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Not-So-Informed Consent: Using the Doctor-Patient Relationship to Promote State-Supported Outcomes

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NOTES

NOT-SO-INFORMED CONSENT: USING THE DOCTOR-PATIENT RELATIONSHIP TO PROMOTE STATE-SUPPORTED OUTCOMES

Over the past several decades, the informed consent doctrine has become a staple of our health care system, creating a monumental shift in the way we practice medicine. For much of our medical history, the Hippocratic Oath to "do no harm" meant doctors paternalistically determined what they believed to be the appropriate course of treatment for their patients.[1] Now, instead of simply following the will of their doctors, patients generally prefer to take a more active role in their health care, deciding which treatments, if any, are most appropriate for their individual circumstances.[2]

The informed consent doctrine highlights patient autonomy as its core value, emphasizing the importance of providing patients with the medical information needed to make a treatment decision that is both fully informed and in accordance with the patient's beliefs and priorities.[3] Although both the common law and its later statutory embodiment set baseline standards for the types of information to be provided, the informed consent doctrine has traditionally left doctors significant leeway to determine the appropriate treatment information

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[1] *See* MARSHA GARRISON & CARL E. SCHNEIDER, THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION 41 (2003) ("For years, medical paternalism—the belief that doctors should make decisions for patients—ruled.").

[2] *See* JESSICA W. BERG, PAUL S. APPELBAUM, LISA S. PARKER & CHARLES W. LIDZ, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 26–27 (2d ed. 2001).

[3] *Id.* at 24–26; *see also id.* at 25 ("Although a person cannot autonomously choose an option she does not understand, usually patients can be provided with information relevant to their treatment decisions, in terms that they can comprehend, so they can decide whether to authorize implementation of a treatment plan.").

to share with their patients and how best to convey it.[4] Ideally, the process is one that promotes the type of thoughtful and effective communication between a patient and her physician that ultimately allows the patient to realistically and objectively balance the risks and benefits of a proposed course of care.[5]

The relatively recent development of informed consent statutes for specific procedures, however, seems to have upended the traditional notion of informed consent. Instead of promoting autonomous choice, these statutes mandate that doctors provide particular disclosures about certain procedures. In addition, rather than providing patients with objective information, some of these statutes appear to provide patients with slanted information that pushes them toward a predetermined "right" choice.[6] This is especially true with abortion,[7] which, as a hot-button issue, has received a great deal of legislative attention with regard to specific informed consent requirements.[8] Given recent developments in the courts, this attention is only likely to increase.[9]

Specific informed consent statutes, though purportedly intended to enhance informed consent and protect patients when physicians fail to

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[4] *See id.* at 40–64 (describing the historical development of general informed consent requirements through common law, the resulting standards of disclosure, and the lingering ambiguity as to the exact scope of the disclosure necessary under these standards).

[5] *See id.* at 315 (identifying the theoretical goal of the doctrine as allowing patients to utilize a "rational decisionmaking process" that promotes more informed health care decisions "in accordance with patients' values").

[6] *See* Rachael Andersen-Watts, *The Failure of Breast Cancer Informed Consent Statutes*, 14 MICH. J. GENDER & L. 201, 203–04 (2008) ("These laws do not promote individualistic decision-making. In fact, they stem in part from the assumption that individual women were making an 'incorrect' [treatment] decision [by choosing mastectomy over lumpectomy]. This is not merely the law overstepping its role by proffering medical advice, but moreover it is a perversion of the goal of informed consent." (footnotes omitted)).

[7] *See* Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, GUTTMACHER POL'Y REV., Fall 2006, at 6, 11 ("[P]olicymakers and public health officials frequently disregard the basic principles of informed consent in favor of furthering a highly politicized antiabortion goal."). Despite the seeming inconsistency of such action in light of traditional informed consent, the Supreme Court has readily acknowledged a state's ability to use its regulatory power "in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life." Gonzales v. Carhart, 550 U.S. 124, 158 (2007). That the Court has condoned such action does not negate the fact that the statutes are contrary to the original spirit of informed consent.

[8] See Rachel Benson Gold & Elizabeth Nash, State Abortion Counseling Policies and the Fundamental Principles of Informed Consent, GUTTMACHER POL'Y REV., Fall 2007, at 6, 8–9.

[9] *See, e.g.*, *id.* at 13 ("With the Court having signaled its willingness to accept requirements aimed at influencing rather than informing a woman's decision, as well as those premised on data that have not been fully vetted by or are outside of the scientific consensus, the signs are ominous indeed."); Matthew Gordon, *State Attempts to Expand Abortion Informed Consent Requirements: New Life After* Gonzales v. Carhart*?*, 35 J.L. MED. & ETHICS 751 (2007) (discussing how *Carhart* may lend support to two state bills that would expand informed consent requirements in the abortion context).

provide the appropriate level of information, have often failed to bring about the desired improvements.[10] With abortion statutes, some state legislatures have gone even further, creating statutes that dispense with the need to provide objective information, and instead impose a clear moral prerogative to manipulate women's ultimate decisions regarding the procedure.[11] In some cases, these statutes have even gone so far as to force doctors to provide information in a way that is not only undesirable, but also potentially misleading or inaccurate. To make matters worse, rather than examining such statutes to determine whether they have any scientific or medical basis, courts, including the Supreme Court, have become increasingly deferential to the legislature, even in the face of blatant misstatements of fact.[12] As a result, instead of enhancing informed consent by providing a more educated patient base, these statutes undercut the traditional goals of the doctrine in favor of greater legislative say in patient action.[13]

This Note argues that there is no place for medically unfounded statutes that interfere with the doctor-patient relationship by posing as requirements for informed consent. Although it is questionable whether legislatures should be creating statutory informed consent requirements for specific procedures under any circumstances, statutes without scientific foundation are especially problematic. The Note will proceed in four parts. Part I will provide an overview of the history of informed consent, along with a discussion of some

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[10] *See* Andersen-Watts, *supra* note 6; *see also infra* notes 27–30 and accompanying text.

[11] *See, e.g.*, S.D. CODIFIED LAWS § 34-23A-10.1 (2008) (providing a script for doctors that requires them to refer to the fetuses as a "human being" and forces them to warn patients of potentially severe side effects that, as discussed below, have little, if any, scientific basis); *see also* Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 375–79 & 375 n.112 (2008) (noting sixteen states' passage of legislation providing for mandatory ultrasound for women seeking abortions and commenting that "[a]lthough couched in the protective terms of informed consent, these statutes are unabashedly meant to transform the embryo or fetus from an abstraction to a baby in the eyes of the potentially aborting mother").

[12] *See, e.g.*, *Carhart*, 550 U.S. at 174–76 (Ginsburg, J., dissenting) (observing that Congress disregarded statements from numerous physicians and medical organizations that disagreed with its ultimate findings, noting that "[m]any of the Act's recitations are incorrect," and concluding that Congress did not carefully consider the evidence in arriving at its findings); Planned Parenthood Minn., N.D., S.D. v. Rounds, 530 F.3d 724, 749–50 (8th Cir. 2008) (Murphy, J., dissenting) (disagreeing with the majority's decision to uphold an informed consent statute that requires physicians to inform abortion patients about likely nonexistent long-term emotional harms without examining the scientific validity of the legislature's questionable findings).

[13] Arguably neither the judiciary nor the legislature is adequately equipped to direct the doctor-patient relationship to a level of detail that essentially specifies the way medicine should be practiced. When the legislature oversteps its bounds, however, the judiciary would be remiss not to serve as a more stringent check on legislative ambition to ensure that informed consent remains both true to form and constitutionally valid.

concerns raised by specific informed consent statutes. Part II will provide a discussion of the seminal cases that inform judicial interpretation of these statutes in the abortion context. Part III will look at the more controversial cases and statutes that have arisen in the wake of *Gonzales v. Carhart*. Finally, Part IV will propose a more stringent standard of review to be used by courts in evaluating contested informed consent legislation. The proposed standard of review will incorporate a closer examination of the scientific foundation underlying specific informed consent statutes that gives greater deference to the views of the scientific and medical communities at large, rather than deferring to legislative determinations of medical fact. Such review is imperative to maintain the integrity of informed consent given legislatures' increasing proclivity to misuse scientific or medical information to achieve a particular, typically political, end.

I. INFORMED CONSENT BY STATUTE: HISTORY AND CONCERNS

Informed consent came about "to ensure that each patient gets the information she needs to meaningfully consent to medical procedures."[14] It "purported to solve medicine's paternalism," seeking to overcome the fact that "doctors too often dictat[ed] treatments rather than discussing options."[15] Informed consent is often looked at as a patient right; its ultimate goal is "to allow patients to pursue their own conceptions of good" and "to safeguard their own subjective welfare."[16] Though all decisions are, to some extent, affected by outside influences, the informed consent process ideally limits such influences to allow patients the autonomy necessary to best pursue these goals.[17]

Courts have been largely responsible for creating concrete requirements for physicians obtaining patient informed consent.[18]

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[14] Andersen-Watts, *supra* note 6, at 201; *see also* Linda P. McKenzie, *Federally Mandated Informed Consent: Has Government Gone Too Far?*, 20 J.L. & HEALTH 267, 272 (2007) ("The underlying public policy [of informed consent] is to ensure that patients have sufficient facts for making health care decisions.").

[15] Andersen-Watts, *supra* note 6, at 201.

[16] BERG ET AL., *supra* note 2, at 26–27; *see also* Richardson & Nash, *supra* note 7, at 6 ("[I]nformed consent is both a legal obligation and an ethical principle. . . . [E]mbedded in the idea [is the principle] that individuals should be empowered to make autonomous decisions regarding their own care.").

[17] *See* BERG ET AL., *supra* note 2, at 25 (discussing the spectrum between decisions based on influences that have so overwhelmed the patient as to compromise the patient's autonomy, and decisions based on independent deliberation of significant and relevant information). "The ethical mandate for society and its institutions is to promote, as much as possible, the conditions that enable individuals to make substantially autonomous decisions." *Id.*

[18] *Id.* at 41.

State legislatures have played a relatively minor role, in many cases merely codifying the common law requirements.[19] Their combined efforts have created two prevailing requirements: "the historical requirement that physicians obtain patients' consent before proceeding with treatment, and the more recent requirement that physicians disclose such information to patients as will enable them to participate knowledgably in making decisions about treatment."[20] The ultimate goal is to create a process that provides patients with all material information regarding the nature of the procedure, its risks, alternatives, and anticipated benefits. While laws embodying these requirements generally leave it to physicians to determine the appropriate level of disclosure,[21] a few statutes do require specific disclosures for certain, extremely serious risks generally recognized as associated with a given procedure.[22]

In a few contexts, more specific statutory informed consent requirements have come about largely to address perceived disconnects in communication between physicians and their patients. Legislators working directly or indirectly[23] to enact specific informed consent statutes often do so out of concern that, for certain procedures, physicians simply are not providing their patients with all of the necessary information.

