the pregnant woman”). The Court thus explicitly linked the abortion right to the Court’s other medical treatment cases, some of which specifically referenced informed consent law. *Id.*

large extent on her own conception of her spiritual imperatives and her place in society.¹⁷¹

The Court went on to state that “[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.”¹⁷² Numerous scholars have noted the shift in rhetoric from *Roe*’s emphasis on the physician’s interest in abortion decision-making to *Casey*’s emphasis on women’s interest in abortion decision-making,¹⁷³ rhetoric which starkly differs from that employed by the Court in *Carhart*.¹⁷⁴

Casey’s holdings failed to deliver on the promise of its rhetoric and to apply the law consistently.¹⁷⁵ Despite emphasizing gender equality, *Casey*’s reasoning deviated from equal treatment principles, particularly in its analysis of Pennsylvania’s abortion “informed consent” law. The general law of informed consent protects patient autonomy by ensuring that patients receive the necessary information to make their own decisions about medical treatment. Obviously, patients cannot be self-determining if given information biased towards one outcome. Yet, *Casey* permitted states to mandate information biased against abortion under the guise of abortion-specific “informed consent” legislation. *Casey* concluded that “the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth” did not amount to an undue burden.”¹⁷⁶ At the same time, *Casey* held that this state-mandated information need not be unbiased as to the woman’s choice. The Court emphasized that it was:

Depart[ing] from the holdings of *Akron I* and *Thornburgh* to the extent that [it now] permit[s] a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.¹⁷⁷

171. *Id.* at 852.

172. *Id.* at 856. The Court also emphasized, in discussing *stare decisis*, that: “An entire generation has come of age free to assume *Roe*’s concept of liberty in defining the capacity of women to act in society, and to make reproductive decisions.” *Id.* at 860. *Casey*’s rhetoric regarding women’s equality starkly contrasts with *Carhart*’s portrayal of women. See *Gonzales v. Carhart*, 550 U.S. 124, 184 (2007) (Ginsburg, J., dissenting).

173. See, e.g., Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 AM. U. L. REV. 77 (1995).

174. See *infra* Part III.C.

175. Many scholars have found it difficult to reconcile the opinion’s holdings as to the abortion restrictions at issue with its grand language on the importance of reproductive rights to achieving liberty and equality for women. See Martha A. Field, *Abortion Law Today*, 14 J. LEGAL MED. 3, 13–16 (1993); Gillian Metzger, *Unburdening the Undue Burden Standard: Orienting Casey in Constitutional Jurisprudence*, 94 COLUM. L. REV. 2025 (1994); Wharton et al., *supra* note 156, at 335 (“[T]he joint opinion has been widely criticized by commentators who have correctly noted the perplexing inconsistency between its treatment of the spousal notification provision and most of the other challenged provisions.”).

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

177. *Id.* at 883. The Court also placed significantly less weight on the second reason given by *Akron* and *Thornburgh* for striking down “informed consent” laws, which was the interest of the physician in preserving his or her medical judgment. “Whatever constitutional status the doctor-

This rationale for upholding the “informed consent” law at issue contradicts the underlying purposes of the doctrine of informed consent.¹⁷⁸ *Casey* claimed to be supporting women’s fully informed, autonomous decisions, but then allowed the government to use the “informed consent” process to pressure women to choose childbirth over abortion. *Casey*’s reasoning in this context also seems quite contradictory—if the abortion-specific “informed consent” regulation must be “nonmisleading,” how can the Court permit the regulation to be biased in one direction?

Not only did *Casey* permit information biased against abortion that would pressure patients’ decisions under the misnomer of an “informed consent” law, but also much of the Court’s rationale displayed little deference to women’s equal capacity to make sound medical decisions. The *Casey* opinion assumed that women lacked the judgment to make “mature and informed” abortion decisions on their own, without pressure from the State, as other patients do with respect to other important medical decisions. Statutes singling out abortion for state-mandated information enforced by criminal sanction imply that women patients cannot be trusted to elicit information from their physicians and sue in malpractice if necessary, as is the norm.¹⁷⁹ As Justice Stevens pointed out

patient relation may have as a general matter, in the present context it is derivative of the woman’s position. The doctor-patient relation does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy. On its own, the doctor-patient relation here is entitled to the same solicitude it receives in other contexts. Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure.” *Id.* at 884. The Court also linked the “informed consent” provisions with the mandated waiting period: “The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision.” *Id.* at 885.

178. Note, *Abortion Regulation*, 15 GA. L. REV. 681, 707 (“Detailed descriptions of the fetus’ physical appearance, development and sensory capacity, information about birth control and provisions labeling abortion as major surgery with the possibility of severe, long term complications are inconsistent with informed consent requirements in general because such information is irrelevant to the decision whether to abort. Such details post no material risks to the woman, nor does prevailing medical practice require such disclosure.”). See also *Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981) (stating that the description of the fetus required in state informed consent to abortion “presents no information whose essence most, if not all, women do not understand before receiving it”); *Planned Parenthood Ass’n of Kansas City v. Ashcroft*, 483 F. Supp. 679, 698 (W.D. Mo. 1980) (“It is . . . clear that many physicians believe that there are no long-term physical or psychological effects of abortion or are unaware of such efforts.”); *Margaret S. v. Edwards*, 488 F. Supp. 181, 210 (E.D. La. 1980) (“The evidence demonstrated, and the Court so finds, that in the overwhelming number of cases, abortion is a *minor* surgical procedure, not a major surgical procedure.”) (emphasis added); *Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979); *Freiman v. Ashcroft*, 584 F.2d 247 (8th Cir. 1978); *Wynn v. Scott*, 449 F. Supp. 1302 (N.D. Ill 1978); *Planned Parenthood Ass’n v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975); Note, *Restrictions on Women’s Right to Abortion: Informed Consent, Spousal Consent, and Recordkeeping Provisions*, 5 WOMEN’S RTS. L. RPTR. 35, 40 (1978) (“Women seeking abortions obviously wish to terminate their pregnancies and already know that one result, in fact the desired result, of the procedure is termination of the pregnancy.”).

179. See Susan Frelich Appleton, *Physicians, Patients, and the Constitution: A Theoretical Analysis of the Physician’s Role in “Private” Reproductive Decisions*, 63 WASH. U.L.Q. 183, 233 (1985) (“When the state singles out abortion patients or female birth-control patients for special protection from their physicians by mandating waiting periods and detailed disclosure requirements, the state

in his separate opinion in *Casey*, the joint opinion “rests on outmoded and unacceptable assumptions about the decision-making capacity of women.”¹⁸⁰ For example, in upholding the constitutionality of the “informed consent” provision, *Casey* stated: “Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed.”¹⁸¹ Therefore, “[m]easures aimed at ensuring that a woman’s choice contemplates the consequences for the fetus do not necessarily interfere with the right recognized in *Roe*.”¹⁸² As Linda McClain stated, “it would appear that the Court assumes that women who seek abortions do not understand what abortion means with respect to a pregnancy.”¹⁸³ McClain also noted, “[e]nhancing deliberative autonomy would appear to be the joint opinion’s goal only to the extent that those [J]ustices accept that women are choosing abortion out of ignorance or without due attention to arguments against abortion.”¹⁸⁴ A number of scholars have also argued that abortion-specific “informed consent” statutes inherently reflect sex discrimination, because they “fundamentally perpetuate[] the stereotypical notion of the indecisiveness of women, questioning a woman’s ability to make decisions about the course of her life . . . [and reflect] stereotypical assumptions that women choose to obtain abortions carelessly, without thinking through the implications of their decisions.”¹⁸⁵

Casey marks a turning point where abortion law explicitly began treating women as decision-makers less capable than other competent adults. It permitted the State to impose biased information when women are choosing to reject the traditional role of motherhood.¹⁸⁶ *Casey* opened the door to so-called

perpetuates outmoded and pernicious stereotypes of women as indecisive and incompetent health-care consumers, incapable of obtaining necessary information and time for reflection without paternalistic government intervention.”).

180. *Casey*, 505 U.S. at 918. (Stevens, J., dissenting).

181. *Id.* at 872.

182. *Id.* at 873.

183. Linda C. McClain, *The Poverty of Privacy?*, 3 COLUM. J. GENDER & L. 119, 143–44 (1992) [hereinafter McClain, *The Poverty of Privacy?*] (“In particular, the piece of information the Court fears the woman may lack is ‘the impact on the fetus,’ something the Court claims that ‘most women considering an abortion would deem . . . relevant, if not dispositive to the decision.’ This remarkable, if enigmatic, sentence stands without any cited support.”).

184. *Id.* at 142.

185. See David H. Gans, *Stereotyping and Difference: Planned Parenthood v. Casey and the Future of Sex Discrimination Law*, 104 YALE L.J. 1875, 1902 (1995) (“The mandatory delay provision should receive heightened scrutiny under the Equal Protection Clause because it reflects the assumption that a woman’s proper role is to be a mother and that she must be required to rethink any decision to forgo that role.”). See also Susan Frelich Appleton, *supra* note 179, at 231. (“[E]ven when [abortion-specific] laws do not limit access, they demean women by perpetuating stereotypes of women as a special class of medical patients in need of governmental protection.”); Sylvia Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1035 (1984) (arguing that non-neutral, abortion-specific legislation “reinforces the cultural stereotype that motherhood is women’s destinyexpress[es] disapprobation for abortion, [and] regard[s] the woman as a ‘mother machine’”).

186. See *id.* See also Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 AM. U. L. REV. 77, 78 (1995) (“The Court’s opinions have traditionally reflected the view that women cannot make decisions about their pregnancy on their own.”); Wharton et al., *supra* note 156, at 336 (“[I]n upholding the state-mandated counseling scripts as a ‘reasonable measure designed to ensure an informed choice,’ [the joint opinion authors] turned a

“informed consent” laws in the abortion context that have deviated far from the principles of the tort law doctrine of informed consent. In fact, although *Casey* emphasized that only “truthful, nonmisleading” information should be constitutionally permissible (even if designed to bias the woman’s decision against choosing abortion), post-*Casey* decisions have permitted “informed consent” statutes that are neither truthful nor factually non-misleading.¹⁸⁷

Some have reasoned that although the general law of informed consent would not permit physicians to impart information designed to pressure a patient’s choice, there are different considerations at play as a constitutional matter that could justify *Casey*’s holding.¹⁸⁸ *Casey* specifically claimed that, under its new “undue burden” test, the government need not be bound by informed consent doctrine (which regulates physicians) with respect to governmental regulation of abortion:

We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her

blind eye to the reality that both [the spousal notification] requirement and the mandatory waiting period likewise rested on outmoded and unacceptable assumptions about the decision-making capacity of women.”).

187. Approximately thirty two states have an abortion-specific law or policy related to informed consent. In ten of these states, the law mandates similar information as is generally required in the informed consent process. The laws in the remaining twenty two states go beyond the general requirements of informed consent in various respects. Some statutes require abortion providers to provide specific information verbally or to provide state written materials to the patient as part of the informed consent process. This material may contain medically unsupported claims, information that is medically irrelevant to the particular patient, or material that is inflammatory and expresses moral rather than medical judgments. For example, South Dakota includes infertility without any qualification as a risk of abortion, although medical evidence is to the contrary. See Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL’Y REV., 11 (Fall 2007). Anti-abortion advocates have consistently pushed the claim of a link between abortion and breast cancer. Although the National Cancer Institute issued a statement categorically denying any link between induced abortion and an increase in breast cancer risk after a thorough study of the scientific literature on the topic, six states include medically inaccurate statements about abortion and breast cancer in their “informed consent” literature. Some states also mandate information about fetal pain that is medically unsupported or refer women to “crisis pregnancy centers” some of which falsely proclaim to provide abortion “counseling.” See Chinue Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, GUTTMACHER POL’Y REV., 13 (Fall 2006) (noting how *Carhart* implicitly, and many state laws explicitly, “diverge from the principles of informed consent”). Some states also mandate clinically unnecessary ultrasounds as part of the abortion “informed consent” process. At least thirteen states have requirements related to ultrasound. *Id.* at 10. See also *Planned Parenthood of Minn. v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (upholding South Dakota “informed consent” to abortion statute mandating that physicians inform patients “that abortion will terminate the life of a whole, separate, unique living human being”); Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1 (2008) (arguing that emotional information now included in many state “informed consent” to abortion statutes burden women’s right to autonomous decision-making because they are “calculated to bias a woman’s free choice, not inform it”).

188. See, e.g., Robert D. Goldstein, *Reading Casey: Structuring the Woman’s Decisionmaking Process*, 4 WM. & MARY BILL RTS. J. 787 (1996) (analyzing *Casey* under three alternative models by which the state can structure the woman’s decisionmaking process).

health . . . [I]nformed choice need not be defined in such narrow terms that all considerations of the effect on the fetus are made irrelevant.¹⁸⁹

Yet, *Casey* largely failed to explain why the government can impose information *biased* towards childbirth and against abortion if its goal is truly informed choice. The government acts disingenuously when it claims that biased legislation serves to provide “informed consent” for women when in fact the goal of abortion “informed consent” laws are to impose the government’s normative views about what decisions women *should* make. *Casey* misused “informed consent” terminology to further goals antithetical to the imperatives animating informed consent law. Interestingly, *Casey* relied upon the same woman-protective reasoning later used by *Carhart* as one of the primary justifications for upholding biased “informed consent” legislation. *Casey* opined that “informed consent” legislation, even if biased against abortion, would benefit women’s mental health:

It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.¹⁹⁰

As in *Carhart*, the Court lacked any evidence to support its mental health claim, but nevertheless invoked the rhetoric of informed consent (ensuring that the woman’s decision is “fully informed”) to justify mandating biased information that informed consent law would not tolerate.¹⁹¹ The seeds of the woman-protective argument were planted in *Casey* and came to fruition in *Carhart*.

C. “Informed Consent” and Abortion Decision-Making After *Carhart*

Although there is much to criticize in the *Carhart* decision, this section focuses solely on the Court’s woman-protective rationale for restricting access to abortion.¹⁹² This rationale invokes “informed consent” as a justification for a decision that is antithetical to informed consent law. Informed consent law rejects the notion that patients cannot balance the risks and benefits of medical treatments and determine where their own best interests lie.¹⁹³ In stark contrast

189. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 882–83 (1992).

190. *Id.* at 882.

191. The Court did not have data to support this conclusion and studies at the time did not show evidence that women suffered negative psychological consequences from abortion. *See McClain, The Poverty of Privacy?*, *supra* note 183, at 142 (“Moreover, the Court makes no mention of evidence before it suggesting that for the great majority of women, the primary reaction to abortion is relief, . . . [and] there is no significant evidence of adverse psychological consequences resulting from abortion, and that a decision to continue a pregnancy may have potential negative impacts upon the life of a woman . . .”).

192. *See, e.g., Update: Phasing Out Abortion: One Step Closer to Terminating a Woman’s Constitutional Right*, in *Gonzales v. Carhart*, 24 T.M. COOLEY L. REV. 597, 628 (2007) (discussing doctrinal shifts made by *Carhart*).

193. *See supra* Part III.A (discussing general law of informed consent).

to this notion, *Carhart* assumes that female patients (in particular pregnant women) lack equal capacity to make judgments about their own well-being. Although *Carhart* invokes informed decision-making as a reason for upholding the federal abortion ban, the Court's divergence from informed consent's basic principles exposes abortion law's treatment of women as less trustworthy decision-makers.

Casey established that an abortion regulation is unconstitutional if "its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."¹⁹⁴ Purporting to address this precedent, *Carhart* discussed the "purpose" behind the Act and set forth three purposes justifying the ban on intact D&E, with one of the rationales being to protect women from their own "regret."¹⁹⁵ In articulating the woman-protective purpose for the Act, the Court incapacitated pregnant women as decision-makers.

The Court began its explanation of how the ban on intact D&E can "protect" women with the declaration: "Respect for human life finds an *ultimate* expression in the bond of love the mother has for her child."¹⁹⁶ This language harkens back to the century old decision of *Bradwell v. Illinois*, in which women were denied the right to practice law in part because "[t]he *paramount* destiny and mission of woman are to fulfill the noble and benign offices of wife and mother."¹⁹⁷ The *Carhart* Court gave no explanation for why the mother-child bond is the ultimate bond, as opposed to father-child or parental bonds,

194. *Casey*, 505 U.S. at 878 (emphasis added).

