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INFORMED CONSENT TO ABORTION: A REFINEMENT

*Thomas L. Jipping**

Much controversy has ensued from the Supreme Court's decision in Roe v. Wade that a woman has a fundamental constitutional right to decide whether to terminate her pregnancy by abortion. The efforts of state legislatures to regulate abortion in various ways have given rise to many questions regarding what this right actually is and how it may best be protected. One such effort toward state regulation has been the establishment of informed consent laws which require the physician to present certain information to the pregnant woman before performing an abortion.

This Article examines and rejects the contention that physicians have a right to be free from government regulation in their practice of medicine. It then looks at the nature of the abortion right, the nature of abortion, and the context in which the abortion right is exercised. Finally, it concludes that a framework focusing on the rights of women rather than physicians and employing an "unduly burdensome" test and a broad definition of "health" would best help courts to assess the constitutionality of informed consent statutes.

I. INTRODUCTION: A GENERAL CRITIQUE OF THE SUPREME COURT'S ABORTION DOCTRINE

THE SUPREME COURT of the United States declared in 1973 that "a woman's decision whether or not to terminate her pregnancy" is a fundamental constitutional right protected against unjustified state interference by the due process clause of the fourteenth amendment.¹ The Court also recognized that two "sepa-

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1. Roe v. Wade, 410 U.S. 113, 153 (1973).

rate and distinct" state interests are implicated in the abortion context—one in maternal health and one in fetal life. These interests are at all times at least "important"² and each eventually becomes "compelling."³ The Court developed a trimester framework of rules, a "model statute" in Professor Alexander Bickel's words⁴ to balance this fundamental right and these state interests. This framework in fact leaves the states little room to actually protect preborn human life.⁵

Not only are increasingly significant state interests at stake in

2. *Id.* at 162.

3. *Id.* at 163.

4. A. BICKEL, *THE MORALITY OF CONSENT* 28 (1975). See also J. NOONAN, *A PRIVATE CHOICE: ABORTION IN AMERICA IN THE SEVENTIES* 27 (1979).

5. A state may, even potentially, proscribe abortion only during the third trimester of pregnancy, or after the preborn child is considered viable by the abortionist. *Roe*, 410 U.S. at 164-65. See also *Colautti v. Franklin*, 439 U.S. 379, 388 (1979) (Court held that a Pennsylvania statute which imposed a strict standard of care on a physician if the fetus "may be viable" was unconstitutional because this standard deviated from the standard established in *Roe*.); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (Held a provision of a Missouri statute, which required the physician to preserve the fetus' life and health regardless of the stage of pregnancy, to be unconstitutional). Even then, however, a state may not prohibit abortions "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, 410 U.S. at 165 (emphasis added). In *Roe*'s companion case, the Supreme Court construed "health," as a reason justifying abortion, to mean anything "relevant to the well-being of the patient." *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

Professor Lynn Wardle argues that this very broad definition of "health" from *Doe* applies to the reasons a woman would seek a first-trimester abortion but that a more restrictive definition applies to the third-trimester concerns that can still result in an abortion despite the Court's holding that states can prohibit them during late pregnancy. L. WARDLE, *THE ABORTION PRIVACY DOCTRINE: A COMPENDIUM AND CRITIQUE OF FEDERAL COURT ABORTION CASES 7-18* (1980). This distinction may be intuitively appealing, and may help construct a framework with more logical coherence than the Court's actually has, but the Court itself made no such distinction.

Since the very reason a woman would seek an abortion itself relates to her well-being, even during the third trimester a state is effectively prevented from ever proscribing abortion. See R. ADAMEK, *ABORTION AND PUBLIC OPINION IN THE UNITED STATES* 5 (1982) ("Given this broad definition of the components of health, the Court in effect legalized abortion in the third trimester as well."); J. NOONAN, *supra* note 4, at 12 ("The restriction on the [abortion] liberty appeared to be illusory. For the nine months of life within the womb the child was at the [mother's] disposal—with two restrictions: She must find a licensed clinic after month three; and after her child was viable, she must find an abortionist who believed she needed an abortion."); Stone, *Judges as Medical Decision Makers: Is the Cure Worse Than the Disease?*, 33 CLEV. ST. L. REV. 579, 580 (1984-85) (This author asserts that "Of course, the Chief Justice [in his *Roe* concurrence] turned out to be completely wrong: the consequences predicted by the dissent were as accurate as any judicial prediction can be. As Justice White correctly interpreted the decision, 'any woman is entitled to an abortion at her request if she is able to find a medical adviser willing to undertake the procedure.'" (footnote omitted); Balch, *Roe v. Wade: Abortion Is Legal Throughout Pregnancy* 1 (1983) ("Under the Supreme Court decisions of [*Roe* and *Doe*], it is constitutionally impossible for any state to prohibit abortions at any time during pregnancy.").