Breast cancer statutes, for example, came about in response to perceived physician overuse of the radical mastectomy and underuse of breast-conserving surgery (also known as lumpectomy) when treating early-stage breast cancer.[24] The statutes generally require physicians to give patients specific information by providing comprehensive brochures, creating an affirmative duty for physicians

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[19] *Id.*

[20] *Id.*

[21] *See* Alan Meisel & Lisa D. Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 426–27 (1980) (discussing common disclosure elements and noting that courts have not required disclosure of risks that are either very unlikely or very common).

[22] The American Medical Association's Model Informed Consent Law, for example, would require consent in writing, disclosure of the general nature of the proposed medical procedure, and disclosure of "the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars . . . with the probability of each such risk if reasonably determinable." *Id.* at 560 n.898 (quoting 236 JAMA 1010, 1011 (1976)).

[23] In a few cases, rather than undertaking such legislation directly, states have authorized medical panels to identify treatments and procedures that require more particularized informed consent, and enumerate specific disclosure requirements. BERG ET AL, *supra* note 2, at 58. While such systems may make informed consent more precise, "they are contrary to the spirit of the informed consent doctrine," and that "[t]heir effect is to depersonalize the physician-patient relationship . . . in the name of enhancing patient autonomy." *Id.* "This," they argue, "is a serious problem." *Id.*

[24] Andersen-Watts, *supra* note 6, at 204.

to orally disclose certain treatment alternatives, or both.[25] Whether written or oral, the mandatory disclosures usually consist of an objective discussion of the advantages and disadvantages of the various treatment options, and typically do not recommend one form of treatment over another.[26]

The breast cancer statutes have had, at best, marginal success. Though intended to address a lack of proper communication between patients and physicians, many of them instead have "gummed up the works even further by giving cookie-cutter, often lackluster, medical advice . . . ."[27] While the laws certainly increase the likelihood that patients will receive more comprehensive information about their treatment options, it is not clear that this flood of information actually benefits patients in any significant way. The information required by these statutes, especially in brochures, varies significantly in terms of relevance, especially for patients whose breast cancer is at an early stage.[28] Coupled with research demonstrating notable differences in how patients absorb and respond to information from their physicians, this creates a significant possibility "that legislation on disclosure of treatment options may complicate the decision-making process, rather than enhance it, by imposing a decision-making style that may be inappropriate for a majority of breast cancer patients."[29] Inundating patients with information in this way also assumes that those patients want the information in the first place, which is not always the case.[30]

Specific informed consent statutes related to abortion have gone even further astray from the original principles of informed consent. Like the breast cancer statutes, these also attempt to inundate patients with information regarding the procedure through oral physician disclosures or state-sponsored materials.[31] Unlike the breast cancer statutes, however, the goal is not always to provide comprehensive and objective knowledge. On the contrary, these statutes are transparently in place to deter women, if at all possible, from

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[25] *See* Susan G. Nayfield et al., *Statutory Requirements for Disclosure of Breast Cancer Treatment Alternatives*, 86 J. NAT'L CANCER INST. 1202, 1203–04 (1994).

[26] *Id.* at 1204.

[27] Andersen-Watts, *supra* note 6, at 209; *see also* BERG ET AL., *supra* note 2, at 35 (stating the authors' skepticism of a "one size fits all process" (internal quotation marks omitted)); Meisel & Kabnick, *supra* note 21, at 430 ("[W]e view such a statutory scheme, in which the extent of the required disclosure depends upon a predetermined list of procedures and their risks, as implicitly characterizing the doctor-patient relationship as mechanical rather than human.").

[28] *See* Nayfield, *supra* note 25, at 1203–04 & tbl.2.

[29] *Id.* at 1207.

[30] *See* GARRISON & SCHNEIDER, *supra* note 1, at 96–100 (indicating that patients are often reluctant to receive relevant information regarding their health conditions).

[31] *See infra* notes 33, 106–13 and accompanying text.

choosing abortion. Abortion informed consent statutes require disclosure of specific risks in a way that is unlike the risk disclosure required for any other medical procedure.[32] Most problematically, some of these enumerated risks have little or no scientific basis.[33] Unlike the breast cancer statutes which, though possibly undesirable, are not legally objectionable, some of the abortion statutes have crossed the line differentiating permissible and impermissible uses of informed consent.

As a preliminary matter, there are numerous reasons why specific informed consent statutes may not be a good idea. The American Medical Association has long opposed them,[34] and while this is certainly not dispositive as to the statutes' merit, it does speak to the fact that the medical profession, in general, believes that the process of informed consent falls more appropriately within the realm of the individualized physician-patient relationship.[35] These problems are compounded when the accuracy of such statutes is seriously called into question.

When the state forces doctors to provide it, the inaccurate or incomplete information detailed in some of these statutes undermines the physician-patient relationship and the informed consent process as a whole. Informed consent is supposed to be "a process through which accurate and relevant information is presented to a patient so that he or she is able to knowledgeably accept or forgo medical care,

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[32] *See* Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1614–15 (2008) (arguing that "the law's treatment of informed consent to abortion is unusual, to say the least," and noting that "[t]hrough their mandatory disclosure laws, state legislatures expand the informed consent doctrine to incorporate information that goes beyond what is mandated in other medical situations").

[33] *See* Gold & Nash, *supra* note 8, at 9, 11. As discussed later in this Note, the broader scientific community does not recognize risk of breast cancer and psychological turmoil from abortion. Despite such evidence, statutes in seven states mandate that physicians (either orally or by providing written materials) disclose only negative emotional responses—in some cases grossly exaggerated—instead of correctly describing the range of possible emotional responses. *Id.* at 9 (describing statutes in Michigan, Nebraska, South Carolina, South Dakota, Texas, Utah, and West Virginia). Two of these states also mandate that physicians inaccurately portray risks to future fertility. *Id.* (South Dakota and Texas). Finally, six states inaccurately inform patients of a possible breast cancer link, despite the fact that such a link has been categorically disproven. *Id.* (Alaska, Kansas, Mississippi, Oklahoma, Texas, and West Virginia).

[34] *See* Richardson & Nash, *supra* note 7, at 7.

[35] *See* Andersen-Watts, *supra* note 6, at 211, 214 ("Legal informed consent sets standards for physician disclosure that do not address the needs of patients because no patient is the generic ideal that the law has invented."). She goes on to note that "while physicians may be well aware of still-existing problems in communicating with their patients, they are understandably wary of the law's ability to improve things by usurping the doctor's role . . . ." *Id.* at 214. *But cf.* Nayfield, *supra* note 25, at 1206 (noting that despite their initial controversy, the breast cancer legislation has generally received a positive reception by physicians, but also recognizing the possibility that these laws "set a precedent for further (and more problematic) legislative incursions into the patient-physician relationship").

based on an appreciation and understanding of the facts presented."[36] As Professor Robert Post noted, "when physicians speak to us as our personal doctors, they must assume a fiduciary obligation faithfully and expertly to communicate the considered knowledge of the 'medical community.'"[37] If the state has the ability to manipulate this information to fit political ends, there is significant cause for concern. According to a report by the Guttmacher Institute, as of 2006, seven states "mandate the provision of negative and unscientific information about abortion and its implications," either by supplying doctors with a script or by requiring doctors to provide state-sponsored brochures to patients seeking abortions.[38] As a result, patients may begin to question the quality of the information presented. If they cannot trust their doctors, where else can these patients turn?[39]

Despite these shortfalls, states are continuing to develop specific informed consent statutes. Though the Supreme Court has ruled that these statutes are a valid exercise of legislative ability to regulate the medical profession,[40] this ability should not be without limits. After *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[41] many states followed Pennsylvania's lead in crafting specific informed consent statutes mandating the information a physician must provide to a woman before performing an abortion.[42] As of 2007, thirty-one states had enacted such requirements.[43] In fact, the development of such statutes has become another potent tool in the arsenal of abortion opponents.[44]

Since *Gonzales v. Carhart*,[45] another wave of legislation that further promotes expansion of mandated informed consent has been making its way through the country.[46] These latest informed consent

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[36] Richardson & Nash, *supra* note 7, at 6.

[37] Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 977.

[38] Richardson & Nash, *supra* note 7, at 7.

[39] *See* Gregory D. Curfman et al., *Physicians and the First Amendment*, 359 NEW ENG. J. MED. 2484 (2008) (arguing that a patient's awareness that her physician's words are state mandated may lead to distrust that significantly strains the physician-patient relationship).

[40] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) (evaluating the risk disclosures in an informed consent statute and concluding "[w]e see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here"); *see also* Gonzales v. Carhart, 550 U.S. 124, 157 (2007) ("Under our precedents it is clear the State has a significant role to play in regulating the medical profession.").

[41] 505 U.S. 833.

[42] *See* Gordon, *supra* note 9, at 751 (noting that, in *Casey*'s wake, many states have increased the amount of information physicians must disclose to patients seeking abortions).

[43] *Id.*

[44] *See, e.g.*, David C. Reardon, Informed Consent: The Abortion Industry's Achilles' Heel, http://www.afterabortion.org/PAR/V2/n2/INCONSNT.htm (last visited Jan. 6, 2010).

[45] 550 U.S. 124.

[46] *See* Gordon, *supra* note 9, at 751.

statutes are taking greater liberties with scientific fact and asking courts to turn the other cheek in the name of judicial deference.[47] When legislatures begin tampering with scientific fact and going against the recommendations of the majority of the medical community, such legislative exercise is no longer legitimate. This recent development of scientifically questionable informed consent statutes in the abortion context highlights the pressing need to draw a firm line between allowable and non-allowable uses of informed consent.

II. JUDICIAL INTERPRETATION OF SPECIFIC INFORMED CONSENT STATUTES

Among the more recently enacted abortion informed consent statutes, a few are beginning to push the boundary between permissible informed consent legislation and requiring physicians to convey unscientific, state-approved ideology. To better understand the development of these statutes, it is useful to look at a couple of seminal cases that shaped the evolution of courts' analysis in this area.

A. Planned Parenthood of Southeastern Pennsylvania v. Casey

Prior to *Casey*, courts generally prohibited mandatory disclosure laws that deviated from traditional notions of informed consent, even for abortions.[48] For the most part, courts required states to follow the common law doctrine "in which physicians were expected to disclose to individual patients [the] medical facts relevant to the interventions they were considering."[49] Statutes that attempted to surpass the boundaries of the common law doctrine by requiring doctors to provide additional, more slanted information were struck down.[50] This all changed with the Supreme Court's decision in *Casey* in 1992.