195. *Gonzales v. Carhart*, 550 U.S. 124, 155–60 (2007). The Court also opined that the Act "expresses respect for the dignity of human life" and preserves medical ethics. *Id.* at 157. A full discussion of whether the Act may be justified by the State's interest in protecting potential life or in preserving medical ethics is beyond the scope of this article. Briefly, the Court posited that "[i]t is a reasonable inference that a necessary effect of the regulation and the knowledge it conveys will be to encourage some women to carry the infant to full term, thus reducing the absolute number of later-term abortions." *Id.* at 160. However, the Court did not further explicate how a ban on only one method of abortion would reduce the overall number of second trimester abortions. *See id.* at 181 (Ginsburg, J., dissenting) (stating that "the law saves not a single fetus from destruction, for it targets only a *method* of performing abortion"). Furthermore, it is rather ironic that the Court discussed "protecting the integrity and ethics of the medical profession" as one of the purposes for the Act, but failed to mention the ethical principle of informed consent as an integral component of medical ethics. *See Planned Parenthood v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006) (noting that physicians testified that being forced to use less safe procedures on patients to avoid criminal liability violated ethical duties). It is unclear how the Court thought that the Act protects medical ethics. The Court relied in part on the Congressional findings, which claimed that "partial-birth abortion . . . confuses the medical, legal and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life." *Carhart*, 550 U.S. at 157. However, anytime a physician performs any method of abortion, he or she acts "against the physical life of a child." *Id.* Nevertheless, the Court concluded that when the State "has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn." *Carhart*, 550 U.S. at 158.

196. *Id.* at 159 (emphasis added).

197. 83 U.S. 130, 141 (1873) (Bradley, J., concurring).

especially for a woman with an unwanted pregnancy.¹⁹⁸ Rather, the Court simply declared that the Act recognizes the supposedly “self-evident” reality of women’s nature and role as mothers.¹⁹⁹ The Court’s statement not only echoes archaic notions of women’s proper roles, it also contradicts *Casey*’s reasoning that the government cannot impose “its own vision of the woman’s role, however dominant that vision has been in the course of our history and our culture.”²⁰⁰ *Casey* also spoke of the “bond of love” between a woman and her child, but specifically noted that “[this] bond of love cannot alone be grounds for the State to insist she make the sacrifice” of her bodily integrity and right to equal citizenship.²⁰¹ Following its statement about women’s “ultimate” role as mothers, the *Carhart* Court declared: “While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”²⁰² As the Court acknowledged, it had no data to support its claim that women “regret” their abortions.²⁰³ In fact, studies on the psychological impact of abortion show that women generally do not regret decisions to terminate a pregnancy.²⁰⁴

Relying on this unsupported claim of women’s regret, the *Carhart* Court expressed concern that because the decision “[is] so fraught with emotional consequence,” doctors “may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails.”²⁰⁵ The Court recognized that the law of informed consent generally does not require disclosure of every detail of a particular medical procedure and that “[a]ny number of patients facing imminent surgical procedures would prefer not to hear all the details, lest the usual anxiety preceding invasive medical procedures become the more intense.”²⁰⁶ However, it was “precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State.”²⁰⁷ The Court concluded:

198. See *Carhart*, 550 U.S. at 184 n.8 (Ginsburg, J., dissenting) (noting that Court failed to explain why mother-child bond is the “ultimate” bond especially for an unwanted pregnancy or pregnancy resulting from rape, and citing studies on prevalence of rape).

199. *Id.* at 159.

200. *Casey*, 505 U.S. at 852. See also *Carhart*, 550 U.S. at 185 (Ginsburg, J., dissenting) (“Though today’s majority may regard women’s feelings on the matter as ‘self-evident,’ this Court has repeatedly confirmed that ‘[t]he destiny of the woman must be shaped . . . on her own conception of her spiritual imperatives and her place in society.’”).

201. *Casey*, 505 U.S. at 852.

202. *Carhart*, 550 U.S. at 159.

203. *Id.* See also *id.* at 184 (Ginsburg, J., dissenting) (stating that the Court’s woman-protective reasoning is “an anti-abortion shibboleth for which [the Court] concededly has no reliable evidence”).

204. See *id.* at 184 n.7 (Ginsburg, J., dissenting) (citing studies repudiating the claim that women suffer psychological harm from abortion); BRENDA MAJOR ET AL., REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION (2008) (reporting that meta-analysis of all available scientific studies does not support link between an adult woman’s decision to have a single abortion and mental health problems); Siegel, *The New Politics of Abortion*, *supra* note 5, at n.44 (citing literature repudiating notion of “post-abortion syndrome”).

205. *Carhart*, 550 U.S. at 159.

206. *Id.*

207. *Id.*

The State has an interest in ensuring so grave a choice is well-informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.²⁰⁸

Even presuming that the Court correctly concluded that physicians should provide detailed information on the available procedures to ensure a fully informed choice for women, the obvious (although controversial) solution to a problem of lack of information would be for government to mandate more information, as *Casey* permits.²⁰⁹ Rather than requiring, for example, that doctors disclose more details about the intact D&E procedure, the Court invoked the rhetoric of informed consent (that women's choices should be "well-informed") to justify banning a potentially safer medical procedure.²¹⁰ The Court's concern for informed decision-making hardly seems genuine when its solution denies decision-making altogether.

In addition, the Court's "regret" rationale proves too much. Any medical treatment decision can lead to regret in some percentage of patients. If protection from regret were sufficient to permit government regulation, government could override patient decision-making for any medical procedure, eviscerating the legal and ethical norm of informed consent in healthcare. For example, a recent study concluded that as many as one in five men who undergo prostate surgery (which may not always be necessary to preserve life or health) regret their decision, typically because of reduced sexual function.²¹¹ Taking *Carhart's* reasoning to its logical extreme, why not permit the State to protect men from the regret that may result from their reduced virility, which may lead to depression and other psychological harms?²¹² Treatment for prostate cancer can also be an emotionally fraught decision for men, particularly

208. *Id.*

209. *See id.* at 184 (Ginsburg, J., dissenting) ("The solution the Court approves, then, is *not* to require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety.").

210. *See Resnik, supra* note 17, at 4–5 (arguing that, rather than uphold the ban, the Court could have insisted on disclosures of all risks, but noting that this approach is controversial since it imposes on the physician's prerogative to determine what information is material for disclosure under the law of informed consent).

211. Tara Parker-Pope, *Regrets After Prostate Surgery*, N.Y. TIMES, August 27, 2008, <http://well.blogs.nytimes.com/2008/08/27/regrets-after-prostate-surgery/?scp=1&sq=Regrets%20After%20Prostate%20Surgery&st=cse>. (stating that the finding that men who were long past surgery experienced more regret, "likely speaks to the fact that as time passes after surgery, men gain a more realistic view of lingering health and quality-of-life issues like erection problems and other changes in their sex lives.").

212. Prostate surgery for cancer treatment may not always be necessary to protect the patient's life or health—the benefits of treatment are in fact not certain for all patients. *See* Gerald L Andriole, Robert L Grubb, Sandra S Buys, David Chia et al., *Mortality Results from a Randomized Prostate-Cancer Screening Trial*, 360(13) THE NEW ENGLAND J. OF MED. 1310 (Boston: Mar 26, 2009); Gina Kolata, *Prostate Test Found to Save Few Lives*, N.Y. TIMES, March 18, 2009, at A1 (discussing the results of two recent longitudinal studies of prostate screening); Fritz H Schröder, Jonas Hugosson, Monique J Roobol, Teuvo L Tammela et al., *Screening and Prostate-Cancer Mortality in a Randomized European Study*, 360(13) THE NEW ENGLAND J. OF MED. 1320 (Boston: Mar 26, 2009)

due to possible sexual side effects. Yet, lawmakers do not respond to this proven risk of regret by limiting men's treatment options; rather lawmakers and physicians work to ensure the provision of more accurate information to improve men's decision-making.²¹³ Only in the case of the gender-specific abortion decision does the law react to the possibility of patient regret—present to some degree with any medical treatment—by permitting the government to ban the treatment entirely and endanger the patient's health.

Carhart's justification for departing from the norm of informed consent is admittedly not evidence-based, but rather based solely on sex-role stereotypes. The Court parades as factual, "self-evident" description what is in fact a normative view of the proper role of women.²¹⁴ The woman-protective reasoning portrays women who are "mothers" as too emotionally unstable to make significant decisions and it treats pregnant women as "hysterical" and childlike.²¹⁵ *Carhart* also implies that women's role as mothers mandates that they sacrifice themselves for their fetuses or else they will become psychologically unstable if they do not. It treats pregnant women who make decisions judged to be contrary to their "ultimate" role as mothers as insane. As Jack Balkin noted, *Carhart* basically claims that "[e]ither a woman is crazy when she undergoes an abortion, or she will become crazy later on."²¹⁶

Relying on stereotypical assertions about women's "emotional" nature and their proper role as mothers, *Carhart* denies women's ability to determine for themselves what choices will protect their overall health.²¹⁷ According to the Court's logic, a mentally competent woman is not capable of deciding how best to protect her own mental health. The State is the final decision-maker, because the State knows better than the woman herself that her "ultimate" role is as a mother.²¹⁸ In her dissent, Justice Ginsberg emphasized that the majority's reasoning "reflects ancient notions about women's place in the family and under

213. See Parker-Pope, *supra* note 211. The traditional legal and medical response to the inevitable likelihood that some patients may regret their decision is generally to ensure that patients receive more accurate information such that they can make better decisions for themselves. *Id.*

214. *Carhart*, 550 U.S. at 159.

215. See Siegel, *The New Politics of Abortion*, *supra* note 5, at 1032–33 (arguing that the "woman-protective" anti-abortion argument portrays pregnant women like "the woman hysteric who figures prominently in nineteenth-century antiabortion tracts"); *Carhart*, 550 U.S. at 184 (Ginsburg, J., dissenting) (challenging the Court's reliance on gender stereotypes, such as emphasizing "women's fragile emotional state" and the "bond of love the mother has for her child").

216. Linda Greenhouse, *Adjudging a Moral Harm to Women From Abortions*, N.Y. TIMES, April 20, 2007 at A18 (reporting a comment on Balkinization blog by Professor Jack Balkin that calls *Carhart's* reasoning a "new paternalism"). See also Resnik, *supra* note 17, at 5 ("*Carhart* is a judicial foray into psychology as well as religion, for the plurality opinion is an amalgam of presumptions about the emotions and motivations of mothers and of doctors (fathers remain missing in action) interspersed with moral or religious views about when life begins and what a pregnancy means for a woman.>").

217. Throughout the opinion, the majority refers to the woman seeking the abortion as a "mother," rather than as a "woman" or "patient." The opinion also describes women largely in terms of body parts or "anatomical landmarks," rather than as moral agents making complicated decisions. These and other rhetorical moves—such as referring to physicians as "abortion doctors" and the fetus as "infant" or "unborn child"—signal important shifts in the Court's view of abortion rights. See generally *Carhart*, 550 U.S. 124.

218. *Id.* at 159.

the Constitution—ideas that have long since been discredited.”²¹⁹ Constitutional scholar Reva Siegel has also extensively demonstrated that this twisted “informed consent” paradigm—that abortion should be banned to protect women from their own poor decisions—relies on gender-stereotyped notions of women’s capacity and women’s roles long rejected under equal protection jurisprudence.²²⁰

Carhart’s reasoning also runs directly contrary to general principles of informed consent that treat competent adults as capable decision-makers. Adults make important emotional medical decisions that may lead to regret in many situations, such as the prostate cancer treatment example discussed above, but the law does not interfere with those decisions on the ground that someone other than the patient knows better what life choices will lead to mentally healthy consequences. To the contrary, informed consent law ensures that even physicians, the presumed experts on medical treatment, do not interfere with patients’ decisions. The law defers to patients by mandating that physicians provide sufficient information to the patient so that the patient can ultimately make her own decision whether to accept or reject treatment.²²¹ Although invoking notions of informed consent, the woman-protective anti-abortion reasoning turns on its head informed consent law’s respect for patient decision-making capacity.

Carhart’s use (and misuse) of informed consent rhetoric exposes abortion law’s anomalous treatment of women as healthcare decision-makers.²²² The Court’s woman-protective reasoning claims to follow the general principle of protecting patients’ interests in informed decision-making, but applies that principle differently to pregnant women seeking abortion. Contrary to the Court’s assertion, there are in fact sound reasons a woman might choose the banned intact D&E procedure. Foremost, there are safety benefits to the intact version of the procedure. Three separate trial courts and three appellate courts accepted the expert testimony of physicians who explained why an intact D&E

219. *Id.* at 185 (Ginsburg, J., dissenting). Ginsburg’s stinging dissent also stressed that challenges to abortion restrictions “do not seek to vindicate some generalized notion of privacy,” but rather “center on a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature.” *Id.*

220. See Siegel, *The New Politics of Abortion*, *supra* note 8, at 991–93, 1034 (arguing that the “woman-protective” anti-abortion argument’s claims “about the competence of women as decisional agents taps perniciously (or, depending on one’s standpoint, fortuitously) into longstanding traditions of gender paternalism, increasing the likelihood that lawmakers will make judgments about regulating women’s decision making that rest on stereotypical assumptions about women”); Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1688 (2008) (discussing *Carhart’s* use of “woman-protective” anti-abortion claim and noting that the “claim is that by restricting *all* women, government can free women to be the mothers they naturally are”) [hereinafter Siegel, *The Right’s Reasons*].

221. See *supra* Part III.A.

222. Several other commentators have noted that the Court’s reasoning in *Carhart* runs directly counter to the principles enshrined in the doctrine of informed consent and criticized the rationale from a bioethical perspective. See Dresser, *supra* note 6, at 14; Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1620–21 (2008); Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL’Y REV., 6–13 (Fall 2007).

procedure would be the safest method of abortion for some women.²²³ If the State can require a woman to undergo a riskier abortion procedure in order to “protect” her from regret at the method of abortion, why not allow the State to ban all D&E abortions? Under the Court’s reasoning, the State could argue that if women knew the details of the non-intact D&E procedure, which the Court acknowledged could be characterized as equally “brutal,”²²⁴ women would similarly regret such a decision. If all the State must do to satisfy the Constitution is allow some alternative but less safe method of abortion, why not permit the State to ban D&E entirely and force women to undergo induction abortions? Induction abortion involves inducing labor, which entails more health risks to the patient, is significantly more costly as it requires a hospital stay, and is far more emotionally and physically painful for the woman.²²⁵ Given women’s supposed lack of decision-making capacity due to their emotional nature and their proper role as mothers, the State could readily argue that women should only have access to induction abortion since this method appears arguably less gruesome and, perhaps, more “natural” as it simulates the birth process. Yet, contrary to the Court’s description of women’s “self-evident” nature (that no woman would knowingly choose the intact D&E method of abortion), studies show that when given the option of either induction abortion or D&E, many women choose D&E.²²⁶ Of course, some percentage of women

223. Intact D&E limits the number of times a physician must insert instruments into the uterus, which reduces the risk of uterine perforation. Intact D&E may also decrease the likelihood of retained tissue, which could cause infection, hemorrhage, and infertility. Intact D&E may take less operating time than “standard” D&E, and therefore may reduce bleeding, the risk of infection and the risk of complications relating to anesthesia. *Carhart*, 550 U.S. at 161. See also *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 923–29 (D. Neb. 2004), *aff’d sub nom Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev’d*, 550 U.S. 124 (2007); *National Abortion Federation v. Ashcroft*, 330 F. Supp. 2d 436, 470–74 (S.D.N.Y. 2004); *Planned Parenthood Fed’n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 982–83 (N.D. Cal. 2004). Some providers feel that all late second-trimester abortions are more safely completed by intact D&E, although this conclusion was disputed by the government’s expert witnesses. One study comparing the D&E procedure and the intact variant concluded that both were safe, although there was not sufficient data to conclude whether or in what instances intact D&E would be safer for the patient. Chasen, *supra* note 29, at 1180–83. After the Act was signed into law in 2003, at least one physician called for further study on the procedures to determine the safety benefits. See Manuel Porto, *A Call for an Evidence-Based Evaluation of Late Midtrimester Abortion*, 190 AM. J. OBSTETRICS & GYNECOLOGY 1175, 1175–76 (2004). Of course, after the Court upheld the Act, no such studies will be possible in the United States. *Carhart*, 550 U.S. at 133 (concluding that the Partial-Birth Abortion Ban Act of 2003 should be upheld).