the abortion context, but public opinion has also consistently favored abortion regulation. Both opponents and proponents of abortion claim the support of public opinion. However, a careful analysis of relevant research shows that, with respect to both the acceptable reasons for obtaining an abortion and the period during pregnancy when abortion for any reason is acceptable, public opinion does not support the breadth of the abortion policy established by the Supreme Court in 1973. Reasons other than the life or physical health of the woman or a pregnancy resulting from rape, situations which amount to fewer than two percent of abortions currently performed in the United States,⁶ do not find support from a majority of Americans.⁷ In general abortion beyond the first trimester fails to garner substantial public support.⁸ Sociologist Raymond Adamek concluded, in his study of popularly cited opinion polls, that less than ten percent of abortions currently being performed in the United States have majority public approval.⁹ Today, after 15 years of widely available legal abortion and many Supreme Court decisions to back up the notion that abortion is a fundamental constitutional right,¹⁰ less than a quarter of the American people favor unrestricted access to legalized abortion.¹¹

Public opinion and state interest have combined to prompt continuing efforts by state legislatures to regulate abortion. These efforts have been challenged in nearly two dozen Supreme Court cases.¹² In his 1982 analysis, Professor Lynn Wardle examined more than 145 additional reported decisions by the lower federal

6. See *infra* note 228 and accompanying text.

7. R. ADAMEK, *supra* note 5, at 5 ("The middle majority . . . believes that abortion should be legal only for hard reasons of life/serious health threat or rape/incest.").

8. *Id.* ("only a minority approves of abortion beyond the first three months").

9. *Id.*

10. Researchers commonly find that changes in the law affect public opinion, at least in the short run. See Arney & Trescher, *Trends in Attitudes Toward Abortion, 1972-75*, 8 FAM. PLAN. PERSP. 117, 124 (1976); Granberg & Granberg, *Abortion Attitudes, 1965-1980: Trends and Determinants*, 12 FAM. PLAN. PERSP. 250, 252 (1980). In view of this fact, one might think that repeated Supreme Court rulings upholding the constitutional significance and breadth of the abortion right would strengthen public support for it.

11. See *Constitutional Amendments Relating to Abortion: Hearings on S.J. Res. 17, S.J. Res. 18, S.J. Res. 19, and S.J. Res. 110 Before the Subcomm. on the Constitution of the Senate Comm. on the Judiciary, 97th Cong., 1st Sess.* 890 (1981) (testimony of sociologist Raymond Adamek) [hereinafter *Hearings*]; Francome, *Abortion Politics in the United States*, 28 POL. STUD. 613, 616 (1980); *America's Abortion Dilemma*, NEWSWEEK, Jan. 14, 1985, at 22.

12. Most recently, on December 14, 1987, the Supreme Court affirmed, by a 4-4 vote, the judgment of the Seventh Circuit invalidating a portion of the Illinois Parental Notice of Abortion Act. *Hartigan v. Zbaraz*, 108 S. Ct. 479 (1987). The Supreme Court denied the State of Illinois' petition for a rehearing. *Hartigan v. Zbaraz*, 108 S. Ct. 1064 (1988).

courts dealing with substantive abortion issues.¹³ Nevertheless, the parameters of permissible state abortion regulation are still far from clear. The Supreme Court's abortion doctrine remains unsettled, fraught with ambiguity and inconsistency. Its abortion decisions, and *Roe* in particular, continue to be sharply criticized by a growing minority of Supreme Court justices¹⁴ and, to an almost unprecedented degree, by scholars spanning the political horizon.¹⁵

13. L. WARDLE, *supra* note 5, at xiii.

14. The Court voted 7-2 to overturn Texas' anti-abortion statute in 1973. *Roe v. Wade*, 410 U.S. 113 (1973). The Court voted 6-3 to overturn the city of Akron's anti-abortion ordinance ten years later. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983). The Court voted 5-4 to overturn Pennsylvania's anti-abortion statute in 1986. *Thornburgh v. American College of Obstetricians & Gynecologists*, 106 S.Ct. 2169 (1986).

Former Chief Justice Warren Burger had joined the majority in *Roe* and *Akron* but dissented in *Thornburgh*, writing that "I regretfully conclude that some of the concerns of the dissenting Justices in *Roe*, as well as the concerns I expressed in my separate opinion, have now been realized." *Id.* at 2190. He called for reexamination of *Roe*. Justice Byron White, joined by now-Chief Justice William Rehnquist, has written in dissent that "the time has come to recognize that *Roe v. Wade* . . . 'departs from a proper understanding' of the Constitution and to overrule it." *Thornburgh*, 106 S.Ct. at 2193. As Justice Powell observed in his majority opinion in *Akron*, Justice Sandra Day O'Connor's dissent in that case "rejects the basic premise of *Roe* and its progeny. [It] stops short of arguing flatly that *Roe* should be overruled. Rather, it adopts reasoning that, for all practical purposes, would accomplish precisely that result." *Akron*, 462 U.S. at 420 n.1.