In *Casey,* the Court upheld an informed consent statute that required doctors to provide specific information to patients before performing an abortion, including the nature of the procedure, the health risks of abortion and childbirth, the probable gestational age of

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[47] *See* Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 253 (2009) ("[P]ost-*Casey* decisions have permitted 'informed consent' statutes that are neither truthful nor factually non-misleading.").

[48] *See* Dresser, *supra* note 32, at 1606.

[49] *Id.* at 1606–07.

[50] *See* Manian, *supra* note 47, at 34 (discussing Supreme Court and lower court decisions regarding the validity of abortion-specific informed consent statutes in the period after *Roe v. Wade* but before *Casey*).

the fetus, the availability of state printed information, the existence of agencies that provide alternatives (such as adoption), and the father's financial liability.[51] *Casey* established that the government may require "the giving of truthful, nonmisleading information" about a medical procedure.[52] In upholding the informed consent statute, the Court contended that, despite the rigid requirements, the statute did not interfere with physician judgment because it excused physicians from providing information in cases in which disclosure could have an adverse affect on the patient's physical or mental health.[53]

The Court argued that it is acceptable for the state to create regulations that "express profound respect for the life of the unborn,"[54] as long as those regulations do not create "undue burden" on a woman's right to choose.[55] An undue burden exists and invalidates a law only if that law's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion . . . ."[56] According to the Court, information that is truthful and nonmisleading does not constitute such a burden, so requiring a physician to provide information about the nature of the procedure, its risks and those of childbirth, and the probable gestational age of the fetus was permissible.[57] In fact, the Court further surmised that mandating such information actually "reduc[es] the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."[58]

Contrary to the majority's belief, Justice Blackmun asserted that the statute was clearly an imposition on physician judgment. He argued, "[r]igid requirements that a specific body of information be imparted to a woman in all cases, regardless of the needs of the patient, improperly intrude upon the discretion of the pregnant woman's physician and thereby impose an 'undesired and uncomfortable straitjacket.'"[59] Justice Blackmun maintained that requiring physicians to provide such information is "the antithesis of

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[51] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 881 (1992).

[52] *Id.* at 882.

[53] *See id.* at 883–84.

[54] *Id.* at 877.

[55] *Id.*

[56] *Id.* at 878.

[57] *See* Manian, *supra* note 47, at 251 (noting the contradiction inherent in requiring truthful and "nonmisleading" information that is biased in nature). To point out this paradox, Manian asks, "If the abortion-specific 'informed consent' regulation must be 'nonmisleading,' how can the Court permit the regulation to be biased in one direction?" *Id.*

[58] *Casey*, 505 U.S. at 882.

[59] *Id.* at 934 (Blackmun, J., dissenting) (quoting Thornburgh v. Am. Coll. of Obstetrics & Gynecologists, 476 U.S. 747, 762 (1986)).

informed consent" and that in reality, it serves no legitimate interest, and merely advances the state's view of abortion "under the guise of informed consent."[60]

Discussing *Casey*'s lasting significance, Professor Maya Manian notes, "*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."[61] It is therefore unsurprising that in *Casey*'s wake, legislatures began "alter[ing] the informed consent doctrine to a degree that is unprecedented."[62] Traditionally, the informed consent doctrine never required physicians to inform patients of health risks that were unrecognized by the expert medical community at large.[63] Since *Casey*, however, legislatures have increasingly designed statutes that mandate either disclosure of obscure risks or risks that, despite legislative findings to the contrary, have little or no basis in science. With its holding in *Gonzales v. Carhart*,[64] the Court expressly condoned this practice, a move that will allow states to push the boundaries of informed consent even further.[65]

B. Gonzales v. Carhart

In *Gonzales v. Carhart*, the Supreme Court upheld a statute banning "partial-birth abortion."[66] Though the case did not deal specifically with an informed consent statute, the law at issue did rely heavily on scientific findings by Congress. The case established that

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[60] *Id.* at 936 (stating further that the required information "goes far beyond merely describing the general subject matter relevant to the woman's decision" and arguing that the fact that the state does not "compel similar disclosure of every possible peril of necessary surgery or of simple vaccination, reveals the anti-abortion character of the statute and its real purpose" (quoting *Thornburgh*, 476 U.S. at 763, 764) (internal quotation marks omitted)).

[61] Manian, *supra* note 47, at 252.

[62] Dresser, *supra* note 32, at 1617.

[63] *Id.* at 1618. Dresser also notes two other distinctions between abortion informed consent and the traditional doctrine: traditional informed consent does not require physicians to provide graphic information regarding the procedure, nor does it require physicians to make moral judgments about the patient's treatment decision. *Id.* at 1617–19.

[64] 550 U.S. 124 (2007).

[65] *Cf.* Manian, *supra* note 47, at 226 (discussing the impact of the Court's decisions in *Casey* and *Carhart*). Manian asserts:

> 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. 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.

Id.

[66] 550 U.S. at 168.

states may use their regulatory powers to allow or ban particular procedures to further "its legitimate interests in regulating the medical profession in order to promote respect for life . . . ."[67] It is no stretch to apply this same logic and level of deference to statutes regulating informed consent.

Carhart is problematic for a number of reasons. For one, Justice Kennedy referred to a fetus as both a baby and an unborn child, stating that "by common understanding and scientific terminology, a fetus is a living organism while within the womb, whether or not it is viable outside the womb."[68] According to one author, such claims could easily "pave the way for a court . . . to find that the status of a fetus as a baby is now a 'truthful and non-misleading' fact rather than an 'unsettled medical, scientific, and theological issue.'"[69] Secondly, in a strikingly paternalistic move, the Court declared that "[w]hile 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."[70] As a result, the Court determined that state has an interest in making sure that such a decision is "well informed."[71]

The Court maintained that "[w]hen Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad."[72] Such deference is problematic given the rapidly changing nature of science and the law's inability to keep up with such frequent and sweeping changes. In this case, the

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[67] *Id.* at 158.

[68] *Id.* at 147.

[69] Gordon, *supra* note 9, at 752. This is exactly what happened in the Eighth Circuit, where the court upheld a South Dakota statute requiring doctors to make a statement to this effect. *See* discussion *infra* Part III. Because of the Eighth Circuit's ruling, North Dakota is poised to follow suit, having proposed a similar statute that defines an embryo or fetus as a "separate, unique, living human being" from the moment of conception. H.R. 1445, 61st Leg. (N.D. 2009).

[70] *Carhart*, 550 U.S. at 159. As Professor Manian points out:

> 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.

Manian, *supra* note 47, at 225.

[71] *Carhart*, 550 U.S. at 159. The Court also states that "[t]he State's interest in respect for life is advanced by the dialogue that better informs the political and legal systems, the medical profession, expectant mothers, and society as a whole of the consequences that follow from a decision to elect a late-term abortion." *Id.* at 160. Despite this statement, the Court makes no assessment as to whether the statute would actually serve such a purpose. In fact, the state is hardly advancing its interest by promoting dialogue; instead, it is simply removing the option for women to even have the procedure of which it disapproves.

[72] *Id.* at 163 (quoting Marshall v. United States, 414 U.S. 417, 427 (1974)).

Court deferred to congressional findings that the prohibited procedure is never necessary.[73] This was despite contrary opinions by three district courts that illustrated the biased nature of the congressional findings and highlighted many physicians' conclusions that for certain women, "partial-birth abortions" are actually safer than the alternative procedure.[74] These district court opinions spanned "a combined 700 pages and recount[ed] exhaustive medical testimony regarding the range of abortion procedures . . . pointedly condemn[ing] Congress for its biased 'fact-finding' process and conclusions."[75] In her dissent, Justice Ginsburg also argued that the congressional record did not support Congress's finding of a medical consensus against the banned procedure, and determined that, in fact, the bulk of the evidence demonstrated the opposite.[76] For example, despite Congress's conclusive finding that "partial-birth abortion is *never* medically indicated,"[77] the congressional record contained reference to statements by the American College of Obstetricians and Gynecologists, which stated that "[e]specially for women with particular health conditions, there is medical evidence that [the procedure being banned] may be safer than available alternatives."[78] Thus, on this point alone, the Court's willingness to simply defer to such a severely defective fact-finding process sets a troublesome precedent.

III. COERCION OR CONSENT?

Since *Carhart*, a few legislatures have taken even more leeway in their fact-finding processes. Presumably, they assume that, like in *Carhart*, courts will continue to defer despite significant deficiencies

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[73] *Id.* at 176, 191 (Ginsburg, J., dissenting) (recognizing Congress's finding that the procedure is never medically necessary despite the presence of significant conflicting information in the congressional record, and concluding that "[a]lthough Congress' findings could not withstand the crucible of trial, the Court defers to the legislative override of our Constitution-based rulings").

[74] Gordon, *supra* note 9, at 753; *see also* Carhart v. Ashcroft, 331 F. Supp. 2d 805 (D. Neb. 2004); Nat'l Abortion Fed'n v. Ashcroft, 330 F. Supp. 2d 436 (S.D.N.Y. 2004); Planned Parenthood Fed'n of Am. v. Ashcroft, 320 F. Supp. 2d 957 (N.D. Cal. 2004).

[75] Cynthia Dailard, *Courts Strike 'Partial-Birth' Abortion Ban; Decisions Presage Future Debates*, GUTTMACHER REP. ON PUB. POL'Y, Oct. 2004, at 1.

[76] *Carhart*, 550 U.S. at 176 (Ginsburg, J., dissenting) ("[T]here was no evident consensus in the record that Congress compiled. There was, however, a substantial body of medical opinion presented to Congress in opposition. If anything . . . the congressional record establishes that there was a 'consensus' in favor of the banned procedure." (quoting Carhart v. Ashcroft, 331 F. Supp. 2d 805, 1008-09 (D. Neb. 2004)) (alteration in original) (internal quotation marks omitted)).

[77] Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2(14)(O), 117 Stat. 1201 (codified at 18 U.S.C. §1531 (2006)) (emphasis added).