224. *Carhart*, 550 U.S. at 159.

225. See Chasen et al., *supra* note 29, at 1161–64 (finding that D&E is safer than induction and that most women prefer D&E to induction abortion); Amy M. Autry et al., *A Comparison of Medical Induction and Dilatation and Evacuation for Second-Trimester Abortion*, 187 AM. J. OBSTETRICS & GYNECOLOGY 393, 393–97 (2002) (finding that induction methods of abortion are riskier in the second-trimester).

226. Chasen et al., *supra* note 29, at 1163. It’s interesting to note that in *Roe v. Wade*, the Court stated that historically one of the state’s concerns in criminalizing abortion was to protect women from the *physical* harm that was likely to result due to unsafe abortion techniques: “Thus, it has been argued that a State’s real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy.” *Roe v. Wade*, 410 U.S. 113, 149 (1973). The Court explained that since abortion techniques were now safe, the state could no longer justify criminalizing abortion on the ground of protecting

may regret having an abortion, but rather than seriously engage with the question of how to ensure better decision-making for pregnant women, *Carhart's* approach takes the decision away entirely.²²⁷

The Court's adoption of the woman-protective anti-abortion claim has already had an impact on abortion law and policy, particularly with respect to abortion-specific "informed consent" legislation. For example, relying on *Carhart's* woman-protective rationale, the Eighth Circuit recently upheld an extremely biased South Dakota "informed consent" to abortion statute, which among other requirements mandates that physicians inform their patients that abortion will terminate the life of a "whole, separate, unique living human being; that the pregnant woman has an existing relationship with that unborn human being . . . [and] that by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated."²²⁸ The misuse of "informed consent" terminology in abortion law is also likely to encourage more malpractice actions against abortion providers for failure to fully inform patients of the "scientific and medical fact that [the fetus is] a complete, separate, unique and irreplaceable human being."²²⁹ Efforts to mandate clinically unnecessary ultrasounds under the guise of "informed consent" to abortion have also been spurred on by *Carhart's* woman-protective rationale, even though mandatory ultrasounds impose a medical procedure on a patient in violation of the right to refuse treatment protected by informed consent law.²³⁰ Each of these legal approaches claims to act on behalf of women

women's health. *Id.* *Carhart* attempts to make a similar public health argument, except on the unsupported claim that abortion is bad for women's mental health. See *Carhart*, 550 U.S. at 159.

227. See Tracy A. Weitz, et al., *You Say "Regret" and I Say "Relief": A Need to Break the Polemic About Abortion*, 78 *CONTRACEPTION* 87, 88 (2008) (critiquing "regret" rationale for restricting abortion and arguing for recognition of "full range of feelings women have about abortion" and renewed focus on research and policy measures supporting women's autonomous decision-making regarding abortion and childbirth). See also Reva Siegel, *The Right's Reasons*, *supra* note 220, at 145 (criticizing woman-protective anti-abortion argument for failure to actually address concerns about emotional harm resulting from abortion and instead offering "a one-size-fits-all cure for the many social circumstances that lead women to end a pregnancy"); Susan Frelich Appleton, *Toward a "Culturally Cliterate" Family Law?*, 23 *BERKELEY J. OF GENDER, L. & JUSTICE* 267, 333-34 (2008) (noting that shift to focus on women's decision-making in abortion should "permit a more nuanced inspection of a variety of constraints on women's agency that prompt abortion decisions and other choices" rather than paternalistic responses to ban abortion for women's own "protection").

228. *Planned Parenthood of Minn. v. Rounds*, 530 F.3d 724, 726 (8th Cir. 2008). See also Matthew Gordon, *State Attempts to Expand Abortion Informed Consent requirements: New Life After Gonzales v. Carhart?*, 35 *J. L. MED. & ETHICS* 751, 753 (2007) (reviewing significant doctrinal changes made by *Carhart* in reducing judicial scrutiny of abortion restrictions and arguing that "*Carhart* may ultimately spur expansions of informed consent requirements that go even farther in promoting a state's view of when life begins").

229. See *Acuna v. Turkish*, 930 A.2d 416, 418 (N.J. 2007) (discussing complaint of plaintiff Rose Acuna who sued her abortion provider for his failure to obtain her informed consent prior to abortion). See also Maya Manian, *Privatizing Bans on Abortion: Eviscerating Constitutional Rights Through Tort Remedies*, 80 *TEMP. L. REV.* 123 (2007) (discussing use of tort law to undermine constitutional right to abortion).

230. See *Nova Health Systems v. Henry*, District Court of Oklahoma, No. CJ-2008-9119, 2008 WL 4874107 (Okla. Dist. Oct. 9, 2008) (trial court petition challenging Oklahoma's mandatory ultrasound law, which requires an ultrasound prior to all abortions and verbal description of the image but also excuses doctors from liability for withholding information from the pregnant woman about the fetus such as existence of severe developmental defects). See also Carol Sanger, *Seeing and Believing:*

and to care about ensuring their well-informed decision-making, but on closer analysis operate as “harassment masquerading as knowledge.”²³¹

Carhart’s woman-protective rationale ignores the lessons learned long ago within the law of informed consent—primarily that “it is the prerogative of the patient . . . to determine for [her]self the direction in which [her] interests seem to lie.”²³² As Rebecca Dresser has argued, the debate over abortion “should focus on the basic substantive issue—whether the value of developing human life justifies depriving women of the choice to have an abortion,” not disingenuous arguments about protecting women’s psychological well-being.²³³ *Carhart’s* true goal appears to be thwarting abortions and enforcing normative views of motherhood, not protecting women’s health.²³⁴ In her dissent, Justice Ginsburg articulated this point best: “Eliminating or reducing women’s reproductive choices is manifestly *not* a means of protecting them.”²³⁵

IV. THE STATE AND THE PATIENT: SOME EXCEPTIONS TO PATIENT AUTONOMY

Carhart’s woman-protective reasoning is not only antithetical to informed consent law’s deference to patient decision-making, but also finds no support in constitutional law precedent on medical treatment decisions. The woman-protective anti-abortion rationale’s striking departure from both informed consent law properly understood *and* from public law precedents on medical care exposes abortion law’s sex discriminatory treatment of women as healthcare decision-makers. Although informed consent doctrine primarily governs the patient-physician relationship, it is a common law rule that has provided guidance to the Court’s understanding of the constitutional rights of patients vis-à-vis the State. As scholars have noted, there is quite a bit of convergence between the principles underlying the tort law doctrine of

Mandatory Ultrasound and the Path to a Protected Choice, 56 U.C.L.A. L. REV. 351, 360 (2008) (arguing that mandatory ultrasound requirements “disrupts the law’s traditional respect for privacy, bodily integrity, and decisional autonomy in matters of such intimacy as reproduction, pregnancy, and family formation”).

231. Sanger, *Seeing and Believing*, *supra* note 230, at 360.

232. *Canterbury v. Spence*, 464 F.2d 772, 781 (1972).

233. Dresser, *supra* note 6, at 14. Dresser criticizes both the Court’s reasoning in *Carhart* and biased abortion-specific “informed consent” legislation such as in South Dakota, arguing that “it is disingenuous to portray abortion bans and mandatory disclosures of one-sided and inaccurate information as policies protecting women.” *Id.*

234. See *Gonzales v. Carhart*, 550 U.S. 124, 191 (2007) (Ginsburg, J., dissenting) (arguing that true purpose of the Act and Court’s defense of it is to chip away at abortion rights). See also *Rust v. Sullivan*, 500 U.S. 173 (1991) (upholding federal regulation prohibiting Title X clinics from disseminating any information about abortion). *Carhart* claims to care about giving women full information about abortion, but *Rust* is another example of the Court denying information about abortion altogether, here by gagging the physician. See *id.* at 213–14 (Marshall, J., dissenting) (criticizing Court’s decision and stating, “In addressing the family-planning needs of their clients, the physicians and counselors who staff Title X projects seek to provide them with the full range of information and options regarding their health and reproductive freedom. Indeed, the legitimate expectations of the patient and the ethical responsibilities of the medical profession demand no less.”).

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

informed consent and the constitutional right of privacy.²³⁶ Both doctrines ultimately reflect concern for protecting individual autonomy, although this concern may at times be balanced against contrary societal interests in health or safety. In the limited instances where the government has overridden patient medical treatment choices, the government has *not* done so on the ground that the State knows better than individual patients what kinds of treatment they might regret. In no other context besides abortion does the law deny a competent adult patient's right to give her informed consent to a medical treatment that is proven to be safe, and possibly safer than other available treatments, based on the government's unsubstantiated belief that the treatment will be psychologically harmful to the patient.

Justice Kennedy noted in *Carhart* that the government heavily regulates the medical profession to protect public health and safety.²³⁷ For example, state governments directly regulate the medical profession through licensing schemes and scope of practice laws. These laws regulate who can practice medicine and have been upheld by the Supreme Court.²³⁸ However, although states license physicians and enforce scope of practice laws that regulate *who* can practice medicine, the government generally does not dictate *how* physicians practice medicine or what procedures they should use for any particular treatment.²³⁹ Similarly, although the government indirectly regulates physicians' practice of medicine through tort law and medical malpractice claims, the standards for liability for medical malpractice are generally set by professional standards of care, not state fiat.²⁴⁰ Decisions about how to proceed with medical care are ultimately preserved for the patient, as reflected in the background rule of informed consent. Thus, while *Carhart* correctly notes that government has played a significant role in regulating the medical profession,²⁴¹ historically this regulation has also served to protect patient autonomy through laws such as informed consent.²⁴²

The Supreme Court has only permitted the government to ban access to medical treatments in certain narrow instances, generally to protect the public

236. "Upon analysis it is evidence that both informed consent law and the constitutional right of privacy arose to protect the same interest, the right of autonomous self-determination, and that both are subject to the same qualification, the community's and family's interest in the health and well-being of their members." Note, *Abortion Regulation*, *supra* note 84, at 701. See also Meisel, *The "Exceptions" to the Informed Consent Doctrine*, *supra* note 80, at 431 n.70 (stating that "the 'presumption of individual self-determination' is the common-law analog of the constitutional right of privacy").

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

238. See *Collins v. Texas*, 223 U.S. 288 (1912) (upholding Texas licensing requirement for practitioners of medicine).

239. See George J. Annas, *Medical Judgment in Court and in Congress: Abortion, Refusing Treatment, and Drug Regulation*, 34 HUM. RTS. 2 (2007) (discussing the amount of deference physicians have been given in certain situations). There are some limitations on how physicians practice medicine, such as use of experimental drugs, discussed *infra* Part IV.B.1.

240. See *id.* at 3.

241. See *Carhart*, 550 U.S. at 157.

242. See *supra* Part III.A (discussing law of informed consent).

health.²⁴³ In fact, *Carhart's* woman-protective reasoning—that it is self-evident that abortion would damage women's psychological health—invokes the public health paradigm for government regulation of patient decision-making in order to justify the federal abortion ban.²⁴⁴ *Carhart's* woman-protective reasoning claims that Congress banned intact D&E for the legitimate purpose of protecting maternal health. Justice Kennedy's opinion attempts to frame the federal abortion ban as a public health issue, and suggest that, like the Court's other public health cases, the Court should leave it to the legislature to determine what is in the public's best interests.²⁴⁵ *Carhart* opines that it appropriately leaves to Congress the determination of which treatments are medically necessary to preserve pregnant women's health, just as the Court has left healthcare decision-making to legislatures with regard to compulsory vaccinations, drug regulations, and physician assisted suicide.²⁴⁶

Yet, a close examination of these cases reveals that the woman-protective rationale adopted in *Carhart* is readily distinguishable from precedent allowing government restrictions on medical treatment. There are four general areas where the Supreme Court has allocated decision-making power to the State rather than the patient: (1) compulsory vaccination laws; (2) bans on controlled substances; (3) regulation of experimental drugs; and (4) bans on physician assisted suicide.²⁴⁷ These precedents, many of which *Carhart* relies upon, do not support its reasoning not only because of the lack of reliable evidence regarding alleged detrimental psychological consequences to abortion, but also because none of these precedents permit the government to ban a medical treatment proven to be *physically* safer based on the government's unproven view that the treatment will be *psychologically* harmful to the patient. In other words, in no

243. See Hill, *A Tale of Two Doctrines*, *supra* note 15 at 344 (categorizing the Supreme Court's medical treatment decision cases as falling under either an "Autonomy Model" or "Public Health Model").

244. *Id.* at 320 (arguing that *Carhart's* "reasoning and language often resembled the analytic structure of the public-health line of cases").

245. See *id.* at 320; *Carhart*, 550 U.S. at 163 (citing, in support of lack of health exception, *Lambert v. Yellowley*, 272 U.S. 581, 597 (1926) and *Jacobson v. Massachusetts*, 179 U.S. 11, 30–31 (1905)).

246. See *Carhart*, 550 U.S. at 164 ("Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.").

247. See *Washington v. Glucksberg*, 521 U.S. 702 (1997) (upholding bans on physician assisted suicide); *United States v. Rutherford*, 442 U.S. 544 (1979) (addressing regulation of experimental drugs); *Lambert v. Yellowley*, 272 U.S. 581 (1926) (upholding ban on alcohol even for medical uses); *Jacobson v. Massachusetts*, 179 U.S. 11 (1905) (upholding compulsory vaccination law). The Court also upheld compulsory sterilization in the infamous case of *Buck v. Bell*, 274 U.S. 200 (1927). However, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942), essentially overruled *Buck* by upholding a fundamental right to refuse government mandated sterilization. See *id.* at 542. Therefore, government mandated sterilization is not discussed here. Several other cases cited by *Carhart* as support for permitting judicial deference to the government on matters of medical or scientific uncertainty are not discussed here because they address rights of criminal defendants, not medical decision-making. See *Kansas v. Hendricks*, 521 U.S. 346, 360, n. 3 (1997) (upholding civil commitment of persons convicted of sexually violent offenses); *Jones v. United States*, 463 U.S. 354, 364–365, n.13, 370 (1983) (upholding civil commitment of persons acquitted of criminal offense by reason of insanity); *Marshall v. United States*, 414 U.S. 417, 427 (1974) (upholding denial of access to optional federal treatment program to convicted criminal under rational basis review). It is nonetheless disturbing that *Carhart* compares pregnant women seeking abortion to convicted criminals in stating that these precedents support its decision. See *Carhart*, 550 U.S. at 163–64.

other context does the law ban a medically necessary treatment on the ground that the State knows better than a mentally competent adult what will be best for her mental health. That kind of paternalism only applies to women seeking an abortion.

These public health precedents can be boiled down into a few simple principles for when and why the government can restrict patients' medical options or deny patient capacity for decision-making. Restrictions on a competent adult patient's right to informed consent are justified when the State intervenes to protect *third parties* other than the competent adult patient—the justification being that the State may intervene “for the common good.”²⁴⁸ The State can intervene *on the patient's own behalf* only where there is a lack of information about the medical treatment such that the informed consent process cannot be expected to function properly and there is a risk of physical harm to the patient—the justification being that the State can then intervene “for the patient's own good.”²⁴⁹ Neither of these rationales supports *Carhart's* reasoning that the State can trump a woman's right to consent to a physically safer medical procedure, where full information is available, in order to protect her from unsubstantiated psychological harm resulting from her supposedly incompetent decision-making.

To summarize the argument below, the Supreme Court has held that the government can mandate vaccinations and ban controlled substances in order to protect third parties from communicable diseases and from recreational, that is, non-medical, drug abuse.²⁵⁰ Further, the government can protect patients from their own poor decision-making only in cases where there exists such a lack of information that the informed consent process cannot be expected to function appropriately *and* there is a risk of serious physical harm to the patient—the primary justification given by the federal courts for permitting government regulation of experimental drugs.²⁵¹ Finally, the Supreme Court's justifications for permitting state bans on physician assisted suicide meaningfully differ from *Carhart's* woman-protective rationale in several ways. Primarily, the Court reasoned that states could criminalize physician assisted suicide in order to protect vulnerable patients from coercion in end-of-life decision-making—that is, to protect the life of patients who are in fact not mentally competent or not making fully informed and voluntary decisions.²⁵² In contrast, *Carhart* holds that the government can endanger the health of competent women patients, making voluntary choices, where there is no lack of information, in order to protect them from a speculative risk of regret.

It is important to carefully review and distinguish the Supreme Court's precedents on the constitutionality of government bans on medical treatments,

248. See *infra* Part IV.A. Of course, one could argue that fetuses are “third parties” that the State is protecting by banning intact D&E. Although the Court's medical treatment cases suggest that government can impose health risks on individual patients for the protection of other persons and thus the public health at large, never before has the Court suggested that government can impose health risks on women in order to preserve the potential life of the fetus. See *infra* Part IV.A.2.

249. See *infra* Part IV.B.

250. See *infra* Part IV.A.

251. See *infra* Part IV.B.1.

252. See *infra* Part IV.B.2; *Washington v. Glucksberg*, 521 U.S. at 732–33.

because Justice Kennedy cites case law from each of these areas as if they directly support *Carhart's* reasoning.²⁵³ Moreover, demonstrating that the woman-protective anti-abortion rationale in fact finds no support in existing precedent further bolsters the claim that abortion law discriminates against women, because it permits the State to treat pregnant women as having lesser decision-making capacity (and therefore needing more "protection") than other patients making similarly important medical decisions.

A. Exceptions to Patient Autonomy "For the Common Good"

The easiest public health precedents to distinguish from *Carhart's* woman-protective rationale are those cases in which the Supreme Court permitted the government to deny patient choice "for the common good" rather than based on a paternalistic "for the patient's own good" rationale. That is, the government may deny patient choice in order to protect third parties from collateral harm—the paradigmatic public health case.²⁵⁴ The Court has relied upon the "for the common good" rationale to justify compulsory vaccination laws and regulations of controlled substances. *Carhart's* reliance on these precedents in support of its decision also represents a move towards establishing the fetus as a third-party "person" with interests sufficient to trump the woman's right to preserve her own health.

1. Compulsory Vaccination

Although patients generally have a right to refuse medical treatment, one glaring exception to this general rule is the law on compulsory vaccination.²⁵⁵ In *Jacobson v. Massachusetts*, the Supreme Court held that the government could override an individual's right to refuse medical treatment through mandatory vaccination laws.²⁵⁶ In response to fears about the spread of smallpox, a Massachusetts local board of health adopted a regulation requiring that "all the inhabitants of the city who have not been successfully vaccinated since March 1st, 1897, be vaccinated or revaccinated."²⁵⁷ Massachusetts law permitted local boards of health to "require and enforce the vaccination and revaccination of all the inhabitants" and to "provide them with the means of free vaccination."²⁵⁸ Notably, the regulation provided for a health exception for children "who present[ed] a certificate, signed by a registered physician, that they are unfit subjects for vaccination."²⁵⁹ The compulsory vaccination law at issue had no health exception for adults and those who refused vaccination were subject to a fine of five dollars.²⁶⁰

253. *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

254. See generally LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW* 20 (Univ. of Cal. Press 2000).

255. See Kristine M. Severyn, *Jacobson v. Massachusetts: Impact on Informed Consent and Vaccine Policy*, 5 J. PHARMACY & L. 249, 255 (1995) (arguing that compulsory vaccination laws violate informed consent).

256. 197 U.S. 11 (1905).

257. *Id.* at 13.

258. *Id.* at 12.

259. *Id.*

260. *Id.*

Jacobson refused to be vaccinated under the regulation, and as a result was prosecuted and fined.²⁶¹ Jacobson asserted that he had suffered adverse health consequences as a result of previous vaccination and had witnessed a similar adverse reaction in his son as well.²⁶² In his argument to the Supreme Court, Jacobson asserted that compulsory vaccination violated his right to control his body and to preserve his health. He claimed that compulsory vaccination is “hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best.”²⁶³ Although this case came before the Supreme Court in 1905, before the doctrine of informed consent was well-established, Jacobson’s argument fit squarely within the common law rule affirming a patient’s right to refuse medical treatment. The Supreme Court acknowledged that patients have a common law right to refuse medical treatment, but held that compulsory vaccination was justified by the government’s interest in protecting third parties from the spread of disease. In justifying its denial of patient autonomy in this manner, the Court noted that society imposes “manifold restraints to which every person is necessarily subject *for the common good*.”²⁶⁴ The Court particularly emphasized the State’s interest in protecting the public health: “Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.”²⁶⁵ Discussing the reasons behind the law, the Court emphasized evidence that smallpox was in fact a threat in certain parts of Massachusetts. The Court worried that disallowing compulsory vaccinations “would practically strip the legislative department of its function to care for the public health and the public safety when endangered by epidemics of disease.”²⁶⁶ Vaccination can only operate successfully as a public health measure if it avoids the “free rider” problem. One scholar explains the rationale for compulsory vaccination as follows:

Vaccination is effective as a public health measure only when it is universally applied. Compulsion was therefore upheld in order to protect everyone and to prevent a few from attempting to get a ‘free ride’ by obtaining the benefit of vaccinated neighbors without taking the risk themselves. The calculus of authority in such cases involves patient-citizen and state rather than patient-subject and physician; the decision to proceed despite the individual’s unwillingness is grounded on the superior collective good, not on the superiority of medical judgment.²⁶⁷

All fifty states and the District of Columbia today cite *Jacobson* as the key legal precedent for compulsory vaccinations laws. *Jacobson* still stands as the paradigmatic public health case because although it did arguably impose a health risk on the plaintiff,²⁶⁸ it did so not on the ground of protecting his own

261. *Id.* at 22.

262. *Id.* at 36.

263. *Id.* at 26.

264. *Id.* (emphasis added).

265. *Id.* at 27.

266. *Id.* at 37.

267. Capron, *supra* note 106, at 399.

268. Hill, *A Tale of Two Doctrines*, *supra* note 15, at 297 (noting that *Jacobson* presented strong evidence of the health risks of vaccination).

health or doubting his ability to make decisions about his own healthcare, but to protect other people.²⁶⁹ For example, in denying Jacobson's right to refuse vaccination, the Court could have argued that he should be subject to compulsory vaccination because the State knows better than Jacobson how to protect individual health from infectious diseases and vaccination would be in Jacobson's own best health interests. In its analysis, the Court did emphasize the vast amount of medical and other expert opinion concluding that vaccination is the best method for prevention of communicable diseases. Yet, the Court did not impose vaccination for Jacobson's own sake, but for the sake of the greater community. Since the government must mandate vaccination for all to ensure that vaccination works effectively, the Court found that the State was justified in trumping an individual patient's healthcare decisions in order to protect third parties.²⁷⁰

It is important to note that I am not suggesting that compulsory vaccination laws should *not* include health exceptions for adults as well as children. In fact, all vaccination laws today do include a health exemption.²⁷¹ Even in *Jacobson*, the Court suggested that there may be cases where a health exception to compulsory vaccination would be constitutionally necessary for adults, such as when it "can be shown with reasonable certainty that [the individual] is not at the time a fit subject of vaccination or that vaccination, by reason of his then condition, would seriously impair his health, or probably cause his death."²⁷² From the language of the opinion, the Court appears to be suggesting that there are limits to the health risks the State can impose even for the public good. Where there is evidence that government regulation will cause serious harm to health, *Jacobson* seems to be saying that the Constitution may require a health exception, yet *Carhart* denied women such an exception.²⁷³

Furthermore, the justification for compulsory vaccination laws differs materially from *Carhart's* woman-protective rationale. In contrast to *Jacobson*, *Carhart's* woman-protective reasoning justifies imposing health risks on women patients not for the protection of others, but supposedly for their own good because they lack the judgment to make sound healthcare decisions on their own.²⁷⁴ The woman-protective anti-abortion argument claims that the government can endanger women's health by denying them the opportunity to consent to a particular form of treatment in order to protect them from regret and "depression and loss of esteem."²⁷⁵ *Jacobson* and the compulsory vaccination

269. Statutes on mandatory vaccinations generally apply to children entering schools, and in some states to children entering licensed daycare facilities. States may also mandate vaccination for adult students entering college. See Severyn, *supra* note 255, at 249.

270. *Jacobson*, 197 U.S. at 39 (upholding the State's vaccination law, which was "adopted in execution of its provisions for the protection of the public health and the public safety, confessedly endangered by the presence of a dangerous disease").

271. Today "[e]very state provides a medical exemption, i.e., a physician certifies in writing that the vaccine(s) may be harmful, or are contraindicated." Severyn, *supra* note 255, at 260

272. *Jacobson*, 197 U.S. at 39.

273. *Id.*

274. See *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) ("While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.").

275. *Id.*

laws that followed from it do not support *Carhart's* paternalistic treatment of women's medical decision-making.

2. Controlled Substances

Although government regulation of medical practice is largely left to the states, the federal government has asserted broad authority to regulate drugs related to federal treatment pursuant to the Commerce Clause. In a number of instances, patients have asserted a constitutional right to access banned drugs for medical purposes, but the Supreme Court has upheld the federal government's right to regulate controlled substances—recreational drugs—against the wishes of individuals seeking those substances for purely medical purposes.²⁷⁶ Similarly to *Jacobson*, the Supreme Court and lower federal courts have articulated a “for the common good” rationale for allowing the State to limit patient access to controlled substances even for medically necessary treatment—not because the State knows better what is good for the patient but rather that the State must enforce drug laws primarily for the protection of third parties. The Court has held that the government has the power to ban controlled substances, even where patients have asserted a health need for a particular drug, with respect to two separate issues: bans on alcohol during Prohibition and the current federal ban on medical marijuana.²⁷⁷

One of the first cases to address the medical need for a controlled substance was *Lambert v. Yellowley*,²⁷⁸ to which Justice Kennedy in *Carhart* specifically refers in support of his conclusion that the federal “partial-birth” abortion ban need not include a health exception.²⁷⁹ Samuel Lambert was a distinguished New York physician who challenged a Prohibition era law that limited the amount of “spirituous” liquors he could prescribe to his patients for medicinal purposes.²⁸⁰ The National Prohibition Act, enacted pursuant to the Eighteenth Amendment, limited the amount of liquor physicians could lawfully prescribe to “[n]ot more than a pint of spirituous liquor to be taken internally . . . by the same person within any period of ten days

. . . .”²⁸¹ Lambert brought suit to enjoin Edward Yellowley, the acting federal Prohibition director, from interfering with his ability to prescribe these “medications” as he thought necessary in his professional medical judgment to protect his patients’ health. In other words, Lambert argued for a health

276. *Gonzales v. Raich*, 545 U.S. 1 (2005); *United States v. Oakland Cannabis Buyers’ Coop.* (OCBC), 532 U.S. 483 (2001); *Lambert v. Yellowley*, 272 U.S. 581 (1926).

277. *Raich*, 545 U.S. at 1 (2005) (addressing Congress’ Commerce Clause power to ban medical marijuana); *Oakland Cannabis Buyers’ Coop.* (OCBC), 532 U.S. at 483 (2001) (addressing statutory issue with regard to federal ban on medical marijuana); *Lambert*, 272 U.S. at 581 (1926) (addressing medical need for alcohol during Prohibition).

278. 272 U.S. 581 (1926). See also *James Everard’s Breweries v. Day*, 265 U.S. 545 (1924) (holding that Congress could allow the sale of certain alcohols but not others for medicinal use during prohibition).

279. *Carhart*, 550 U.S. at 163.

280. *Lambert*, 272 U.S. at 588.

281. *Id.* at 587. The Eighteenth Amendment prohibited the “manufacture, sale, and transportation of intoxicating liquors for beverage purposes” and granted Congress the “power to enforce prohibition by appropriate legislation.” *Id.* at 589.

exception to Prohibition.²⁸² Lambert lost in the Second Circuit and, on appeal to the Supreme Court, argued that the provision was unconstitutional “because it ha[d] no real or substantial relation to the appropriate enforcement of the Eighteenth Amendment” and thereby violated his fundamental rights as a physician.²⁸³

Justice Brandeis delivered the opinion of the Court, holding that the Eighteenth Amendment gave the federal government the power to enact and enforce the challenged legislation. The Court noted that although medical opinion differed, Congress considered evidence that the “preponderating opinion” was against the use of liquor for medicinal purposes.²⁸⁴ The Court emphasized that Congress could ban medicinal alcohol because it had evidence of the potential for alcohol abuse by persons other than the patient, as well as the difficulty of regulating illegitimate uses of the drug. For example, “[a]mong those [physicians] who prescribe them there are some who are disposed to give prescriptions where the real purpose is to divert the liquor to beverage uses.”²⁸⁵ This concern parallels similar concerns expressed in the more recent medical marijuana cases discussed below.

Lambert granted the government the authority to ban a medical treatment that some physicians believed necessary for their patients’ health, but for reasons quite different than the women’s “regret” rationale presented by *Carhart*. *Lambert* denied access to medicinal liquors, but not on the ground that it served the patient’s own good because patients lack the ability to understand the risks of such treatment. Like in *Jacobson v. Massachusetts*, which *Lambert* relied upon, the Court rested its decision on the ground that Congress could act for the common good of others as reflected in the Eighteenth Amendment.²⁸⁶ Primarily, the Court opined that Congress could act to limit the amount of liquor prescriptions because of the “difficulties always attendant upon the suppression of traffic in intoxicating liquors.”²⁸⁷ The Court repeatedly emphasized that Congress had the power to address the “liquor problem” by “keeping the quantity that may be prescribed within limits which will minimize the temptation to resort to prescriptions as pretexts for obtaining liquor for beverage uses.”²⁸⁸ Thus, the Court justified denying a potentially medically

282. *Id.* at 588.

283. *Id.* at 589. The Court did not address whether patients possessed a constitutional right to a health exception. *Id.*

284. *Id.* at 590.

285. *Id.* In his dissent, Justice Sutherland argued that, given that the challenged act implicitly concedes liquor to be of medicinal value, Congress could not limit prescription to an inadequate quantity. Sutherland asserted that the effect of upholding the legislation at issue was “to deprive the states of the exclusive power, which the Eighteenth Amendment has not destroyed, of controlling medical practice and transfer it in part to Congress.” *Id.* at 604 (Sutherland, J., dissenting).

286. *Id.* at 595–97.

287. *Id.* at 594.

288. *Id.* at 596. The Court also stressed that in limiting alcohol for medical treatment, Congress could consider “the lessons of half a century of experience in the several States in dealing with the liquor problem.” *Id.* at 589. *See also* *Everard’s Breweries v. Day*, 265 U.S. 545, 561 (1924) (upholding challenge to federal prohibition on prescription of malt liquor and noting difficulties of enforcing bans on alcohol if permitted for medicinal purposes since a prescription “opens many doors to clandestine traffic”).

necessary treatment based on the government interest in protecting third parties from alcohol abuse.