[78] 149 CONG. REC. S12,917 (daily ed. Oct. 21, 2003) (statement of Sen. Boxer).

in their statutes' medical bases. South Dakota has the statute with perhaps the most problematic lack of scientific foundation. The statute mandates that physicians inform patients of the following information twenty-four hours before performing the abortion:

> (b) That the abortion will terminate the life of a whole, separate, unique, living human being; (c) That the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota; (d) That by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated; (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including: (i) Depression and related psychological distress; [and] (ii) Increased risk of suicide ideation and suicide.[79]

Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds,[80] the circuit case upholding the biological disclosures in the statute, is equally problematic. Initially, the district court granted a preliminary injunction based on Planned Parenthood's claim that the statute violates physicians' First Amendment rights to be free from compelled speech, as well as concerns about the statute's use of the term "human being."[81] The Eighth Circuit, sitting en banc, set aside the injunction, determining there was no constitutional violation "where physicians merely were required to give 'truthful, nonmisleading information' relevant to the patient's decision to have an abortion."[82] The court also cited *Carhart* for its assertion that "[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman."[83] The Eighth Circuit determined that, taken together,

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[79] S.D. CODIFIED LAWS §34-23A-10.1 (2008). *But see* Richardson & Nash, *supra* note 7, at 8 (stating that the "implication that abortion is psychologically riskier than carrying an unwanted pregnancy to term is misguided, as the most methodologically sound research conducted over the past two decades does not find a causal relationship between abortion and severe negative mental health outcomes" and that "the best indicator for a woman's mental health after an abortion is her mental health before the abortion").

[80] 530 F.3d 724 (8th Cir. 2008) (en banc).

[81] Planned Parenthood Minn. v. Rounds, 375 F. Supp. 2d 881, 887–88 (D.S.D. 2005), *vacated by* 530 F.3d 724 (8th Cir. 2008) (en banc).

[82] *Rounds*, 530 F.3d at 734 (quoting Planned Parenthood of Se. Pa v. Casey, 505 U.S. 833, 882 (1992)).

[83] *Id.* (quoting Gonzales v. Carhart, 550 U.S. 124, 157 (2007)).

> *Casey* and [*Carhart*] establish that, while the State cannot compel an individual simply to speak the State's ideological message, it can use its regulatory authority to require a physician to provide truthful, non-misleading information relevant to a patient's decision to have an abortion, even if that information might also encourage the patient to choose childbirth over abortion.[84]

The court did not critically evaluate the legislative findings or determine the validity of the scientific information mandated by the legislature's script for physicians. Instead, it deferred to the legislature's determination that it is "scientific fact" that an embryo or fetus is a separate, unique human being from the moment of conception, thereby finding the disclosure to be a valid exercise of the state's power to regulate medicine.[85] The Eighth Circuit decision did not even address the dubious statements regarding mental health implications.

Interestingly, two recent comprehensive reviews of the scientific literature seeking to identify a causal link between abortion and mental health concluded that, based on the best available evidence, no such link exists.[86] In one of these reviews, a team of researchers from Johns Hopkins University reviewed twenty-one high-quality studies on the subject.[87] The studies, which involved over 150,000 women, determined there is no significant evidence to support the existence of adverse mental health outcomes in women who sought abortions versus those who elected other alternatives in the face of unwanted pregnancies.[88] The researchers also found that the studies with the most reliable methodologies tended to have neutral findings with "few, if any, differences between aborters and their respective comparison groups in terms of mental health . . . ."[89] The studies with the most flawed methodologies, on the other hand, "consistently found negative mental health sequelae of abortion."[90] The researchers concluded that "[p]rograms and policies based on claims derived from

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[84] *Id.* at 734–35.

[85] *Id.* at 727–29.

[86] *See* Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 CONTRACEPTION 436 (2008); BRENDA MAJOR ET AL., REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION (2008), http://www.apa.org/releases/abortion-report.pdf.

[87] Charles et al., *supra* note 86, at 438; *see also Abortion Not Seen Linked with Depression*, REUTERS, Dec. 4, 2008, http://www.reuters.com/article/healthNews/idUSTRE4B30UE20081204.

[88] Charles et al., *supra* note 86, at 448–49.

[89] *Id.* at 448.

[90] *Id.* at 449.

flawed research should be modified to reflect the most scientifically sound literature," and that "the enforcement of so-called 'informed consent' laws (which often provide misinformation regarding mental health risks of abortion) is unwarranted based on the current state of the evidence."[91]

A report by the American Psychological Association (APA) similarly concluded that many studies attempting to link abortion with mental health issues are methodologically unsound.[92] The researchers determined that "the prevalence of mental health problems observed among women in the United States who had a single, legal, first-trimester abortion for nontherapeutic reasons was consistent with normative rates of comparable mental health problems in the general population of women in the United States."[93] Though the report recognized that some women feel sadness, grief, and feelings of loss after terminating a pregnancy, there was no evidence sufficient to support a causative link between the abortion procedure and those feelings.[94] In fact, the report noted that "[a]cross studies, prior mental health emerged as the strongest predictor of postabortion mental health."[95]

Unlike the majority in *Rounds,* which took the legislative findings at face value, the four dissenting judges seemed to support the view that the statute should be evaluated with an eye toward its scientific merit. Judge Murphy, who authored the dissenting opinion, noted that South Dakota's informed consent statute goes "far beyond" those previously upheld.[96] She argued that a "constitutionally significant difference between regulation of verifiable fact as opposed to metaphysical belief—between neutral information and subjective idea—has been well recognized by the Supreme Court,"[97] and maintained that "[t]he script physicians are compelled to give . . . incorporates a value judgment and therefore escapes scientific verification."[98] Citing *Carhart*'s proposition that, despite a general deference to legislative fact-finding, courts have a duty to review such findings when constitutional rights are at issue, Judge Murphy clearly

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[91] *Id.*

[92] MAJOR ET AL., *supra* note 86, at 5–6.

[93] *Id.* at 6.

[94] *Id.* (noting the likely predictive value of factors such as personal characteristics and prior mental health problems as indicative of negative mental health outcomes following an abortion, or for that matter, any other stressful life event).

[95] *Id.*

[96] Planned Parenthood Minn., N.D., S.D. v. Rounds, 530 F.3d 724, 739–43 (8th Cir. 2008) (en banc) (Murphy, J., dissenting).

[97] *Id.* at 742.

[98] *Id.* at 746.

favored a lower level of deference under the circumstances presented.[99] She argued that, rather than providing factually accurate medical information aimed at facilitating the patient's informed choice, the statute instead imposes subjective value judgments on physicians and their patients, an act the dissent argued was a constitutional violation.[100]

Judge Murphy also distinguished the psychological distress and suicide risk disclosures in the abortion statute from the risk disclosure requirements in commonly accepted informed consent statutes. She noted that typical informed consent statutes "entrust[] the communication of particular medical risks to the doctor's best professional judgment."[101] In contrast, the specific risk disclosures for women undergoing abortion "undercut[] a physician's best medical judgment and discretion,"[102] especially in light of the significant evidence demonstrating that the disclosures at issue were medically unsound.[103]

Promisingly, on remand, the district court declared the unfounded suicide risk disclosures unconstitutional.[104] Citing the American College of Obstetricians and Gynecologists, the APA, and the dearth of evidence to demonstrate that suicide ideation and suicide are generally recognized risks, the court concluded that "the suicide disclosure language of the statute is untruthful and misleading."[105] Time will tell whether the Eighth Circuit upholds the decision on appeal.

Although South Dakota's statute is undoubtedly the most egregious, numerous other states have passed, or are in the process of passing, legislation that similarly incorporates medically unsound information. In Texas, for example, a physician must disclose "when medically accurate . . . the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer."[106] This

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[99] *See id.* at 752. Interestingly, despite the Court's statement regarding non-deferential review of issues involving constitutional rights in *Carhart*, the *Carhart* Court did not review Congress's fact-finding in the Partial-Birth Abortion Ban Act with any additional scrutiny.

[100] *Id.* at 753.

[101] *Id.* at 750.

[102] *Id.*

[103] *Id.* (noting a 2006 congressional report on the subject, which concluded, "there is considerable scientific consensus that having an abortion rarely causes significant psychological harm" (quoting MINORITY STAFF OF H.R. COMM. ON GOV'T REFORM, SPECIAL INVESTIGATIONS DIV., 109TH CONG., FALSE AND MISLEADING HEALTH INFORMATION PROVIDED BY FEDERALLY FUNDED PREGNANCY RESOURCE CENTERS 11 (Comm. Print 2006))).

[104] Planned Parenthood Minn., N.D., S.D. v. Rounds, 650 F. Supp. 2d 972 (D.S.D. 2009).

[105] *Id.* at 983.

[106] TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(iii) (Vernon 2008).

requirement is in place despite numerous studies indicating that such a risk is never medically accurate, as the link between breast cancer and abortion does not appear to exist.[107] Likewise, in Minnesota, Mississippi, and Montana, the decision to abort is considered informed only if the physician has described the "particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility."[108] As with the breast cancer risk, these statutes' suggestion that abortion causes risks to future fertility are generally inaccurate.[109] Though these statutes are less objectionable because doctors have slightly more discretion under the "when medically accurate" language, these are still areas in which legislatures are writing into law nonexistent medical risks.

Disclosures about the alleged psychological effects of abortion are also becoming increasingly common. Wisconsin physicians must orally disclose a risk of "psychological trauma," a claim that suffers from the same scientific deficiencies as the South Dakota statute's assertions of suicide and depression risks.[110] Like South Dakota, Texas, Utah, and West Virginia mandate that physicians provide patients with materials that cite either suicide or "postabortion traumatic stress syndrome" as possible side effects of abortion.[111] In addition, a number of states' abortion informed consent statutes cite as legislative findings[112] the alleged serious emotional and psychological consequences of abortion, along with *Casey*'s related assumption that women elect to have abortions "only to discover later, with devastating psychological consequences, that her decision was not fully informed."[113] Given the Eighth Circuit's recent decision in *Rounds*, it is certainly not outside the realm of possibility that states

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[107] *See, e.g.*, NAT'L CANCER INST., SUMMARY REPORT: EARLY REPRODUCTIVE EVENTS AND BREAST CANCER WORKSHOP (2003), http://www.cancer.gov/cancerinfo/ere-workshop-report (stating that based on the available evidence, it is well established that "[i]nduced abortion is not associated with an increase in breast cancer risk").

[108] MINN. STAT. ANN. § 145.4242 (West 2009); *see also* MISS. CODE ANN. § 41-41-33 (2008); MONT. CODE ANN. § 50-20-104 (2007).

[109] *See* Gold & Nash, *supra* note 8, at 11 (stating that "[t]he overwhelming scientific consensus . . . is that vacuum aspiration—the most common first-trimester procedure—poses virtually no long-term risk of infertility, ectopic pregnancy, spontaneous abortion or congenital malformation," and that, although second-trimester abortion may pose some increased risk, such complications are unlikely due to medical advances).

[110] *See* WIS. STAT. ANN. § 253.10(3)(f) (West 2008).

[111] Gold & Nash, *supra* note 8, at 11.