Very similar rationales are implicit in the Supreme Court's treatment of challenges to government restrictions on access to medical marijuana. The Supreme Court has not directly addressed whether patients have a fundamental constitutional right to access medical marijuana in order to protect their health or life; however, it has considered other issues related to medical marijuana that at least provide a hint of justification for allowing the government to ban medical marijuana despite medical need. The Court considered the issue of medical marijuana in two separate challenges: *Oakland Cannabis Buyers' Cooperative (OCBC) v. United States*²⁸⁹ and *Gonzales v. Raich*.²⁹⁰ In *OCBC*, the Court addressed only the statutory question of whether the Controlled Substances Act should be interpreted to incorporate a medical necessity defense. In *Raich*, the Court considered only the question of whether the federal government had the power pursuant to the Commerce Clause to ban locally grown and consumed marijuana. In both cases, the Court tangentially discussed the issue of patient need for medical marijuana. Its rationale for allowing the government to ban medical marijuana despite medical need, as in *Lambert*, appears to be one of protecting the common good by preventing non-medical use and abuse of recreational drugs by third parties.²⁹¹

In *OCBC*, the Court rejected the Ninth Circuit's conclusion that medical necessity is a defense under the Controlled Substances Act (CSA).²⁹² The CSA prohibits the "manufacture and distribution of various drugs, including marijuana."²⁹³ In *OCBC*, a marijuana cooperative that distributed medical marijuana to patients with physician-certified need argued that "because necessity was a defense at common law, medical necessity should be read into the Controlled Substances Act."²⁹⁴ *OCBC* contended that marijuana was the only drug that could alleviate its patients' severe pain and other debilitating symptoms.²⁹⁵ The district court recognized that "human suffering" could result from the federal ban on medical marijuana, but denied *OCBC's* request to allow it a common law medical necessity defense to federal seizure of its property.²⁹⁶ The Ninth Circuit disagreed, and held that medical necessity is a cognizable defense under the Controlled Substances Act.²⁹⁷ The federal government obtained immediate Supreme Court review of the Ninth Circuit's decision.

The Supreme Court rejected *OCBC's* argument on the ground that the common law defense of necessity cannot be applied to a statute where the

289. *United States v. Oakland Cannabis Buyers' Coop. (OCBC)*, 532 U.S. 483 (2001).

290. *Gonzales v. Raich*, 545 U.S. 1 (2005).

291. *OCBC*, 532 U.S. at 490; *Raich*, 545 U.S. at 33.

292. *OCBC*, 532 U.S. at 490.

293. *OCBC*, 532 U.S. at 486. *See also* Controlled Substances Act, 21 U.S.C. § 801 (2007).

294. *OCBC*, 532 U.S. at 490.

295. *Id.* at 487.

296. *Id.* at 488.

297. The Ninth Circuit then remanded to the district court for reconsideration of whether a medical necessity exemption should be granted to *OCBC*. *Id.* at 488. Following remand, the district court incorporated a medical necessity defense into its injunction prohibiting *OCBC* from possessing or distributing marijuana in violation of federal law. *Id.* at 488 n.2.

legislature had already made its own determination against incorporating such a defense.²⁹⁸ The Court noted that federal law “reflects a determination that marijuana has no medical benefits worthy of an exception.”²⁹⁹ Marijuana is a Schedule I drug under the Controlled Substances Act, and the Attorney General can only include a drug in Schedule I under three conditions: (1) the drug “has no currently accepted medical use in treatment in the United States”; (2) has “a high potential for abuse”; and (3) has “a lack of accepted safety for use . . . under medical supervision.”³⁰⁰ Furthermore, the Court stated in dicta that no medical necessity defense exists under the statute not only for manufacturing and distributing medical marijuana as OCBC did, but also for other restrictions such as mere possession, “even when the patient is ‘seriously ill’ and lacks alternative avenues for relief.”³⁰¹ Three Justices concurred in the judgment, specifically limiting their conclusion to the holding that manufacturers and distributors of marijuana could not raise the medical necessity defense.³⁰² The concurring Justices suggested that medical necessity may be a defense for seriously ill patients with no other treatment alternatives who possess and use marijuana solely out of medical necessity, but no such plaintiffs were before the Court.³⁰³ The Court limited its review to the statutory question and did not address any constitutional arguments regarding a patient’s fundamental right to access medically necessary treatment.³⁰⁴ The Court stated that it had granted review “[b]ecause the decision raises significant questions as to the ability of the United States to enforce the Nation’s drug laws.”³⁰⁵ At least implicitly, *OCBC* suggests that the federal government can deny a health exception to bans on medical marijuana in order to ensure proper enforcement of the CSA and thereby protect public health by preventing recreational use of the drug. This rationale for permitting the government to ban medical marijuana became more apparent in the Court’s next case addressing the issue.

In *Gonzales v. Raich*, the Supreme Court held that the federal ban on locally grown and consumed medical marijuana was within Congress’ power pursuant to the Commerce Clause.³⁰⁶ In upholding Congress’ power to apply the CSA even to those patients with desperate medical need, the Court emphasized Congress’ concerns with controlling the market in illicit drugs. The Court explained Congress’ main objectives in enacting the CSA: “to conquer drug

298. *Id.* at 490–94.

299. *See id.* at 491 (stating that “for purposes of the Controlled Substances Act, marijuana has ‘no currently accepted medical use’ at all. § 811.”).

300. *Id.* at 492 (quoting Controlled Substances Act, 21 U.S.C. § 812 (2007)).

301. *Id.* at 495 n.7.

302. *Id.* at 499 (Stevens, J., concurring).

303. *Id.* at 501 (“[W]hether the defense might be available to a seriously ill patient for whom there is no alternative means of avoiding starvation or extraordinary suffering is a difficult issue that is not presented here.”).

304. The Oakland Cannabis Buyers’ Cooperative asserted that, if the statute were not read to include an implied medical necessity defense, the statute would violate the substantive due process rights of patients and offend the fundamental liberties of the people under the Fifth, Ninth, and Tenth Amendments. *Id.* at 494. The Court found that it need not address the underlying constitutional issues, because the Court of Appeals had not addressed those claims. *Id.*

305. *Id.* at 489.

306. *Gonzales v. Raich*, 545 U.S. 1 (2005).

abuse and to control the legitimate and illegitimate traffic in controlled substances.”³⁰⁷ In particular, the Court stressed that “Congress was particularly concerned with the need to prevent the diversion of drugs from legitimate to illicit channels.”³⁰⁸

Raich did not reach the question of whether patients have a substantive due process right to access medical marijuana, although the patients had raised that claim in the lower courts.³⁰⁹ Angel Raich and her fellow patients presented significant evidence that the government ban on this particular medical treatment imposed health risks and suffering on patients.³¹⁰ However, in contrast to *Carhart*, the Court did not question the capacity of the patients themselves to render informed decisions about the use of marijuana for medical treatment. Instead, the Court emphasized that the purpose behind the CSA, including its application to medical marijuana, was to conquer recreational drug abuse through the orderly enforcement of drug laws.³¹¹ The Court relied heavily on “[t]he congressional judgment that an exemption for such a significant segment of the total market would undermine the orderly enforcement of the entire regulatory scheme

...”³¹² Like in *Jacobson* and *Lambert*, the Court permitted the government to sacrifice some individuals’ health for the sake of “the common good”—protecting third party non-patients from the negative effects of recreational drug abuse. Of course, one could characterize bans on *recreational* drug use as paternalistic as well, but that presents a different issue than the law’s treatment of patients’ capacity for *medical* decision-making in order to preserve their own health. Again, it is important to note that I am not arguing that the rationales put forth by the legislature and the courts are a sufficient or valid justification for denying a health exception for medical marijuana. Rather, the key point here is that denying a health exception based on protecting third parties “for the common good” does not justify *Carhart*’s woman-protective rationale, which incapacitates pregnant women for purely paternalistic reasons.

In sum, pursuant to these precedents on compulsory vaccination and bans on controlled substances, the government can deny patient exemptions from or access to certain medical treatments, even if a health exception may be medically necessary, but only to protect other persons and not because of paternalistic doubt about the capacity of patients to make informed treatment decisions. Whether or not one agrees with compulsory vaccination or total bans on

307. *Id.* at 12.

308. *Id.* at 12–13.

309. *Id.* at 33 (stating that the Court would not reach the patients’ substantive due process and medical necessity claims). The patients challenging the government action alleged that enforcing the CSA against them would violate the Commerce Clause, the Due Process Clause of the Fifth Amendment, the Ninth and Tenth Amendments, and the doctrine of medical necessity. *Id.* at 8.

310. *Id.* at 28 n.37 (noting that plaintiffs presented strong evidence of medical uses for marijuana, which “would case serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I,” but nevertheless, Congress could regulate because “most of the substances classified in the CSA ‘have a useful and legitimate medical purpose’ . . . even if respondents are correct that marijuana does have accepted medical uses” the CSA can impose limits beyond what California wants to allow).

311. *Id.* at 28.

312. *Id.* at 1, 28.

medically necessary alcohol or marijuana, these cases do not provide support for the denial of a health exception to the ban on intact D&E. These precedents do not treat competent adult patients as incompetent medical decision-makers in need of government “protection.”

More broadly, *Carhart’s* suggestion that the *Jacobson* and *Lambert* line of cases support its imposition of health risks on pregnant women seeking abortion represents a move towards treating the fetus as a person. *Jacobson* and the rest of the public health line of cases permit governmental denial of medically necessary treatment in order to protect existing members of the public—government can choose to force some persons to risk their health for the protection of other persons. To suggest that government can deny a health exception to an abortion regulation by analogy to *Jacobson* and *Lambert* positions the fetus as a third party with status equal to the pregnant woman. *Carhart* implies that, just as the government can choose to protect third persons from alcohol abuse by forcing patients with medical need for alcohol to sacrifice their health needs, the government can choose to protect the fetus by forcing the pregnant woman to jeopardize her health. Until *Carhart*, the Court had always required a health exception to abortion restrictions, even for post-viability abortions.³¹³ In fact, abortion is the only medical treatment for which the Court has articulated a constitutional right of access.³¹⁴ At least in part, this is because the fetus has not been given status as a constitutional person such that the State could be justified in impinging on the medical needs of women. If *Carhart* holds that fetuses are third parties that the government can choose to protect as a “public health” matter, that would logically lead to a justification for denying the abortion right altogether.

B. Exceptions to Patient Autonomy “For the Patient’s Own Good”

The more difficult medical decision-making precedents to differentiate from *Carhart’s* woman-protective rationale are the ones that, like *Carhart*, offer the paternalistic, “this is for the patient’s own good” reasoning for government limits on patient choice in medical care. Two examples of paternalistic limits on patient decision-making are government regulation of experimental drugs and bans on physician assisted suicide. This section argues that neither of these precedents supports abortion law’s woman-protective justification for abortion restrictions.

1. Experimental Drugs

The federal government’s broad authority to regulate interstate commerce in drugs includes the regulation of pharmaceuticals as well as controlled substances. The federal Food, Drug, and Cosmetic Act of 1938 (FDCA) regulates

313. *Gonzales v. Carhart*, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting).

314. See Hill, *A Tale of Two Doctrines*, *supra* note 15, at 315 (arguing that outside the context of abortion courts have not explicitly recognized a constitutional right to choose appropriate medical treatment); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813 (2007) (arguing for right of medical self-defense, i.e., a constitutional right to access medically necessary treatments).

drug manufacturing, marketing and distribution.³¹⁵ The FDCA bars the introduction of “new drugs” into interstate commerce until the drug has been administratively approved by the Food and Drug Administration (FDA) for both safety and efficacy based on sufficient scientific evidence.³¹⁶ The statute defines a “new drug” as “[a]ny drug . . . not generally recognized among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs as safe and effective for use under the conditions prescribed, recommended, or suggested in the labeling thereof.”³¹⁷

In a number of cases, patients have asserted a right to access experimental drugs not yet approved by the FDA.³¹⁸ The Supreme Court has not addressed whether the Constitution protects a right of access to medications needed for the preservation of health or life; however, the Court has considered statutory challenges to the ban on access to experimental drugs, in which it discussed justifications for the government’s regulation of new drugs.³¹⁹ A number of lower federal courts have addressed the question of whether the Constitution provides an affirmative right of access to particular medical treatments (outside the context of abortion) and all have rejected such a right.³²⁰ The federal courts have justified permitting government regulation of experimental drugs on the rationale that regulation protects patients from making poor decisions. Although this rationale is paternalistic,³²¹ courts have supported their position on the ground that physicians and patients lack basic information about experimental drugs, which undermines the possibility of using the informed consent model of patient decision-making in this context, and that regulation is necessary to protect patients from serious physical harm.³²²

315. 21 U.S.C. §§ 301–397 (2007).

316. Specifically, the statute provides that “[n]o person shall introduce or deliver for introduction into interstate commerce any new drug” without approval by the Food and Drug Administration (FDA). 21 U.S.C. § 355(a) (2007).

317. 21 U.S.C. § 321(p) (2007).

318. See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 695, 710 & n.18 (2007) (summarizing cases).

319. See *United States v. Rutherford*, 442 U.S. 544, 552 (1979) (noting that legislative history suggests that new drug safety and effectiveness standards were intended for persons suffering from both curable diseases as well as fatal illnesses).

320. See *Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach*, 495 F.3d 695, 710 & n.18 (2007) (en banc) (summarizing cases rejecting the claim that patients have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider where the government has reasonably prohibited the type of treatment or provider). See, e.g., *Mitchell v. Clayton*, 995 F.2d 772, 775 (7th Cir. 1993); *N.Y. State Ophthalmologic Soc’y v. Bowen*, 854 F.2d 1379, 1389 (D.C. Cir. 1988); *Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980); *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980), *on remand*, 442 U.S. 544 (1979). See also *Sammon v. N.J. Bd. of Med. Exam’rs*, 66 F.3d 639, 645 n.10 (3d Cir. 1995); *United States v. Burzynski Cancer Research Inst.*, 819 F.2d 1301, 1313–14 (5th Cir. 1987); *Lambert v. Yellowley*, 272 U.S. 581, 588 (1926); *Watson v. Maryland*, 218 U.S. 173, 176 (1910) (“There is perhaps no profession more properly open to such regulation [concerning public health] than that which embraces the practitioners of medicine.”).

321. See Steven R. Salbu, *Regulation of Drug Treatments for HIV and AIDS: A Contractarian Model*, 11 YALE J. ON REG. 401, 419 (1994) (“The FDA traditionally has taken a paternalistic approach to the control of drug access, focusing almost exclusively on protecting patients from exposure to dangerous or ineffective forms of treatment.”).

322. See, e.g., *United States v. Rutherford*, 442 U.S. 544 (1979).

For example, in *United States v. Rutherford* the Supreme Court denied terminally ill cancer patients the right to access an experimental drug, although solely on statutory grounds.³²³ In 1975, a group of patients and their spouses brought suit against the federal government to enjoin interference with access to Laetrile, an experimental cancer drug that was not approved for distribution under the FDCA.³²⁴ The district court ultimately held that “by denying cancer patients the right to use a nontoxic substance in connection with their personal health, the Commissioner had infringed [upon] constitutionally protected privacy interests.”³²⁵ The Tenth Circuit refused to address the constitutional issue, and instead concluded that the requirements of safety and effectiveness in the FDCA had no application to terminally ill cancer patients.³²⁶

The Supreme Court rejected the Tenth Circuit’s interpretation of the FDCA. Instead, the Court emphasized that even individuals suffering from a fatal illness “should be shielded from fraudulent cures.”³²⁷ To support its conclusion, the Court relied on legislative history suggesting that Congress intended to include experimental drugs for the treatment of life-threatening diseases within the ambit of the statute. The Court also deferred to FDA policy, which “never made exception for drugs used by the terminally ill.”³²⁸ The Court opined that safety and effectiveness remain relevant concerns for cancer patients, because “it is often impossible to identify a patient as terminally ill except in retrospect.”³²⁹ The Court also expressed fears of a slippery slope to deregulation of dangerous experimental drugs, noting that to accept the patients’ argument “that the safety and efficacy standards of the Act have no relevance for terminal patients is to deny the Commissioner’s authority over all drugs, however toxic or ineffectual, for such individuals.”³³⁰ Most relevant here, the Court worried that if a “new market” in experimental drugs for terminally ill patients were opened up, those patients would soon be exploited by the pharmaceutical industry:

Since the turn of the century, resourceful entrepreneurs have advertised a wide variety of purportedly simple and painless cures for cancer, including liniments of turpentine, mustard, oil, eggs, and ammonia; peat moss; arrangements of

323. 442 U.S. 544 (1979).

324. *Id.* at 548. The suit was originally filed by a cancer patient and her husband, but after the patient’s death and an amended complaint, the district court certified a class of terminally ill cancer patients as plaintiffs. *Id.* at 549 n.4. The district court ordered the government to permit limited purchase of Laetrile after finding that in proper dosages the drug was nontoxic and effective. The Tenth Circuit did not modify the injunction, but ordered remand to the FDA for a determination of whether Laetrile qualified as a “new drug” under the statute. The Tenth Circuit also ordered the FDA to determine whether Laetrile was exempt from premarketing approval under two “grandfather clauses” in the controlling statute. *Id.* at 549. The Commissioner of the FDA found that Laetrile qualified as a “new drug” and concluded that there was insufficient evidence of its safety or effectiveness. *Id.* The Act does not define what constitutes recognition of a drug’s safety and effectiveness, but in previous case law the Supreme Court has interpreted the FDCA as requiring “expert consensus” on safety and effectiveness founded upon “substantial evidence.” *Id.* at 549 n.7.

325. *Id.* at 550.

326. *Id.* at 550–51.

327. *Id.* at 552.

328. *Id.* at 553.

329. *Id.* at 556.

330. *Id.* at 557–58.

colored floodlamps; pastes made from glycerin and limburger cheese; mineral tablets; and “Fountain of Youth” mixtures of spices, oil, and suet . . . [T]his historical experience does suggest why Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise.³³¹

This statement expresses the heart of the federal courts’ justification for the federal government’s extensive regulation of “new drugs.”³³² Critics often characterize this rationale as paternalistic, because it disparages patients’ ability to make their own healthcare decisions, including by choosing to take on the risks of unproven medications. Some might argue that *Rutherford* provides support for the notion in *Carhart* that government can paternalistically make decisions on patients’ behalf to protect them from their own ignorance and poor judgment.³³³

Yet, the federal courts’ rationale for upholding limits on access to experimental drugs rests primarily on the lack of information about those drugs, such that the usual process of informed consent cannot be expected to function properly. The government must step in as information gatherer and decision-maker because patients cannot otherwise obtain the information on the risks and benefits of novel drugs on their own. For example, recently in *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*,³³⁴ the D.C. Circuit Court of Appeals further articulated the reasons for denying patients’ right to give “informed consent” to experimental drugs. Abigail Alliance represented a group of terminally ill patients who supported expanded access to experimental drugs, and asserted a constitutional right to make “informed decisions” about these drugs—that is, to take on the risks of trying experimental drugs that were their only hope of a cure.³³⁵ As noted above, the FDCA generally prohibits access to new drugs until approved by the FDA, which can be a time-consuming process,³³⁶ but the FDA has some regulations to permit “fast-tracking” of experimental drugs for terminally or severely ill patients.³³⁷ The Alliance argued that these programs were inadequate and submitted a petition, which the FDA rejected, arguing that the FDA should promulgate new regulations allowing “sponsors to market experimental drugs, under some circumstances, after the completion of Phase I trials.”³³⁸

331. *Id.* at 558.

332. *Id.* *Rutherford* did not address whether patients have a fundamental right grounded in substantive due process to access potentially life-saving medications. *Cf. Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980) (stating in dicta that “rights of privacy and personal liberty do not give individuals the right to obtain [the cancer drug] Laetrile free of the lawful exercise of government police power”).

333. The *Carhart* Court implies that the “abortionist,” like the pharmaceutical industry, will exploit women by withholding information the Court views as relevant. *See Gonzales v. Carhart*, 550 U.S. 124, 184 (2007). Certainly the anti-abortion movement has framed the issue in this manner, characterizing women as passive victims to evil abortionists. *See Siegel, The Right’s Reasons*, *supra* note 220, at 1643.

334. 495 F.3d 695 (D.C. Cir. 2007) (en banc).

335. *Id.* at 697.

336. *Id.* at 698 (explaining FDA’s four phase process).

337. *Id.* at n.4.

338. *Id.* at 699.

Initially, a panel of the D. C. Circuit held that the patients in *Abigail Alliance* had properly asserted a constitutional claim based on a due process liberty interest. The court framed the right as one of “access to potentially life-saving post-Phase I investigational new drugs on behalf of mentally competent, terminally ill adult patients who have no alternative government-approved treatment options.”³³⁹ The panel emphasized that, unlike in *Rutherford*, the patients in *Abigail Alliance* sought access to drugs that had cleared FDA’s Phase I safety hurdle.³⁴⁰ Phase I clinical human trials test first for safety in order to authorize further testing on a “substantial number of human beings.”³⁴¹ The panel emphasized that the Alliance was not asserting “an unfettered right of access to all new or investigational new drugs . . . [and] also does not challenge the Controlled Substances Act. . . .”³⁴² Rather, the right encompassed only “the right of terminally ill patients to make an *informed decision* that may prolong life . . . acting on a doctor’s advice, to obtain potentially life-saving medication when no alternative treatment approved by the government is available.”³⁴³

An en banc D.C. Circuit reversed the panel’s decision.³⁴⁴ In rejecting the Alliance’s argument, the court emphasized that the Alliance sought access to medications “that have not yet been proven safe.”³⁴⁵ The Alliance argued that the Supreme Court’s abortion jurisprudence supported its asserted right, specifically relying upon the right recognized in *Roe* and *Casey* that a woman may obtain an abortion “at any stage of a pregnancy if doing so is necessary to preserve her life or health.”³⁴⁶ The court rejected this analogy, opining that unlike in abortion, the Alliance’s case “is about whether there is a constitutional right to assume, in the Alliance’s own words, ‘enormous risks,’ in pursuit of *potentially* life-saving drugs.”³⁴⁷ The court also found it “highly significant” that the Supreme Court, although never directly addressing the constitutional claim of a due process right of access to experimental drugs, had rejected similar

339. *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 445 F.3d 472 (D.C. Cir. 2007), *rev’d en banc*, 495 F.3d 695 (D.C. Cir. 2007).

340. *Id.* at 486 (distinguishing *Rutherford* because in that case patients sought access to “a new cancer drug that had not cleared FDA’s Phase I safety hurdle and thus had not been approved for expanded testing on humans in ongoing clinical trials”).

341. *Id.* at 477.

342. *See id.* at 478.

343. *Id.* at 477–78 (emphasis added).

344. Notably, the court stated that it only addressed the right as framed by the Alliance, which was “the right of a terminally ill patient with no remaining treatment options to decide, in consultation with his or her own doctor, whether to seek access to investigational medications that the [FDA] concedes are safe and promising enough for substantial human testing.” The court specifically did not address “the broader question of whether access to medicine might ever implicate fundamental rights.” *Abigail Alliance*, 495 F.3d at 710.

345. *Id.* at 703. The en banc court noted that “[t]he fact that a drug has emerged from Phase I with a determination that it is safe for limited clinical testing in a controlled and closely monitored environment after detailed scrutiny of each trial participant does not mean that a drug is safe for use beyond supervised trials.” *Id.* at 706.

346. *Id.* at 709 (quoting *Roe v. Wade*, 410 U.S. 113, 152 (1973) and citing *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 879 (1992) (reaffirming the life and health exceptions)).

347. *Abigail Alliance*, 495 F.3d at 710.

challenges to the FDCA and FDA regulations on statutory grounds in *Rutherford*.³⁴⁸

After rejecting the Alliance's assertion of a fundamental right, the court applied the rational basis test to determine whether the FDA regulations should stand. Relevant to the concerns here, the court articulated its justification for preventing terminally ill patients from taking on informed risks with respect to novel medications. It noted that the "Alliance would rather that individual patients make decisions about this risk than have the FDA decide which drugs are safe enough for limited access to the terminally ill."³⁴⁹ However, the court was persuaded by the FDA's contrary claim that "'patients could be exposed to unreasonable risks from investigational drugs that may be neither safe nor effective."³⁵⁰ The court reasoned that the government has "a rational basis for ensuring that there is a scientifically and medically acceptable level of knowledge about the risks and benefits of such a drug."³⁵¹ In particular, it relied heavily on the FDA's argument regarding informed consent: "With so little data available, it is hard to understand how a patient could be truly informed about the risks—or potential benefits—associated with the drug."³⁵² The court emphasized its agreement with the FDA that "'it does not serve patients well to make drugs too widely available before there is a reasonable assessment of such risks to guide patient decisions, and experience in managing them."³⁵³

In other words, the courts reject the general rule protecting patients' right to informed consent with regard to experimental drugs, because an information gap exists about new drugs that the informed consent process cannot address. Patients lack the capability to make the same quality of informed decisions about novel medications because of scientific complexity, lack of expertise and, obviously, lack of full information since the drug remains experimental. Where there is such an information gap, the informed consent process cannot serve its purposes of allowing patients to weigh the risks and benefits of treatment options on their own.³⁵⁴ Although the federal government's extensive regulation of novel medical drugs and devices is paternalistic, lack of information presents a strong argument for rejecting the informed consent paradigm of patient decision-making in this context.³⁵⁵ Furthermore, numerous scholars have argued

348. *Id.* at 710 (citing *Gonzales v. Raich*, 545 U.S. 1, 28 (1979); *United States v. Rutherford*, 442 U.S. 544, 552 (1979); *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 490 (2001)).

349. *Abigail Alliance*, 495 F.3d at 712.

350. *Id.* at 712. The court held that the FDA's reasoning met the rational basis test, a conclusion "compelled by the Supreme Court's decision in *United States v. Rutherford*." *Id.*

351. *Id.* at 713. In justifying its conclusion, the court cited both *Jacobson v. Massachusetts*, 197 U.S. 11, 30 (1905), and *Gonzales v. Carhart*, 550 U.S. 124, 162–63 (2007). *Id.*

352. *Id.* at 700.

353. *Id.*

354. The dissenting judge from the panel opinion argued that "the majority attempts to limit its new right to a patient who is 'mentally competent' and has 'informed access' to experimental drugs . . . [but] [t]he majority never explains what mental competence, in this context, would require." *Abigail Alliance*, 445 F.3d at 496 (Griffith, J., dissenting).

355. See Charles J. Walsh & Alissa Pyrich, *Rationalizing the Regulation of Prescription Drugs and Medical Devices: Perspectives on Private Certification and Tort Reform*, 48 RUTGERS L. REV. 883, 929–30 (1996); Peter Jacobson & Wendy Parmet, *A New Era of Unapproved Drugs: The Case of Abigail Alliance v. Von Eschenbach*, 297 J. AM. MED. ASSOC. 205, 206–07 (2007).

that the denial of access to experimental drugs is primarily justified by “the for common good” rationale, i.e., protecting third parties, since FDA regulation creates needed incentives for the drug trials that lead to evidence of safety and effectiveness of new drugs and thereby serves the public health at large.³⁵⁶

Whether one agrees or disagrees with the FDA’s regulation of new drugs, however, the federal courts’ rationale for permitting government restrictions on patient choice in this context differs significantly from the anti-abortion woman-protective rationale articulated in *Carhart*, for at least two reasons. First, bans on “partial-birth” abortion bar access to a medically necessary treatment that medical evidence has already proven to be safe and effective, and in fact may be the safest procedure in some cases.³⁵⁷ With regard to intact D&E, there is no information gap on safety and effectiveness that requires government intervention.³⁵⁸ In fact, “partial-birth” abortion bans increase the risk of harm to women by criminalizing a medical procedure that medical experts believe to be safer than other alternatives for some patients. *Carhart* permits the government to impose physical health risks for a non-novel medical treatment in order to supposedly protect patients from an unproven risk of regret or depression. There is a significant difference between assuming that competent adults who are laypersons do not have the expertise to evaluate the risks of newfound medical treatments, versus assuming that competent adults cannot consent to medical treatments proven to be safest for their health because these adults do not have a sense of their own moral views and therefore of what might be best for their mental health. *Carhart* thus allows the government to ban the safest and most effective procedure rather than trust competent adult women to make their own decisions about abortion, which could be fully informed in a way that consent to experimental medications could not. *Carhart*’s woman-protective rationale presents a kind of paternalism and a denial of women’s decision-making capacity that is *not* supported by allowing government restrictions on novel and untested medical drugs and devices.

Second, *Carhart*’s woman-protective rationale is readily distinguishable not only because it involves non-experimental treatment, but also because it imposes known *physical* health risks in order to prevent purely speculative

356. See Jacobson & Parmet, *supra* note 355, at 206–07. See also Jerry Menikoff, *Beyond Abigail Alliance: The Reality Behind the Right to Get Experimental Drugs*, 56 U. KAN. L. REV. 1045, 1066 (2008) (stating that “the attempt by the plaintiffs to get early access to such drugs poses a very real conflict between the interests of dying patients desperate to get a chance at any possible treatment, even those that are largely a shot in the dark, and society as a whole, which will benefit from the knowledge learned in clinical trials”); Michael D. Greenberg, *AIDS, Experimental Drug Approval, and the FDA New Drug Screening Process*, 3 N.Y.U. J. LEGIS. & PUB. POL’Y 295, 315 (2000) (“People confronting the prospect of imminent death face very limited risks from experimental medication, and even a small incremental probability for improvement may constitute an enormous benefit to them. The disjunction between the interests of the desperately ill and that of consumer protection for the broader public has long been recognized.”)

357. See *Gonzales v. Carhart*, 550 U.S. 124, 162–63 (2007) (noting that trial courts had found that intact D&E could be safest procedure in some instances).

358. *Carhart* did express concern that physicians would not disclose details of the procedure to their patients. However, if that was truly the concern it could have been resolved by simply requiring physicians to inform patients of all relevant information pursuant to the doctrine of informed consent. Whether physicians should be obligated to disclose detailed information of second trimester abortion procedures is discussed *supra* Part III.C.

psychological harm. The FDA regulates new drugs to prevent serious physical harm to patients by ensuring that medical treatments are both effective and safe.³⁵⁹ *Carhart* oddly suggests that an abortion procedure should be banned despite the fact that it is the most effective and safe procedure,³⁶⁰ because of the unsubstantiated risk that patients may suffer “regret.” Many decisions related to medical care besides abortion may lead to patient regret, yet the State generally does not bar access to those medical treatments.³⁶¹ Mental health is certainly a valid public health issue, and I do not wish to imply that protection from physical harm should be privileged over protection from mental harm as a general matter.³⁶² However, it seems more troublingly paternalistic for the State to substitute its judgment as to a mentally competent adult’s capacity to judge the risk of regret, as opposed to protecting individuals from risks of grave physical harm from untested treatments, particularly where the threat of psychological harm remains unsupported by available evidence.³⁶³ Furthermore, from an equality perspective it is certainly troubling that government second-guesses only women’s medical decision-making on the ground of “protecting” them from an uncorroborated risk of emotional injury, especially where the government imposes proven risks of physical injury in the process.

Notably, once medications have passed the FDA’s approval process, the federal courts have been less willing to allow the FDA to impose further restrictions.³⁶⁴ For example, in *Thompson v. Western States Medical Center*,³⁶⁵ the Court struck down on First Amendment grounds a federal law restricting the ability of drug sellers to advertise and promote compounded drugs, which are moderately altered forms of approved medications.³⁶⁶ Interestingly, *Thompson*

359. Alice K. Marcee, *Expanded Access to Phase II Clinical Trials in Oncology: A Step Toward Increasing Scientific Validity and Compassion*, 63 FOOD & DRUG L.J. 439 (2008); Judy Vale, Note, *Expanding Expanded Access: How The Food And Drug Administration Can Achieve Better Access To Experimental Drugs For Seriously Ill Patients*, 96 GEO. L.J. 2143 (2008); Austin Winniford, Note, *Expanding Access To Investigational Drugs For Treatment Use: A Policy Analysis And Legislative Proposal*, 19 HEALTH MATRIX 205 (2009); Allison J. Goodman, Comment, *Abigail Alliance v. von Eschenbach: Restricting Access to Potentially Lifesaving Drugs Since 2007*, 25 J. CONTEMP. HEALTH L. & POL’Y 107 (2008).

360. *Gonzales v. Carhart*, 550 U.S. 124, 162–63 (2007).

361. *See supra* Part III.C.

362. I thank Lisa Ikemoto for raising this point.

363. *See* Jerry Blumenthal, *Emotional Paternalism*, 35 FLA. ST. U. L. REV. 1, 44–45 (2007) (discussing when and whether government paternalism is justified and noting the strong tradition of autonomy particularly as against government paternalism).