[112] *See, e.g.*, LA. REV. STAT. ANN. § 40:1299.35.6(A)(5)(c) (2008) (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992)); WIS. STAT. ANN. § 253.10(1)(a) (West 2008) (also quoting *Casey*); *see also* ALA. CODE § 26-23A-2 (2008).

[113] *Casey*, 505 U.S. at 882.

will further expand their requirements and force physicians to disclose more detailed information regarding these purported mental health effects.

States are also beginning to create specific informed consent statutes that move beyond expanded risk disclosures, pressing traditional notions of informed consent in new ways. For example, several states are creating mandatory ultrasound requirements,[114] most of which characterize the fetus as a child, a statement that is political rather than scientific.[115] As a result, whether through ultrasound laws or laws such as those enacted in South Dakota and proposed in North Dakota,[116] the idea that life begins at conception has been fixed into law in many states, despite the fact that this is an embodiment of a philosophical or political ideal, rather than a recognized scientific precept.[117]

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[114] Oklahoma recently passed abortion informed consent legislation that requires a woman seeking an abortion to undergo an ultrasound, regardless of whether it is medically necessary. *See* Emily Bazelon, *Required Viewing*, SLATE, Oct. 22, 2008, http://www.slate.com/id/2202765/. The statute dictates that the doctor or technician performing the ultrasound must display the images in the view of the pregnant woman and explain what the ultrasound is depicting. The law essentially specifies a script, mandating that the physician describe the heartbeat and the presence of internal organs, fingers, and toes. S.B. 1878, 51st Leg., 2d Reg. Sess. (Okla. 2008); *see also* Bazelon, *supra*. Because of the perceived imposition on the physician-patient relationship, however, an Oklahoma County district judge granted a temporary restraining order, preventing the law from going into effect until a lawsuit against it has been decided. *See Tulsa Abortion Clinic Fighting New Law*, OKLAHOMAN, Nov. 8, 2008, at 13A. Though the information may not be inaccurate, it is no less of an imposition on the physician-patient relationship. In fact, there is interesting evidence suggesting that even a truthful message can be misleading when it inappropriately takes advantage of emotional influence in order to bias an individual in favor of a particular decision. *See* Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading* Casey, 83 WASH. L. REV. 1, 1 (2008) (suggesting that, in light of current social science research, informed consent statutes should be examined more closely, since many capitalize on emotion to create bias rather than inform free choice). Using recent social science research, Professor Blumenthal argues that use of negative emotion, such as fear or anxiety, to portray a particular message causes increased susceptibility to persuasion. *See id.* at 10–11. What is more, the higher the credibility of the source, the less likely the listener will perceive the manipulation and view the information with skepticism. *Id.* In the abortion context, even with scientifically accurate information, this creates the potential for an informed consent statute to become an undue burden on the woman's choice. *See id.* at 27.

[115] Sanger, *supra* note 11, at 351. Professor Sanger argues that the "visual informed consent" is even more objectionable than the terms used to describe the images on the screen. There are two reasons for this. First, society's perceptions about the ultrasound have made it an extremely powerful visual tool. *Id.* Second, and more importantly, these statutes require women to be complicit in the production of extremely personal images that they prefer not to see. *Id.* Combined, these elements create an undue burden to a woman's exercise of her protected choice regarding whether to abort. *Id.*

[116] *See supra* note 69.

[117] *See* Sanger, *supra* note 11, at 383. In *Acuna v. Turkish*, the New Jersey Supreme Court recognized this divide and declined to impose upon physicians a duty to inform a woman considering an abortion that the procedure results in "the killing of an existing human being." 930 A.2d 416, 425–26 (N.J. 2007). The court refused to mandate the use of such language, citing a lack of consensus in the medical community and the inappropriateness of the court

Under any of these statutes, physicians are free to add commentary and even suggest their disagreement with the state's position. Such statements, however, do not avoid the reality that providing doctors with a state-mandated script flies in the face of traditional notions of informed consent. In addition, physicians and patients in some of these states must verify that the patient fully understands the informed consent information provided.[118] It is therefore possible that a physician's stated disagreement with the state-mandated information could confuse, and therefore nullify, the patient's "informed and voluntary" consent.[119] Thus, rather than promoting a process, these states have transformed informed consent for specific procedures into something more akin to a *Miranda*[120] warning[121]—an approach that hardly comports with mainstream views about why informed consent exists and how it is to be used.

More importantly, patients rely on their physicians for advice and counsel about treatment decisions. If patients begin to question the source and quality of the information provided by their physicians, it undercuts the entire patient-physician relationship. Statutes that require physicians to provide scientifically unsupportable warnings and statements create situations in which the state "forces physicians to violate their obligation to solicit truly informed consent—and thereby detracts from the essential trust between patients and their

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driving public policy in an area so enmeshed in "a deep societal and philosophical divide." *Id.* at 427. The New Jersey court went on to criticize the South Dakota statute at issue in *Rounds* as "pushing the doctrine of informed consent to the edge of a new constitutional fault line," by adopting the "living human being" language without achieving medical or even societal consensus on that issue. *Id.* at 427.

[118] *See, e.g.*, S.D. CODIFIED LAWS § 34-23A-10.1(1) (2008) (requiring a physician to certify in writing that the patient understood the mandated disclosures).

[119] *See* Post, *supra* note 37, at 954.

[120] Miranda v. Arizona, 384 U.S. 436 (1966).

[121] *See* Emily Bazelon, *Script Doctors*, SLATE, Aug. 19, 2008, www.slate.com/id/2198114 (quoting South Dakota Attorney General Larry Long as saying: "[i]f I was a lawyer representing one of these doctors, I'd offer the following sound legal advice: Read the statute to your patient. It's like the police issuing a Miranda warning."); *cf.* Karene M. Boos & Eric J. Boos, *At the Intersection of Law and Morality: A Descriptive Sociology of the Effectiveness of Informed Consent Law*, 5 J.L. SOC'Y 457, 494–95 (2004) (citing a 1982 investigation by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research as stating the goal of informed consent to be "a tactful discussion, sensitive to the needs, intellectual capabilities, and emotional state of the particular patient at that time, in terms that the patient can understand, assimilate, and work with as part of the ongoing decision-making process") The Commission also made clear that it did not recommend adoption of specific regulations for informed consent, *id.* at 478, and that "[p]rofessionals should recognize, and lawyers and courts should perhaps be reminded, that patients' interests are not well served by detailed technical expositions of facts that are germane neither to patients' understanding of their situations nor to any decisions that must be made." *Id.* at 494 (alteration in original).

physicians."[122] In the face of such negative repercussions to the integrity of both informed consent and the physician-patient relationship, courts cannot afford to stand by and defer to legislative judgments that are not based on sound science or supported by at least a reasonable segment of the medical community.

IV. THE MERITS OF A LESS DEFERENTIAL STANDARD OF REVIEW

Typical informed consent statutes are generally unproblematic. Most simply require sufficient explanation of a proposed treatment and its risks, benefits, and alternatives to allow a patient to make an informed decision.[123] Specific requirements that dictate exactly what must be included in the physician's disclosure, however, can be more difficult to assess, and are more likely to create problems of fact or inappropriately limit the physician's role.[124] This is especially the case in highly polarized areas such as abortion.

Discussing the misinformation in fetal pain laws, which embody another increasingly common, but scientifically questionable "informed consent" requirement, one author suggested, "[t]o the extent that fact-finding on sharply contested political issues is inevitably politicized, perhaps heavy judicial deference is misguided."[125] She notes that, in viewing statutes creating specific informed consent requirements,

> the factual question for the court is no longer whether the facts sufficiently support a particular policy; the adoption and dissemination of a particular claim *as fact* is the policy itself . . . . [W]hether certain issues are serious enough to be brought to patients' attention is a matter of judgment, but whether a particular assertion about that issue is *accurate* is nothing more than a matter of fact. This is the difference between policy judgment and simple fact-finding; while

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[122] Zita Lazzarini, *South Dakota's Abortion Script—Threatening the Physician-Patient Relationship*, 351 NEW ENG. J. MED. 2189, 2189 (2008).

[123] *See supra* notes 18–22 and accompanying text.

[124] *See* Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 149 (2008) ("[T]he more specific mandated disclosure requirements are, the more problematic they will be. Such specific statements may require complex qualifications or clarifications to render them truthful and not misleading. Moreover, specific factual claims in statutes, or even printed materials, are likely to become dated and inaccurate in light of continuing medical research.").

[125] *Id.* at 138–39. Tobin argues that "to the extent these laws go beyond flagging topics that should be discussed by health care providers and prescribe specific factual claims that must be conveyed to patients, they should be subject to non-deferential judicial review of their accuracy and fairness." *Id.* at 114.

> courts should generally avoid the former, they are actually designed to do the latter.[126]

This is not to say that courts are any better suited to the task of deciding the content of informed consent statutes than are legislatures. In fact, there are arguments in support of the view that the legislature may be better suited to make such determinations.[127] These arguments assume, however, that the legislature will exhaustively and objectively use its fact-finding capability to create statutes that embody the best available medical evidence, and amend those statutes when the science becomes outdated—assumptions that simply do not always reflect reality. Given the current state of affairs, in cases like abortion, there is a substantial argument that legislatures are "particularly ill suited to [the] task [of objective fact-finding] and that judges, while not ideally suited to making medical decisions, are in a better position to weigh the scientific evidence before them."[128] In fact, as Professor Jessie Hill argues, when it comes to determining medical fact, a legislature's "relative institutional competency [is] at [its] lowest," and courts are actually a better choice.[129]

Unfortunately, when choosing between institutions in policy areas like this one, "[t]he choice is always a choice among highly imperfect alternatives."[130] Imperfect as it is, however, "[j]udicial review of legislation can serve as a means to counteract or deal with political malfunctions . . . ."[131] Such malfunctions include the informed consent statutes at issue here, which arise from preconceived political ideas rather than legitimate science. Thus, it follows that where the

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[126] *Id.* at 137.

[127] *See* Antony B. Kolenc, *Easing Abortion's Pain: Can Fetal Pain Legislation Survive the New Judicial Scrutiny of Legislative Fact-Finding?*, 10 TEX. REV. L. & POL. 171, 215–16 (2005) (discussing legislative fact-finding strengths, including manpower and funding to conduct long-term investigations with an eye toward the evolution of medical science, and more flexibility to adapt without being bound by stare decisis).

[128] B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 282 (2007).