364. *See, e.g.,* *Tummino v. Torti*, 603 F. Supp. 2d 519, 524 (E.D.N.Y. 2009) (holding that FDA must reconsider denial of Plan B emergency contraception over-the-counter to girls under age of seventeen and grant such access to seventeen year olds since FDA decisions were made through improper political influence).

365. 535 U.S. 357 (2002).

366. Drug compounding is a practice in which a doctor or pharmacist combines or alters ingredients of existing medications to tailor the medication to an individual patient’s particular medical needs. *Id.* at 360–61. Compounding “is a traditional component of the practice of pharmacy.” *Id.* at 361. Drug compounding is used when the needed medication is not commercially available, such as for a patient who is allergic to an ingredient in a mass-produced product. The FDA gave pharmacists more leeway for drug compounding since it did not “make sense to require compound drugs created to meet the unique needs of individual patients to undergo the testing required for the new drug approval process,” because pharmacists “do not make enough money

emphasized that speech restrictions could not be justified based on a “highly paternalistic approach” that assumes patients lack the judgment to make decisions about their own healthcare.³⁶⁷

The federal government asserted its substantial interest in preserving public health as a justification for limiting advertising of compounded drugs.³⁶⁸ The government argued that its advertising restrictions achieved the proper balance between the compelling but competing interests of controlling the “new drug” approval process while also preserving the availability of compounded drugs for individual patients who have particularized medical needs and could not otherwise use commercially mass marketed products approved by the FDA.³⁶⁹ The Court rejected the argument that the government’s advertising restrictions could be justified on the ground that direct-to-consumer advertising would put patients at risk by causing them to seek compounded drugs even when not medically necessary.³⁷⁰ Stating that “this concern amounts to a fear that people would make bad decisions if given truthful information about compounded drugs,”³⁷¹ the Court also rejected the dissent’s suggestion that advertising of compounded drugs will be confusing to patients. The Court noted

from small-scale compounding to make safety and efficacy testing of their compounded drugs economically feasible.” *Id.* at 369–70. In essence, requiring such testing would force pharmacists to stop providing compounded drugs and would deny patient need. Although Congress had left regulation of compounding to the states for fifty years after the enactment of the FDCA, the FDA eventually became concerned that some pharmacists were manufacturing and selling “new” drugs in the guise of compounding and thereby avoiding the FDCA’s mandates. *Id.* at 362. The FDA promulgated guidelines restricting the ability of retail pharmacists to manufacture and sell compound drugs, which eventually were in large part adopted by Congress when it enacted the Food and Drug Administration Modernization Act of 1997 (FDAMA). *Id.* at 33–64. A group of pharmacies specializing in drug compounding brought a challenge to a section of the FDAMA that required that prescriptions for compounded drugs be “unsolicited” and that prohibited the advertising or promotion of “the compounding of any particular drug, class of drug, or type of drug.” *Id.* at 365. The pharmacists asserted that these restrictions violated the First Amendment, because these were an unwarranted restriction on truthful and non-misleading commercial speech. *Id.* at 366. The Ninth Circuit had found that the restrictions did in fact violate the First Amendment. *Id.* at 360.

367. *Id.* at 375 (quoting *Virginia Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 48, 77 (1976)).

368. The Court applied the First Amendment test for commercial speech, which included reviewing the government’s substantial interest in the restriction on commercial speech. *Id.* at 366.

369. *Id.* at 368.

370. *Id.* at 374.

371. *Id.* The Court emphasized that it had “previously rejected the notion that the Government has an interest in preventing the dissemination of truthful commercial information in order to prevent members of the public from making bad decisions with the information.” *Id.* The Court quoted from *Virginia Bd. of Pharmacy*, 425 U.S. at 769, which rejected the government’s argument defending restrictions on pharmacists’ advertising of pricing on the ground that if individuals received pricing information they would choose low quality pharmacy to save on cost. *Thompson*, 535 U.S. at 374–75. The Court stated that government should “assume that this information is not in itself harmful, that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them.” *Id.* (quoting *Virginia Bd. of Pharmacy* 425 U.S. at 770). The Court made this proclamation despite considerable evidence, cited by the dissent, that consumer advertising does create significant effects on consumer demand and physicians’ willingness to prescribe. *Id.* at 383 (Breyer, J., dissenting) (citing evidence of effects of consumer-directed advertising on specific medications).

that any such confusion could be addressed by “requiring each compounded drug to be labeled with a warning that the drug had not undergone FDA testing and that its risks were unknown.”³⁷² In other words, where information is available, the solution must be to provide the patient with more information, not less.

Regardless of whether one ultimately agrees with the courts’ decisions on this issue, government regulation of experimental drugs does not provide support for *Carhart’s* public health styled, woman-protective rationale for criminalizing access to the safest methods of abortion. The courts justify bans on access to novel medical treatments on the grounds of protecting patients from physical harm due to a lack of information on safety and efficacy, yet those rationales do not apply to bans on proven methods of abortion.

2. Physician Assisted Suicide

The Supreme Court’s precedents on end of life decision-making are also pertinent to the question of the law’s treatment of patient capacity to make important medical decisions. The Court has expressed the view that, while the Constitution protects patients’ right to refuse even life-saving medical treatment, the Constitution does not protect a fundamental right to physician assisted suicide. In *Washington v. Glucksberg*, the Court unanimously rejected the argument that competent adult terminally ill patients have a substantive due process right to physician assisted suicide (PAS).³⁷³ Justice Kennedy relied heavily on *Glucksberg* to support his reasoning in *Carhart*.³⁷⁴

This section argues that the Court’s rationales for allowing states to prevent patients from choosing assisted suicide do not provide support for *Carhart’s* dismissal of the decision-making capacity of female patients seeking abortion. *Glucksberg* presents the hardest of the Court’s medical decision-making precedents to distinguish, since its reasoning is arguably as thoroughly paternalistic as *Carhart’s* in its assessment of the quality of patient decision-making.³⁷⁵ However, *Glucksberg’s* rationales meaningfully differ from *Carhart’s* woman-protective reasoning in at least three ways. First, bans on PAS serve to protect patients who are not mentally competent or not making voluntary decisions, unlike bans on intact D&E. Second, bans on PAS protect patients from the gravest of physical harms, as opposed to the purely speculative risk of psychological harm that purportedly concerned the *Carhart* Court. Third, bans on PAS apply to all terminally ill persons regardless of gender, whereas *Carhart’s* gender-specific reasoning raises special equal protection concerns.

The Court first addressed end-of-life decision-making in *Cruzan v. Director, Missouri Department of Health*.³⁷⁶ In *Cruzan*, the Court “assume[d] that the United States Constitution would grant a competent person a constitutionally protected

372. *Id.* at 376.

373. 521 U.S. 702 (1997).

374. See *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007).

375. See Capron, *supra* note 106, at 398–99 (noting the “state’s primary interests here have been found to be a paternalistic concern to safeguard the individual from his own unwise decision, a ritualistic desire to uphold ‘the sanctity of life,’ and a collective interest in preserving each person’s productivity for society’s benefit.”).

376. 497 U.S. 261, 279 (1990).

right to refuse lifesaving hydration and nutrition,” but did not decide the issue in that case as the patient, Nancy Cruzan, was incompetent.³⁷⁷ *Cruzan* relied heavily on informed consent law in interpreting the Due Process Clause as a source of protection for patient autonomy. As the Court noted later, *Cruzan* premised its assumption that the Constitution protects a right to refuse lifesaving treatment upon “the common-law rule that forced medication was a battery[] and the long legal tradition protecting the decision to refuse unwanted medical treatment” under the law of informed consent.³⁷⁸ Chief Justice Rehnquist observed that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”³⁷⁹ *Cruzan* emphasized that informed consent doctrine “has become firmly entrenched in American tort law” and that it embodies this “notion of bodily integrity.”³⁸⁰ The Court stressed that “even the touching of one person by another without consent and without legal justification was a battery.”³⁸¹ It reasoned that “[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.”³⁸² The Court also reviewed case law previously addressing the topic, noting that courts had found that the right to refuse medical treatment could be protected both by the common law doctrine of informed consent and by a constitutional right of privacy.³⁸³

Despite recognizing a patient’s right to autonomous decision-making even with respect to ending the patient’s own life, in *Washington v. Glucksberg* the Supreme Court unanimously held that the Constitution does not protect patient access to PAS.³⁸⁴ In numerous separate opinions, the Justices articulated a number of different justifications for upholding bans on PAS. In the majority opinion, Chief Justice Rehnquist stated that the government had three separate interests in criminalizing physician assisted suicide. First, the government had an interest in the preservation of human life, including the terminally ill.³⁸⁵ Notably, in discussing the State’s interest in protecting human life, the Court emphasized that not all patients seeking PAS are mentally competent and that

377. *Id.* at 269.

378. *Washington v. Glucksberg*, 521 U.S. at 725.

379. *Cruzan*, 497 U.S. at 269 (quoting *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

380. *Id.*

381. *Id.*

382. *Id.* at 270.

383. *See id.* at 271–77. Justice O’Connor’s concurrence emphasized that the constitution protects a “liberty interest” in refusing unwanted medical treatment, noting that “the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.” *Id.* at 287 (O’Connor, J., concurring). O’Connor also suggested that a state’s refusal to implement the decisions of a patient’s appointed surrogate could violate a patient’s fundamental right to refuse treatment. *Id.* at 292. “The State’s imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion.” *Id.* at 288.

384. 521 U.S. 702 (1997). In addition, in *Vacco v. Quill*, the Court held that there is no violation of equal protection if the State permits patients to refuse life saving treatment and thereby commit suicide, but does not permit patients to obtain physician assistance in suicide. 521 U.S. 793 (1997).

385. *Glucksberg*, 521 U.S. at 728–31.

physicians often have difficulty detecting lack of mental competence, particularly for patients suffering from depression.³⁸⁶ Thus, “legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons.”³⁸⁷ Second, the Court found that the government had an interest in “protecting the integrity and ethics of the medical profession.”³⁸⁸ The Court relied in part on the American Medical Association’s code of ethics, which prohibits PAS, and reasoned that PAS undermines physician-patient trust and conflicts with the role of the physician as healer.³⁸⁹ Third and finally, the Court reasoned that the State could reasonably fear that permitting assisted suicide “will start it down the path to voluntary and perhaps even involuntary euthanasia.”³⁹⁰ Most relevant here, the Court asserted that the State “has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes.”³⁹¹ The Court stressed the “real risk of subtle coercion and undue influence in end-of-life situations.”³⁹² It worried in particular that poor persons would be pressured to spare their families the costs of treatment and that disabled and terminally ill persons would be subject to discrimination.³⁹³

In his concurring opinion, Justice Souter further explained the rationale for permitting the government to ban PAS. He emphasized that the government could not ban PAS simply because it disagrees with or thinks it knows better what should be a competent adult patient’s voluntary choice.³⁹⁴ Rather, Justice Souter stressed that government could justify overriding competent adult decisions to seek PAS only to protect patients who are not in fact competent or acting voluntarily:

[The State can justify banning physician assisted suicide] not with a moral judgment contrary to [the patient’s], but with a recognized state interest in the protection of nonresponsible individuals.³⁹⁵

Justice Souter particularly expressed concern about mistaken decisions that result from inadequate palliative care or an erroneous terminal prognosis, and “coercion and abuse” stemming from large medical bills.³⁹⁶ He recognized that none of these rationales apply to the patient who is in fact mentally competent, not subject to mistake, coercion or abuse, and voluntarily decides to obtain PAS.³⁹⁷ However, he reasoned that the government’s fear of a “slippery slope”

386. *Id.* at 730–31.

387. *Id.* at 731.

388. *Id.*

389. *Id.* *Carhart* also relied on the government’s interest in protection of life and preservation of medical ethics as rationales for upholding the federal “partial-birth” abortion ban. *See Gonzales v. Carhart*, 550 U.S. 124, 157–58 (2007). A full discussion of these rationales is beyond the scope of this article.

390. *Glucksberg*, 521 U.S. at 732.

391. *Id.* at 731.

392. *Id.* at 732.

393. *Id.*

394. *Id.* at 782 (Souter, J., concurring).

395. *Id.*

396. *Id.*

397. *Id.*

presented a constitutionally sufficient justification for banning assisted suicide even to those patients who are competent and acting voluntarily.³⁹⁸ In particular, “the barrier between assisted suicide and euthanasia could become porous, and the line between voluntary and involuntary euthanasia as well . . . because there is a plausible case that the right claimed [for competent, voluntary decisions to use assisted suicide] would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not.”³⁹⁹

Similarly, in her concurrence which provided the fifth vote for Justice Rehnquist’s majority opinion, Justice O’Connor emphasized that the government’s interest in the protection of patients who are not in fact competent or making voluntary decisions presented the only constitutionally sufficient justification for state bans on assisted suicide: “I agree that the State’s interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician assisted suicide.”⁴⁰⁰ Justice Stevens also opined in his concurrence that “[m]uch more than the State’s paternalistic interest in protecting the individual from the irrevocable consequences of an ill-advised decision motivated by temporary concerns is at stake.”⁴⁰¹ Justice Stevens concurred in the judgment due to what he saw as the State’s legitimate concerns about being able to regulate PAS such that only competent, terminally ill patients making voluntary choices would obtain assisted suicide.⁴⁰²

Glucksberg’s reasoning does not support *Carhart’s* woman-protective rationale for restricting access to abortion. *Glucksberg’s* rationales differ in at least three ways. First, *Glucksberg* permitted government bans on PAS primarily out of concern that the government would not be able to protect dying patients who were not in fact mentally competent or not acting voluntarily in choosing PAS. In other words, the Court justified government bans on PAS as the only means to ensure that mentally incompetent patients or patients subject to coercion are protected from involuntary death, even if this approach results in some competent, uncoerced patients being denied autonomy in seeking PAS.⁴⁰³ This “slippery slope” rationale is in line with cases like *Jacobson* (which *Glucksberg* relied upon as support), and its “for the common good” rationale,⁴⁰⁴

398. *Id.* at 785.

399. *Id.*

400. *Id.* at 737 (O’Connor, J., concurring). See also *id.* at 738 (“The difficulty in defining terminal illness and the risk that a dying patient’s request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.”).

401. *Id.* at 740–41 (Stevens, J., concurring).

402. See *id.* at 740. Justice Stevens also argued that the “State’s legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying,” and that those patients should be able to seek access to PAS on a case-by-case basis. *Id.* at 747.

403. See, e.g., Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 898–901 (1998) (discussing rationales of individual justices for banning PAS).

404. *Jacobson v. Massachusetts*, 197 U.S. 11, 17 (1905). See Also Yale Kamisar, *Some Non-Religious Views Against Proposed ‘Mercy Killing’ Legislation*, 42 MINN. L. REV. 969, 1042 (1958) (arguing that the

in the sense that the Court validated governmental overriding of patient autonomy only to protect third parties other than the competent patient making voluntary decisions.⁴⁰⁵ In contrast, *Carhart* permits the State to override women's decisions about abortion where there are no sound reasons to doubt competence and voluntariness. *Carhart* does not suggest that the federal ban serves to protect women who are in fact mentally incompetent or coerced into their decision. Rather, *Carhart* implies that pregnancy alone renders women incompetent. In other words, a rational pregnant woman would make only one choice—the government's choice. Unlike *Glucksberg*, which recognizes that some patients seeking PAS may be competent and acting voluntarily, *Carhart*'s woman-protective reasoning declares all pregnant women incompetent to choose appropriate medical care related to abortion.⁴⁰⁶

Second, as with experimental drugs, government bans on PAS represent its efforts to protect patients from grave physical harm, not a specious risk of psychological harm. A mistaken terminal prognosis, lack of mental competence, or coercion in the context of PAS results in the involuntary death of the patient. Government override of patient autonomy to protect at least some patients from an unwanted death seems rather compelling. It is a different order of paternalism when the State claims to protect the public from serious physical harm—or death—as opposed to the State protecting patients from an unproven risk of potential emotional consequences resulting from their own allegedly poor decision-making, especially when this “protection” also endangers the patient's physical health. Furthermore, *Glucksberg* appears to support the opposite balance in terms of physical versus psychological harm. *Glucksberg* privileges avoiding physical harm (unwanted death) over the psychological harm that may result from prolonged existence against one's will while terminally ill,⁴⁰⁷ whereas *Carhart* elevates the avoidance of psychological harm over the avoidance of physical harm.⁴⁰⁸ If the government regularly imposed physical health risks to protect patients from regret—as in the case of prostate cancer treatment—perhaps the woman-protective anti-abortion logic would seem less discriminatory. However, *Carhart*'s brand of paternalism—imposing a ban on the physically safest medical procedure on the ground that someone other than the patient knows what is best for the patient's mental health—is particularly disturbing since it only applies to women patients seeking abortion.

Lastly, *Glucksberg* does not support this gender-specific paternalism that animates the woman-protective anti-abortion argument.⁴⁰⁹ There are no sound

potential abuses of PAS outweigh the benefits of relieving suffering for some patients who would voluntarily choose PAS).

405. Again, *Carhart* also claims that intact D&E, like physician assisted suicide, should be banned because of the State's interest in the potential life of the fetus, but to argue that pregnancy renders a competent adult woman incompetent is quite a different and unjustified claim. *Gonzales v. Carhart*, 550 U.S. 124, 157–58 (2007).

406. See *Carhart*, 550 U.S. at 159–60.

407. Norman L. Cantor, *On Kamisar, Killing, and the Future of Physician-Assisted Death*, 102 MICH. L. REV. 1793, 1798 (2004) (stating that “[a]utonomy, constructive preference, and dignity are the crucial objects” of patients seeking PAS).

408. I thank Susan Frelich Appleton for raising this point.

409. See Siegel, *The New Politics of Abortion*, *supra* note 5, at 1049 (arguing that *Carhart*'s paternalism is particularly troubling “because of the mistaken and harmful judgments about women

reasons (other than the sex-based stereotypes articulated in *Carhart*) to treat competent pregnant women as being unable to choose medical treatment for abortion if given appropriate information.⁴¹⁰ Although some of *Glucksberg's* rationales can be fairly characterized as unjustly incapacitating competent adult patients since ultimately they rest on a felt need to protect patients from their own poor decisions,⁴¹¹ *Glucksberg* can still be distinguished from *Carhart's* woman-protective rationale based on differences in the patient population at issue. There, the Court rested on assumptions about terminally ill patients and expressed much concern about the decision-making abilities of dying patients due to the vulnerability and dependency that inevitably results for some patients from their serious illnesses.⁴¹² Even assuming that the rationales in *Glucksberg* and *Carhart* are similarly paternalistic towards the capacity of patients to make significant medical decisions, the assumptions in *Glucksberg* applied equally to all similarly situated patients—to all terminally ill men and women seeking PAS.⁴¹³ Therefore, “the rights of a politically vulnerable group are not at stake. . . . in the same, sure way as are black people subject to race discrimination laws [or] women subject to abortion restrictions.”⁴¹⁴ As Justice O'Connor noted, “Every one of us at some point may be affected by our own or a family member's illness.”⁴¹⁵ Our equal protection jurisprudence does not offer heightened scrutiny for stereotyping based on disability, poverty, or age, but does apply heightened scrutiny to government actions that are gender specific or motivated by gender stereotypes. *Carhart's* woman-protective rationale for

it engenders. Lawmakers reasoning from traditional forms of gender paternalism may not recognize that women who have abortions are competent decision makers grappling with complex practical and relational considerations.”).

410. Although the *Carhart* Court does not explicitly state that physicians are coercing women into intact D&E procedures, it suggests as much in its characterization of “abortion doctors” who refuse to disclose information the Court believes would be relevant to the woman's decision. Yet, rather than requiring disclosure of the information, the Court concluded that women are incapable of determining where their own health interests lie. See *supra* Part III.C.

411. The “coercion” rationale is arguably most paternalistic. See Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501, 1510–11 (2008).

412. *Washington v. Glucksberg*, 521 U.S. 702, 730–31 (1997).

413. Of course, PAS does have gendered implications in terms of its potential implementation. See Susan M. Wolf, *Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia in FEMINISM & BIOETHICS: BEYOND REPRODUCTION* 282–308 (Wolf ed., 1996).

414. Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, (1998) (stating that “[d]ying people are clearly not a discrete and insular minority” and therefore the democratic political processes can be fairly relied upon) (internal quotations omitted). See also Yale Kamisar, *Foreword: Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 106 MICH. L. REV. 1453, 1467 (2008) (distinguishing *Lawrence v. Texas* on the ground that “*Glucksberg* did not demean any politically vulnerable group”); *Vacco v. Quill*, 521 U.S. 793 (1997) (rejecting argument that bans on PAS violate the Equal Protection Clause because of differential treatment of patients who can choose suicide by removing life support).

415. *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring) (“There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure.”)

forcing women to use a less safe method of abortion rests on gender stereotypes that have long been repudiated under the Equal Protection Clause.⁴¹⁶

IV. CONCLUSION

Some scholars have argued that *Carhart* has had little practical effect on abortion rights.⁴¹⁷ To the contrary, not only does the decision detrimentally impact women's health in clinical practice,⁴¹⁸ *Carhart's* woman-protective reasoning has had and will continue to have significant impact both legally and politically, and both within abortion law and beyond abortion law. Within abortion law, *Carhart's* woman-protective rationale has already had significant impact in the courts and in the public arena, as exhibited particularly by legislatures enacting even more biased abortion "informed consent" laws, such as the legislation recently upheld in South Dakota.⁴¹⁹ Beyond abortion law, *Carhart's* incapacitation of women as healthcare decision-makers could have a significant impact on how courts and legislatures view women, particularly pregnant women, as patients. The woman-protective anti-abortion claim not only reinforces the familiar notion that women are irrational decision-makers, but also the notion that women serve their ultimate role in society when they are mothers and that, as mothers, their only choice is to be self-sacrificing. When the Supreme Court places its imprimatur on these kinds of arguments about women's decision-making capacity, or lack thereof, lower courts and legislatures may well feel more free to follow it.

It would not be surprising to see *Carhart's* logic extended to other healthcare issues generally involving "maternal-fetal conflict."⁴²⁰ If women are

416. See Siegel, *The New Politics of Abortion*, *supra* note 5, at 991 (arguing that "woman-protective" anti-abortion reasoning provides grounds for challenging abortion restrictions as violations of Equal Protection).

417. See, e.g., David J. Garrow, *Significant Risks: Gonzales v. Carhart and the Future of Abortion Law*, 2007 SUP. CT. REV. 1 (2007).

418. See Tracy A. Weitz & Susan Yanow, *Implications of the Federal Abortion Ban for Women's Health in the United States*, 16 REPRODUCTIVE HEALTH MATTERS 99, 103-04 (2008) (discussing clinical implications of "partial-birth" abortion bans, including physicians feeling pressured to deviate from safest medical procedures to avoid criminal liability and physicians refusing to perform second trimester abortions entirely due to fear of prosecution).

419. See, e.g., Gold & Nash, *supra* note 222, at 6 ("Kennedy's implication that the pre-abortion counseling process could and perhaps should be used as a forum for dissuading a woman from having the procedure is widely viewed as an invitation to states to take a new look at their abortion-specific 'informed consent' policies."). See also Planned Parenthood of Minn. v. Rounds, 530 F.3d 724, 726 (8th Cir. 2008) (relying on *Carhart's* "regret" rationale to uphold South Dakota's "informed consent" legislation requiring physicians to inform abortion patients that abortion will terminate the life of a "whole, separate, unique living human being").

420. There is an extensive literature discussing the issue of "maternal-fetal conflict." See, e.g., Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV., 451, n.4 (2000) (noting the rich literature on "maternal-fetal" conflicts [hereinafter Oberman, *Mothers and Doctors' Orders*]); *Maternal-Fetal Conflict: Legal and Ethical Issues* (Bibliography), in NATIONAL REFERENCE CENTER FOR BIOETHICS LITERATURE, KENNEDY INSTITUTE OF ETHICS (1990) (bibliography of literature on this topic); Mary Carrington Coutts, *Maternal-Fetal Conflict: Legal and Ethical Issues, Scope Note 14*, in NATIONAL REFERENCE CENTER FOR BIOETHICS LITERATURE, KENNEDY INSTITUTE OF ETHICS (1990). Almost all of the commentators in this field have concluded that, except in extreme circumstances, neither physicians nor the State should interfere with pregnant women's right to informed consent. See Oberman, *Mothers and Doctors'*

irrational decision-makers better served by the substitute judgment of others, then why not allow government to trump women's right to informed consent in the many other areas in which a pregnant woman's decisions could arguably harm her fetus? There are numerous examples of "maternal-fetal conflicts" in medical practice, in particular conflicts related to pregnant women's right to refuse medical treatment.⁴²¹ The woman-protective argument could be deployed to justify denying pregnant women's right to refuse blood transfusions, cesarean sections, drug treatment, or other invasive medical treatment for the benefit of the fetus on the ground that women would "regret" decisions to forgo such care. Courts and legislatures have already justified denying pregnant women's autonomy in these contexts at least in part by impugning their ability to make sound decisions. Those cases that have denied pregnant women's right to refuse treatment have tended to rely on gender-stereotyped claims that women are irrational decision-makers and should be self-sacrificing mothers.⁴²² For

Orders, *supra* note 420, at 451, 452, n.8 (2000) (noting that the majority of commentators conclude that "in all but the most extreme circumstances, it is impermissible to infringe upon the pregnant woman's autonomy rights"). A few scholars have argued to the contrary. See, e.g., Joel Jay Finer, *Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibility, and Decisional Authenticity*, 76 MINN. L. REV. 239 (1991); Jeffrey A. Parness, *Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life*, 22 HARV. J. ON LEGIS. 97 (1985); John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth* 69 VA. L. REV. 405 (1983). Although labeled as "maternal-fetal conflict," it is important to note that the "conflict" only arises through the involvement of the medical profession. Michelle Oberman has argued that these cases should be termed "maternal-doctor conflicts," because these conflicts "originate in the context of the relationship between the doctor and the pregnant woman" and result from the doctor's "seemingly well-motivated efforts" to impose his or her perception of appropriate care. Oberman, *Mothers and Doctors' Orders*, *supra* note 420, at 454. When the patient refuses the physician's advice, physicians and hospitals then seek court orders to obtain permission to trump women's right to refuse treatment. "Maternal-fetal conflicts" thus involve an effort by both the physician and the State to override the pregnant patient's right to informed consent. See *id.* Notably, many of the cases involving forced caesarean sections or forced drug treatment involve poor women of color. See Lisa Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, The Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205 (1992) (discussing regulation of pregnant women and noting targeting of poor women of color); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY* (1997).

421. As discussed in Part III.A, patients' right to refuse medical treatment, even life-saving treatment, is a well-established common law and constitutional right. See *supra* Part III.A. In numerous instances, courts have denied pregnant women's right to refuse treatment by ordering life-saving blood transfusions against women's wishes, or ordering forced Cesarean sections or drug treatment. See, e.g., Ikemoto, *supra* note 420, at 1236-83 (discussing various types of regulation of pregnant women). Many state legislatures have denied pregnant women's right to reject life-saving medical treatment by refusing to recognize their advanced healthcare directives. See Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537 (2006) (discussing limits on pregnant women's advanced healthcare directives).

422. Lisa Ikemoto, *Furthering Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 502 (1992) [hereinafter Ikemoto, *Furthering Inquiry*] (analyzing forced medical treatment cases and concluding that judges and physicians characterized women who refused treatment as irrational). Of the many different possible conflicts between a pregnant patient and her physician, forced caesarean sections have received the most legal attention, from both scholars and the courts. See Oberman, *Mothers and Doctors' Orders*, *supra* note 420, at 478-79 (noting that scholars have been particularly attracted to the "high-drama scenario" of cesarean section litigation). A number of courts have addressed pregnant women's right to refuse medical treatment in this context. See, e.g., *In re. A.C.*, 573 A.2d 1235 (D.C. Cir.1990); *Jefferson v. Griffin*

example, scholars reviewing cases on forced cesarean sections have noted that pregnant women who refuse treatment “are often characterized as stubborn, guilty, and irrational, even when the court specifically finds them to be clearly competent.”⁴²³ The case law also suggests that “good” mothers should be “self-sacrificing and nurturing.”⁴²⁴ *Carhart’s* statement that, if a decision may be characterized as harmful to her fetus, no amount of information can lead to a valid consent from a pregnant woman, logically supports the conclusion that the State should substitute its judgment for pregnant women’s healthcare more generally.⁴²⁵

Although the Court gave other rationales for its holding, *Carhart’s* adoption of the anti-abortion movement’s woman-protective reasoning is particularly troubling for its archaic and stereotyped caricature of the irrational woman.⁴²⁶ As recent media stories have reported, the legal and political battles over abortion now rage not over “what goes on inside a woman’s womb . . . [but] what goes on inside her head.”⁴²⁷ The inconsistency between abortion law’s approach to women’s capacity for sound healthcare decision-making and the general law on healthcare decision-making exposes the sex discrimination inherent in the woman-protective anti-abortion argument. Abortion law’s disrespect for pregnant women’s decision-making abilities unjustifiably diverges from both private and public law’s treatment of patient decision-making in other healthcare contexts. The law obstructs women patients’ self-determination for reasons that have not been tolerated for the male patient population. Most disturbing, *Carhart’s* woman-protective rationale sugarcoats violations of women’s right to equal treatment by cloaking those violations in the language of informed consent and public health. Yet, despite expressing

Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981). The courts have taken two different approaches to the question of whether the physician and the State can force a cesarean section upon a pregnant woman. Some courts set forth a clear rule that upholds the woman’s right to refuse medical treatment under all but the most exceptional circumstances. *See, e.g., In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990) (recognizing pregnant women as capable of making autonomous decisions and having equal rights to give informed consent or refusal to medical procedures); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (holding that pregnant women have right to refuse medical treatment equally deserving of constitutional protection). Other courts set forth a balancing test to weigh the competing interests of the pregnant woman and the State’s interests, although the “balancing” tends to lead to forced treatment. *See, e.g., Pemberton v. Tallahassee Memorial Regional Med. Ctr.*, 66 Fla. Supp. 2d 1247 (N.D. Fla. 1999) (applying balancing test to conclude that forced cesarean section did not violate woman’s constitutional rights); *Jefferson*, 274 S.E.2d at 457 (affirming compelled cesarean section).

423. Ikemoto, *Furthering Inquiry*, *supra* note 422, at 502.

424. *Id.* at 511.

425. *See Resnik*, *supra* note 17, at 5 (arguing that *Carhart* raises the specter of increased government regulation of pregnant women, including “prevent[ing] women from eating certain foods or from drinking alcohol” and “requiring that women submit to fetal monitoring, ultrasounds, or Caesarian sections”).

426. This long-held notion of women’s irrationality is particularly associated with the work of Sigmund Freud. *See SIGMUND FREUD, THREE ESSAYS ON THE THEORY OF SEXUALITY* 87 (James Strachey ed. 1962) (discussing “the greater proneness of women to neurosis and especially to hysteria”).

427. Stephanie Simon, *New Front in Abortion Battle*, WALL ST. J., Aug. 12, 2008, at A16.

concern for women's autonomous decision-making and emotional well-being, abortion law fails to actually address those concerns.⁴²⁸

The woman-protective anti-abortion claim has pernicious and far reaching implications for gender equity in healthcare. In order to counter the force of this claim, lawmakers should recognize that the woman-protective argument against abortion is an anomaly in the law's approach to patient healthcare decision-making and therefore a denial of equal treatment for women.

428. See Tracy A. Weitz, et al., *You Say "Regret" and I Say "Relief": A Need to Break the Polemic About Abortion*, 78 *CONTRACEPTION* 87, 88 (2008) (criticizing "protective" abortion restrictions and arguing for renewed focus on informed consent that actually supports women's autonomous decision-making regarding abortion and childbirth); Reva Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 *YALE L.J.* 1694, 1796 (2008) (arguing that "[b]lanket restrictions on abortion are not designed to address these concerns" about mental health or coercion in abortion decision-making, and that rather than deny women agency, law and policy should focus on measures such as resources to support childrearing, address work-family conflicts, and provide improved resources for counseling).