[129] *Id.* at 339 (noting that one of the main arguments for legislative fact-finding—"that they are democratic, representative bodies—seems to have no applicability where issues of pure medical fact are concerned" and that "[u]nlike those cases in which so-called social facts are involved, there is (or perhaps should be) no significant political element to the determination of medical fact" (footnote omitted)); *see also* John O. McGinnis & Charles W. Mulaney, *Judging Facts Like Law*, 25 CONST. COMMENT. 69, 73 (2008) (arguing for de novo review of the social facts relevant to a statute's constitutionality through a "transparent and adversarial process"). McGinnis and Mulaney further state: "We reject the notion, which the Court often but inconsistently deploys, that the judiciary should treat legislative views of the facts more deferentially than legislative views of the law." *Id.* at 71.

[130] NEIL K. KOMESAR, IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS, AND PUBLIC POLICY 5 (1994).

[131] *Id.* at 137.

legislature abuses its legislative power by manipulating scientific facts to achieve political ends, uncritical judicial deference to the fact-finding process is simply not justified.[132]

Though courts are not the best institution to decide the information doctors should pass on to their patients regarding a specific procedure, legislatures are hardly more adept.[133] Moreover, since legislatures have become increasingly active in areas traditionally left to the judgment of physicians, one has to wonder whether the legislators should be held to the same standard of knowledge as their physician counterparts.[134] From a practical standpoint, it is obviously impossible to impose such a standard,[135] but this lack of qualification has not inhibited increasingly aggressive legislative action in these areas.

Although courts also lack such training, the deficiency in the judicial context is arguably not as problematic given the courts' institutional role of reviewing, rather than writing, these statutes. Moreover, a relatively new program through the Advanced Science and Technology Adjudication Resource Center (ASTAR) may help make judges not only more objective, but also more adept at assessing scientific and medical information, than most lawmakers. ASTAR's proposed "judges' medical schools" are designed to provide a crash course in science and medicine with the hope of ultimately "developing [a] group of judges who understand enough about the science of medicine to be better gatekeepers."[136] Such training would make judges even better suited to the role of reviewing legislative

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[132] *See* Hill, *supra* note 128, at 329 (arguing that "deference may be inappropriate when pure questions of medical or scientific fact are involved").

[133] Especially in contentious areas, it seems that legislatures actually have less incentive to be objective, and fewer procedural checks exist to ensure they do so. *See id.* at 335 (discussing the weaknesses behind the theory of legislative deference); *see also* McGinnis & Mulaney, *supra* note 129, at 71 (arguing that "Congress' fact-finding abilities are less capacious and more biased than those in the judiciary" because Congress is designed to respond to the demands of constituents and interest groups, whereas the judiciary is better insulated from such subjectivity and thus has the capacity to perform a more objective factual review).

[134] *See* McKenzie, *supra* note 14, at 273. McKenzie observes:

> Politicians are increasingly involved in regulating the content of informed consent. As such, it follows that any standard governing physicians' level of knowledge must apply equally to legislators. . . . [T]here is presently no mechanism in place, other than the democratic process, to ensure that policy makers are adequately informed. By contrast, a well developed system exists for monitoring physician practice, including oversight by federal, state, and various private agencies.

Id.

[135] *See id.* at 273–74.

[136] Amy Lynn Sorrel, *Med School for Judges: A Crash Course in Medical Litigation*, AM. MED. NEWS, July 28, 2008, *available at* http://www.ama-assn.org/amednews/2008/07/28/prsa0728.htm (quoting Chief Justice Thomas Moyer of the Supreme Court of Ohio).

fact-findings that purportedly convey scientific fact. Even in the absence of such programs, however, courts have no choice but to serve as a check on legislative ambition when legislators inappropriately attempt to dictate medical practice using facts that lack adequate scientific foundation.

Concededly, no medical consensus is required to validate legislative action.[137] Thus, it seems inescapable that courts must be deferential in the face of "reasonable legislative judgments" in cases where "science has not reached finality of judgment."[138] This does not, however, give legislators carte blanche to find a marginally supported scientific proposition that is opposed by the bulk of the scientific community and call the issue scientifically uncertain to justify regulation. In *Hendricks*, for example, a split between two well-regarded medical organizations created uncertainty whether pedophilia should be characterized as a mental disorder or a mental illness.[139] The issue was not (as is the case with the abortion-mental health link) whether there was any reliable evidence that a condition existed at all.[140] Thus, though the legislature certainly has leeway to establish statutes that affect the medical profession, it should not be acceptable for legislatures to create statutes based on scientific precepts that are not recognized by at least a reasonable portion of the medical community.[141]

Patients count on their physicians to provide accurate, objective information regarding their care. A statute like the one in South Dakota not only makes it impossible for the public at large to receive accurate medical information, but it also "undermines public trust that professional physician speech will reflect the expertise of the 'medical community.'"[142] The physician serves as the patient's link to

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[137] *See, e.g.*, Kansas v. Hendricks, 521 U.S. 346, 360 (1997).

[138] Jones v. United States, 463 U.S. 354, 365 n.13 (1983).

[139] *Hendricks*, 521 U.S. at 375 (Breyer, J., dissenting).

[140] In addition, one author has noted that all of the cases cited in *Carhart* for the proposition that legislatures may act in the face of medical uncertainty involve statutes that allow civil commitment for convicted criminals. *See* Manian, *supra* note 47, at 264 n.247 ("It is nonetheless disturbing that *Carhart* compares pregnant women seeking abortion to convicted criminals in stating that these precedents support its decision."). Thus, at the very least, these cases are distinguishable from those involving informed consent simply by virtue of their drastically differing contexts.

[141] *See* Dresser, *supra* note 32, at 1620 ("[A]lthough it is easy to speculate about physical and psychological risks accompanying a variety of medical interventions, there must be a reasonable evidentiary basis for such risks before doctors are required to warn patients about them.").

[142] Post, *supra* note 37, at 979. Post further argues that such a mandate "strips physician-patient communications of their unique authority and dependability, and in this way jeopardizes the capacity of the medical profession to serve as a reservoir of expert knowledge that can reliably be communicated to the public through physician-patient disclosures." *Id.* at 979–80.

the medical information necessary to make informed decisions regarding treatment and care, and it is the physician's duty to provide that link.[143] Such an interaction is only possible, however, if the physician provides information that is derived from a valid scientific source rather than an outsider with a political agenda.

In addition to the burden it places on the physician-patient relationship, there are a number of other reasons why it is inherently unreasonable to require physicians to convey medical information that does not have some significant factual basis in the scientific and medical communities. For one, it is highly likely that such a requirement would create significant First Amendment concerns by improperly compelling physician speech.[144] In addition to lending scientific credence to an unscientific finding, mandates such as those requiring physicians to inform patients that abortion equates to terminating the life of a human being "deliberately and provocatively incorporate[] the language of ideological controversy and force[] physicians to affirm the side of those who oppose abortion."[145] Such compelled disclosure of state ideology is impermissible, because constitutionally, the state cannot force physicians to "disseminate an ideology, no matter how acceptable to some," without violating physicians' "First Amendment right to avoid becoming the courier for such message."[146]

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[143] *See* Curfman, *supra* note 39, at 2485 ("Doctors have an ethical responsibility to provide their patients with accurate medical information.").

[144] *See* Lazzarini, *supra* note 122, at 2190.

[145] Post, *supra* note 37, at 956.

[146] Wooley v. Maynard, 430 U.S. 705, 717 (1977). Looking at the issue from the opposite perspective, another author has argued for a First Amendment right against compelled listening. *See generally* Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. REV. 939 (2009). Corbin notes:

> Compelled listening can interfere with individual autonomy in two distinct ways. First, it interferes with *the decision-making process* by not allowing adults to choose what information to consider in developing their thoughts and making up their minds. . . . Second, by forcing particular information onto unwilling listeners, compelled listening can unduly influence *the ultimate decision* made.

Id. at 982. Corbin's proposal essentially extends the protections already provided against intrusive private speech under the captive audience doctrine to statements by the government. *See id.* at 980. Thus, in order to apply, the listener (1) must be unable to avoid the government's speech, and (2) should not have to leave or otherwise take action to avoid hearing the government's message. *Id.* at 980–81. According to Professor Corbin, "there is no question that abortion-seeking women in South Dakota and Oklahoma would qualify as a captive audience in terms of their physical inability to avoid the government's message." *Id.* at 1002. Not only are these women captive to their medical condition, in that they must seek the assistance of a medical professional in order to terminate their pregnancies, but they must actually certify that they have received and digested the government's message regarding the procedure, which makes it impossible to avoid hearing the speech. *See id.*

Along with the compelled ideological speech concerns, Professor Robert Post has also argued that, under an analysis roughly analogous to the commercial speech doctrine, statutes requiring physicians to disclose information of questionable scientific validity violate the public's right to receive truthful and non-misleading information.[147] As doctor-patient relationships, like commercial speech, help promote more informed public decision making, First Amendment constraints would prohibit legislatures from imposing mandates that individual doctors provide false or misleading information, thereby protecting the public's access to information.[148] Theoretically, these constraints should be triggered when the state either prohibits the physician from disclosing accurate, nonmisleading information, or requires disclosure of inaccurate or misleading information, such as the adverse mental health effects mandated in the South Dakota statute.[149]

While it is clear that false and misleading statutes have significant First Amendment implications[150] and likely violate the undue burden standard, there is still the problem of determining exactly when a statute mandates the provision of such information. Such a determination requires at least a preliminary evaluation of the scientific merits of the disclosures. Unless courts begin to evaluate underlying scientific precepts, they will continue to defer to legislative determinations under the assumption that those findings reflect current and accurate scientific knowledge.

The phrase "scientific knowledge" "implies a grounding in the methods and procedures of science[,] . . . connotes more than subjective belief or unsupported speculation[,] . . . [and] must be

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[147] For a complete discussion of this analogy, see Post, *supra* note 37. The commercial speech doctrine protects the public's "First Amendment right to 'receive information and ideas.'" Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc., 425 U.S. 748, 757 (1976). By their nature, commercial messages that are untrue or misleading to the public are not protected under the doctrine, as they do not fulfill the goal of creating a better informed public. *See* Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y., 447 U.S. 557, 563 (1980). Such false statements simply have no constitutional value. Gertz v. Robert Welch, Inc., 418 U.S. 323, 340 (1974). Thus, it is permissible for regulations of commercial speech to require disclosure of "accurate information in the interests of promoting more educated consumers." Post, *supra* note 37, at 975.

[148] *See* Post, *supra* note 37, at 978–79. As Post argues, "the same First Amendment value that underlies commercial speech doctrine is also present in professional physician speech designed to convey the knowledge necessary for informed consent." *Id.* at 978. Thus, he reasons, the First Amendment should logically protect "the circulation of accurate information to the public in respect to both kinds of speech." *Id.*

[149] *Id.* at 979.

[150] *See* Dresser, *supra* note 32, at 1621; *see also* Corbin, *supra* note 146, at 1007–08 ("In letting the state try to persuade women seeking abortions to change their minds, the Supreme Court has allowed a degree of paternalism absent in traditional informed consent and forbidden in all other speech cases.").

derived by the scientific method."[151] The Court made these observations in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[152] which dealt with the admissibility of scientific evidence.[153] It is useful, however, to apply similar principles when evaluating the accuracy of statutes that require disclosure of scientific or medical information.

Although *Casey* mandates that informed consent statutes must be "truthful and not misleading,"[154] it is not clear courts are willing to delve deeply enough into the factual predicates of the statutes to determine whether they actually meet that standard. Although this is not likely to change after the Court's deferential approach in *Carhart*,[155] such deference is not justified. On the contrary, courts could utilize a modified *Daubert* analysis to determine whether the purportedly scientific information mandated under an informed consent statute meets *Casey*'s enumerated standard. If judges have the ability to shield juries from expert scientific testimony that does not reach an appropriate standard of reliability, they are also arguably equipped to shield patients from legislative mandates requiring doctors to provide similarly unreliable information. Thus, statutes based on findings that would not meet an appropriate standard of evidentiary and scientific reliability under *Daubert* should not withstand the truthful and nonmisleading standard.

Determining whether an expert's proposed testimony qualifies as scientific knowledge "entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue."[156] As the *New England Journal of Medicine* noted in its amicus brief in *Daubert*:

> "Good science" is a commonly accepted term used to describe the scientific community's system of quality control which protects the community and those who rely upon it from unsubstantiated scientific analysis. It mandates that each

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[151] Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 590 (1993).

[152] 509 U.S. 579.

[153] *Id.* at 590 ("Proposed testimony must be supported by appropriate validation—*i.e.*, 'good grounds,' based on what is known. In short, the requirement that an expert's testimony pertain to 'scientific knowledge' establishes a standard of evidentiary reliability.").

[154] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992).

[155] *See generally* Gordon, *supra* note 9 (discussing how the *Carhart* decision may inspire states to expand their informed consent requirements).

[156] *Daubert*, 509 U.S. at 592–93.

> proposition undergo a rigorous trilogy of publication, replication and verification before it is relied upon.[157]

As under *Daubert*, a court evaluating an informed consent statute could assess a variety of factors to determine whether the information is sufficiently reliable to support a mandate requiring doctors to share it with their patients. These factors include: (1) whether the theory or technique is testable, and whether such tests have occurred,[158] (2) whether the theory or technique has been subjected to peer review and publication, and (3) whether there is widespread acceptance within the medical community.[159] These factors are by no means exclusive, and courts are free to use other measures to discern the reliability of a scientific proposition.[160] Such approaches could include "pre-trial colloquia" between judges and experts, neutral experts serving in an advisory capacity, and references to an established and reputable scientific organization, such as the National Academy of Sciences or the Centers for Disease Control.[161] Training through programs provided by organizations like ASTAR would also be useful in this context.[162]

Courts would also be wise to look beyond peer-review of medical research to potential sources of bias,[163] particularly in contentious areas like abortion law. At a minimum, courts should require some sort of conflict disclosure by all experts testifying about these issues.[164] This would help courts to identify studies that deserve closer

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[157] Brief of the New England Journal of Medicine et al. as Amici Curiae in Support of Respondent at 2, *Daubert*, 509 U.S. 579 (No. 92-102), *quoted in* Paul Giannelli, *The* Daubert *Trilogy and the Law of Expert Testimony*, *in* EVIDENCE STORIES 181, 190 (Richard Lempart ed., 2006).

[158] *Daubert*, 509 U.S. at 593 ("Scientific methodology today is based on generating hypotheses and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." (quoting E. GREEN & C. NESSON, PROBLEMS, CASES, AND MATERIALS ON EVIDENCE 645 (1983) (internal quotation marks omitted)).

[159] Though *Daubert* does not find widespread acceptance of a theory to be dispositive as to its evidentiary reliability, the Court does note that "a known technique which has been able to attract only minimal support within the community may properly be viewed with skepticism." *Id.* at 594 (citation omitted) (internal quotation marks omitted).

[160] *See* Bert Black, Francisco J. Ayala & Carol Saffran-Brinks, *Science and the Law in the Wake of* Daubert*: A New Search for Scientific Knowledge*, 72 TEX. L. REV. 715, 798–800 (1994).

[161] *Id.* at 792–97.

[162] *See* Sorrel, *supra* note 136 and accompanying text.

[163] *See generally* Mark R. Patterson, *Conflicts of Interest in Scientific Expert Testimony*, 40 WM. & MARY L. REV. 1313 (1999) (describing bias as an element of reliability, as well as its ability to corrupt scientific research).

[164] *See id.* at 1336–45 (describing the policy of scientific journals to require conflict disclosures); *see also* Wendy E. Wagner, *Importing* Daubert *to Administrative Agencies Through the Information Quality Act*, 12 J.L. & POL'Y 589, 615–16 (2004) (discussing the problem of bias in "policy-relevant scientific research").

scrutiny, both in terms of methodology and overall reliability.[165] Peer-review, after all, is by no means a fail-safe.[166] When parties try to use peer-review as a means to bolster or discredit scientific evidence, courts can and should look beyond the mere mention of the journal name and examine the circumstances of the peer review.[167]

In the informed consent context, all of this information could help courts determine whether the legislature has justifiably relied upon the scientific precepts behind its mandate, and ultimately whether the sum of the scientific evidence sufficiently supports the informed consent requirement. Legislative findings used to support the creation of the statute would greatly facilitate such a review, as much of the information requiring assessment under the *Daubert* standard is often presented and evaluated in the process of creating the law. Such findings could at least provide a starting point for judicial analysis, allowing a court to evaluate the factual bases underlying the resulting regulation.[168] Beyond the legislative findings, the amicus briefs and additional expert testimony proffered in a case that challenges the constitutionality of an informed consent statute could supplement the information and provide courts with a more complete picture of the available scientific evidence on a particular issue. This would, in turn, allow the court to better determine whether the legislature reasonably used the available science to create the statute.[169]

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[165] *See* Patterson, *supra* note 163, at 1386 (stating that "[t]his approach will determine whether the bias had any concrete effects"); Wagner, *supra* note 164, at 617 (arguing that "these conflict disclosures need not be used to disqualify research or testimony, but they could provide critical information about potential sources of bias that might otherwise be missed").

[166] *See, e.g.*, Keith J. Winstein & David Armstrong, *Top Pain Scientist Fabricated Data in Studies, Hospital Says*, WALL ST. J., Mar. 11, 2009, at A12 (detailing the recent discovery that a prominent pain scientist fabricated twenty-one medical studies to demonstrate alleged benefits of certain painkillers, as well as the recent retraction of those studies from well-respected medical journals).

[167] *See* Patterson, *supra* note 163, at 1391 (arguing that courts can look to the quality of the review, including biases of the researcher and the journal tier in which the publication occurred).

[168] *Cf.* United States v. Lopez, 514 U.S. 549, 563 (1995) (stating that while findings are not required, they are often helpful). Contrary to Congress's statement in the Partial-Birth Abortion Ban Act that it is entitled to judicial deference with regard to its findings, *see* Pub. L. No. 108-105, § 2(8), 117 Stat. 1201, 1202 (2003) (codified at 18 U.S.C. §1531 (2006)), courts are not required to turn a blind eye. In *United States v. Morrison*, for example, despite numerous legislative findings, the Court did not defer to congressional fact-finding for the Violence Against Women Act, which asserted link a between gender violence and interstate commerce to justify congressional regulation. 529 U.S. 598 (2000).

[169] As it happens, the exhaustive district court opinions overturning the Partial-Birth Abortion Ban Act, later upheld in *Carhart*, illustrate the courts' ability to undertake this type of review. *See* discussion *supra* note 74 and accompanying text; *see also* Carhart v. Ashcroft, 331 F. Supp. 2d 805, 1007 (D. Neb. 2004) (noting that the district courts may take "additional evidence to decide the reasonableness of the congressional fact finding"); Nat'l Abortion Fed'n v. Ashcroft, 330 F. Supp. 2d 436, 484–85 (S.D.N.Y. 2004) (asserting that the court does not necessarily have to defer to congressional fact finding when the reasonableness of the facts is in

The legislative findings used to support the statute at issue in *Rounds* provide a useful illustration as to how such an analysis might begin. In creating the statute, the South Dakota legislature utilized the findings presented in the South Dakota Task Force to Study Abortion.[170] The report made a number of "scientific" findings that have readily apparent flaws in reasoning. First, the report concludes, "scientific facts and information . . . establish the fact that abortion terminates the life of a human being" and that this is "indisputable."[171] Second, the findings were heavily reliant on the individual affidavits of hundreds of pro-life advocates from a group known as Operation Outcry, all of whom claimed to have been coerced into having an abortion and to have suffered severe psychological consequences as a result.[172] Finally, the only supplements to the affiants' claims of mental health risks were citations to studies that were either rated in the Johns Hopkins study as having poor methodology (e.g., a number of the studies by Cougle, Reardon, and Coleman upon which the Task Force heavily relies) or by the APA Report[173] as being unreliable.[174]

The Task Force Report does not address any of the studies that the Johns Hopkins researchers and the APA later identified as most methodologically sound, all of which present a conflicting view on the link between mental health and abortion. What is more, the Task

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question); Planned Parenthood Fed'n of Am. v. Ashcroft, 320 F. Supp. 2d 957, 1006 (N.D. Cal. 2004) (observing that the Supreme Court has allowed district courts to look at additional evidence when determining the reasonableness of congressional fact finding).

[170] REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION (2005), *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf [hereinafter TASK FORCE REPORT].

[171] *Id.* at 11. The report relies on advances in scientific techniques, such as polymerase chain reaction (PCR) and DNA fingerprinting, to support the Task Force's belief in the "wholeness and uniqueness of every human being from conception." *Id.* at 25. Under this method of reasoning, a run-of-the-mill tissue culture in a petri dish could be deemed a complete human being. The Task Force also cited some researchers' reluctance to answer the question of when life begins (because of their belief that it would merely be opinion) as a lack of credible evidence against the "scientific fact" that abortion terminates a human being. *Id.* at 12.

[172] *See* Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1652 (2008); *see also* TASK FORCE REPORT, *supra* note 170, at 21 (highlighting the testimonies given by women regarding their abortion experiences); Dresser, *supra* note 32, at 1618 (stating that disclosure of such anecdotal reports has never been required by the informed consent doctrine, and that these individual reports are "insufficient to establish a causal link" under the standards of contemporary medicine).

[173] *See supra* notes 86–95 and accompanying text (discussing the studies' findings).

[174] *Compare* TASK FORCE REPORT, *supra* note 170, at 41–46 (citing these studies with approval), *with* Charles et al., *supra* note 86, at 440–44 (comparing the methodology and strength of several studies), *and* MAJOR, *supra* note 86, at 26–27 (critiquing the validity of several abortion-related psychological studies).

Force writes off the positions of three objective and well-respected organizations regarding possible side effects of abortion. In response to the APA's statement that abortion has no lasting or significant mental health risks, the Task Force states, without foundation, that "the APA's position does not represent that of the majority of its membership, but rather, the opinions of a group of members on various committees of interest."[175] The report proceeds to further question the APA's findings on ideological grounds, and ultimately chooses to ignore them altogether.[176] The Task Force entirely disregards the similar position set forth by the American College of Obstetricians and Gynecologists (ACOG), simply stating its disagreement with ACOG "due to other testimony and materials" presented to the Task Force.[177] It makes no attempt to reconcile the conflicting data. Perhaps most audaciously, the Task Force questions the reliability of abortion mortality statistics issued by the Centers for Disease Control, noting that the CDC is "not funded, or under any mandate, to obtain comprehensive and accurate data on deaths due to abortion."[178] In short, despite the slew of data the Task Force had, or should have had, regarding the non-existence of a mental health detriment due to abortion, it concluded that:

> [I]t is simply unrealistic to expect that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering significant psychological trauma and distress. To do so is beyond the normal, natural, and healthy capability of a woman whose natural instincts are to protect and nurture her child.[179]

Thus, judging simply by the Report itself, serious questions arise raised as to the reliability of the evidence used to support the statute's mandated disclosures. The statement of Dr. Marty Allison, a pro-life advocate and chairwoman of the Task Force, raises further doubts regarding the legitimacy of the Task Force Report, as she later commented that the findings were unscientific and slanted.[180] In describing the process of creating the Report, Dr. Allison detailed

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[175] TASK FORCE REPORT, *supra* note 170, at 46.

[176] *Id.* at 46–47.

[177] *Id.* at 48.

[178] *Id.* at 49. The Task Force further notes that the statistics are underinclusive because they "do not include the vast majority of deaths due to abortions because they do not include deaths from suicide . . . and deaths due to any of the cancers in which abortions may be a significant contributing factor." *Id.* As noted above, there is significant scientific data to suggest neither of these "causes of death due to abortion" is legitimate.

[179] *Id.* at 47–48.

[180] *See* Marty L. Allison, *My View*, 59 S.D. MED. 310, 310 (2006).

proceedings that were generally one-sided, as opposed to pro-choice and pro-life advocates working together to analyze scientific, objective information.[181] She further disclosed that the Task Force "voted down a motion to only accept data that is consistent with current medical science and based on findings obtained through the most rigorous and objective scientific studies."[182] She concluded that the Report is "not based on sound scientific research" and contains "misleading, and in some areas, completely false information."[183]

After considering the legislative findings, a court could look to additional expert testimony and amicus briefs to fill in the gaps and determine the basis behind the legislative position. Where, as here, the bulk of the evidence demonstrates either (1) a medical consensus that goes against the terms of the statute or (2) that the legislature failed to adequately use the available reliable scientific information, the court should impose an injunction until the statute's deficiencies are adequately corrected and the law takes into account the best available scientific evidence. The whole issue of judicial review, of course, could be avoided if legislators would allow doctors to exercise independent judgment when deciding upon specific disclosures. When specific disclosures are legislatively required, however, the court has a responsibility to ensure that they contain a factual basis in science.[184]

Admittedly, there are some limitations to this approach. For one, it would require significant time and expense for courts to adequately sift through the available evidence to make a determination.[185] Second, there is also likely to be a certain amount of "difficulty in finding neutral experts,"[186] especially in contentious areas like abortion. Finally, courts could get the scientific assessment wrong, which would adversely affect their credibility.[187] This last limitation

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[181] *Id.*

[182] *Id.*

[183] *Id.*

[184] On remand, the U.S. District Court for the District of South Dakota determined that the scientific consensus against the risk disclosures in the statute was sufficient to outweigh the limited evidence presented by those defending the statute. Planned Parenthood Minn., N.D., S.D. v. Rounds, 650 F. Supp. 2d 972, 983 (D.S.D. 2009) ("Defendants rely on their experts' opinions and five limited studies to show an association between suicide ideation and abortions. Defendants have produced no evidence, however, to show that it is generally recognized that having an abortion causes an increased risk of suicide ideation and suicide.").

[185] This is not an insurmountable problem, however. *See* McGinnis & Mulaney, *supra* note 129, at 126 ("Delay is simply the price of more accurate and fair fact-finding, and given that social facts constitute precedents no less binding than legal interpretations, the additional cost of delay to the particular parties in the case are likely to be outweighed by the advantages to society as a whole.").

[186] Black et al., *supra* note 160, at 800.

[187] *See* Wagner, *supra* note 164, at 599 (discussing the potential problems if courts

will also result, however, when legislatures misuse information. In those cases, deliberate legislative misuse will presumably create additional skepticism and have an even more damaging reputational effect in the eyes of the scientific community.

Although some might argue that such a review requires courts to invade the policy judgments that properly fall within the province of the legislature, this is not the case. The proposed review looks only at whether the statutes have an appropriate factual basis. Where such a basis exists, a court should not make any judgment as to the propriety or desirability of the statute. If the basis does not exist, the statute is in violation of *Casey*'s truthful and nonmisleading mandate, and a court has a constitutional obligation to intervene.

In sum, though admittedly imperfect, a less deferential look at statutes that so directly affect what doctors do and say with their patients is necessary to ensure a reasonable degree of scientific validity. At the very least, such an approach could prevent the enforcement of some of the more egregious statutes that are most likely to adversely affect the physician-patient relationship. With luck, it could also restore some integrity to the informed consent process by preventing legislative imposition on the physician-patient relationship in areas where it does not belong.

CONCLUSION

Using unsound medical information disguised as informed consent in order to serve the legislative objective of steering patients toward a particular treatment flies is the antithesis of the historical purpose of informed consent. Determining the appropriate course of care is ideally a matter for the physician and the patient to decide in the privacy of the doctor's office. Physicians are simply in a better position than either legislatures or courts to appropriately implement the informed consent process.[188] Mechanical, non-personalized, and sometimes medically unfounded statutes mandating the content of these discussions are not a viable solution for protecting patients.[189]

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improperly apply scientific arguments).

[188] *See* Tobin, *supra* note 124, at 150–51 (noting that doctors are "in a much better position than legislatures or health departments to translate informed consent principles into concrete statements, especially when the science involved is controversial or rapidly developing").

[189] *See* Andersen-Watts, *supra* note 6, at 221–22 ("We ought to be concerned about this legislation in terms of its ministerial costs, increased strain on the physician-patient relationship, and lack of efficacy in terms of decision-making habits of breast cancer patients."). Such concerns also stretch to similar legislation involving specific informed consent requirements in other treatment contexts.

These statutes merely exchange the original paternalism that plagued the doctor-patient relationship for another form, replacing the physician's decision making with the legislature's.[190] In either case, the patient's autonomy suffers. While improving the physician-patient relationship is a noble goal, many current specific statutory requirements are incapable of helping either doctors or patients toward this end.[191] In fact, paradoxically, "these mandates often do little to further the underlying values of the [informed] consent process, and sometimes are even directly at odds with them."[192]

The problems with specific informed consent statutes are compounded when their scientific accuracy is questionable. Under these circumstances the statutes go from merely undesirable to potentially unconstitutional. As one author questioned, "[i]f legislatures can mandate that physicians provide women with ideological, vague, intimidating, and false information about abortion, what is to stop them from intruding further into physician-patient discussions regarding end-of-life decisions, . . . the efficacy of birth control, or the role of condoms in preventing sexually transmitted infections?"[193]

At best, specific informed consent statutes are a beneficent, but misguided, attempt by legislators to produce a better-informed populace. Recently, however, these statutes more often embody deliberate attempts to manipulate women using morality disguised as legitimate science. If lawmakers insist on legislating informed consent to this degree, they must maintain the scientific integrity of the information. Such action is not only necessary to uphold the ideals of informed consent but more importantly, "it is a matter of sound public health policy."[194] As the researchers in the Johns Hopkins study concluded, "[i]f the goal is to help women, we are obligated to

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[190] *Id.* at 222. ("Trading one paternalism for another will not help matters; especially not a paternalism that disregards scientific data about decision-making and exists outside the realm of medical treatment.").

[191] *Id*; *see also* Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL'Y 245, 274 (2000) ("In reality, the law has done little to move actual medical practice closer to the ideal of shared decision-making between physician and patient. Too often, law has been used only to cover the doctor-patient relationship with bureaucratic red tape." (footnote omitted)).

[192] Gold & Nash, *supra* note 8, at 7.

[193] Lazzarini, *supra* note 122, at 2191.

[194] Richardson & Nash, *supra* note 7, at 11 (noting the obligations of state and federal policymakers in this area, and stating that "holding policymakers accountable to these informed-consent obligations may be an uphill battle, but it is no less urgent for being so"); *see also* McKenzie, *supra* note 14, at 273 (stating that "[i]f policy makers fail to rely on internationally agreed upon scientific facts . . . public policy will continue to be irresponsibly based on mere fantasies and wishful thinking" (citing Dr. Dianne Irving)).

base program and policy recommendations on the best science, rather than using science to advance political agenda."[195]

Though for better or worse, it has been established that a state may express a preference for childbirth over abortion, the Supreme Court has not made it acceptable to express this preference through "the provision of medically inaccurate information that effectively could negate a woman's ability to make an informed decision regarding her own life and health."[196] Thus, when legislatures insist upon creating specific informed consent statutes, they must base their laws on objective science, not mere speculation or political ideology.[197] Moreover, when legislators do venture into the realm of medicine, courts must serve as a more stringent check to prevent constitutional violations, especially in areas like abortion. Uncritical deference to legislative factual determinations is simply not enough. Medicine demands a more exacting standard, and the integrity of informed consent and the physician-patient relationship depends on it.

AMANDA MCMURRAY ROE†

[195] Charles et al., *supra* note 86, at 449.

[196] Richardson & Nash, *supra* note 7, at 11.

[197] *See* Dresser, *supra* note 32, at 1620 ("[A]lthough it is easy to speculate about physical and psychological risks accompanying a variety of medical interventions, there must be a reasonable evidentiary basis for such risks before doctors are required to warn patients about them.").

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