Particularly strong or exhaustive substantive dissents from the Court's abortion decisions include those by Justice Rehnquist (joined by Justice White) in *Roe*, 410 U.S. at 171; by Justice White (joined by Justice Rehnquist) in *Roe* and *Doe v. Bolton*, 410 U.S. 179, 221 (1973); by Justice White (joined by Chief Justice Burger and Justice Rehnquist) in *Planned Parenthood v. Danforth*, 428 U.S. 52, 92 (1976); by Justice White (joined by Chief Justice Burger and Justice Rehnquist) in *Colautti v. Franklin*, 439 U.S. 379, 401 (1979); by Justice O'Connor (joined by Justices White and Rehnquist) in *Akron*, 462 U.S. at 452; and by Justice White (joined by Justice Rehnquist) in *Thornburgh*, 106 S.Ct. at 2192.

15. Professor Mark Tushnet writes that "[m]ost academic commentators probably believe that, as a matter of sound public policy, access to abortions should be relatively unrestricted. But none has been able to provide conclusive arguments that the Supreme Court correctly found that policy in the Constitution." Tushnet, *The Supreme Court on Abortion: A Survey*, in *ABORTION, MEDICINE, AND THE LAW* 165 (J. Butler & D. Walbert eds.) (3rd ed. 1986).

The academic criticism of *Roe* and its progeny is so extensive and diverse that the real task has become organizing it rather than simply keeping a current list. Nevertheless, a representative sample shows the continuing and diverse nature of this critical literature. See, e.g., *ABORTION AND THE CONSTITUTION: REVERSING ROE V. WADE THROUGH THE COURTS* 57-114, 123-81 (D. Horan, E. Grant & P. Cunningham eds. 1987); H. ARKES, *FIRST THINGS: AN INQUIRY INTO THE FIRST PRINCIPLES OF MORALS AND JUSTICE* 360-91 (1986); A. COX, *THE ROLE OF THE SUPREME COURT IN AMERICAN GOVERNMENT* 113-14 (1976); S. KRASON, *ABORTION: POLITICS, MORALITY, AND THE CONSTITUTION* (1984); J. NOONAN, *supra* note 4, at 5-32; Arkes, *Abortion: The Court Wasn't Persuasive*, 9 *HUM. LIFE REV.* 95 (Spring 1983); Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *FORDHAM L. REV.* 807 (1973); Csank, *The Lords & Givers of Life*, 3 *HUM. LIFE REV.* 75 (Spring 1977); Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 *U. PITT. L. REV.* 359 (1979); Dellapenna, *Nor Piety Nor Wit: The Supreme Court on Abortion*, 6

Uncertainty and confusion within the Supreme Court's abortion

COLUM. HUM. RTS. L. REV. 379 (1974); Destro, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 CALIF. L. REV. 1250 (1975); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920 (1973); Epstein, *Substantive Due Process by Any Other Name: The Abortion Cases*, 1973 SUP. CT. REV. 159; Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C.L. REV. 375 (1985); Gorby, *The "Right" to an Abortion, the Scope of Fourteenth Amendment "Personhood," and the Supreme Court's Birth Requirement*, 1979 SO. ILL. U.L.J. 1; Horan, Forsythe & Grant, *Two Ships Passing in the Night: An Interpretivist Critique of the White-Stevens Colloquy on Roe v. Wade*, 6 ST. LOUIS U. PUB. L. REV. 229 (1987); King, *The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn*, 77 MICH. L. REV. 1647, 1653-57 (1979); Krason & Hollberg, *The Law and History of Abortion: The Supreme Court Refuted*, in ABORTION, MEDICINE, AND THE LAW 196-225 (J. Butler & D. Walbert eds.) (3rd ed. 1986); Loewy, *Abortive Reasons and Obscene Standards: A Comment on the Abortion and Obscenity Cases*, 52 N.C.L. REV. 223, 223-34 (1973); Noonan, *Raw Judicial Power*, 8 HUM. LIFE REV. 71 (Winter 1982); O'Meara, *Abortion: The Supreme Court Decides a Non-Case*, 1974 SUP. CT. REV. 337; Rice, *The Dred Scott Case of the Twentieth Century*, 10 HOUSTON L. REV. 1059 (1973); Rosenblum, *Abortion, Personhood, and the Fourteenth Amendment*, 11 STUDIES IN LAW & MEDICINE 1 (1981); Strong, *Bicentennial Benchmark: Two Centuries of Evolution of Constitutional Processes*, 55 N.C.L. REV. 1, 96-104 (1976); Vieira, *Roe and Doe: Substantive Due Process and the Right of Abortion*, 25 HASTINGS L.J. 867 (1974); Wardle, *Rethinking Roe v. Wade*, 1985 B.Y.U.L. REV. 231; Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221, 297-311 (1973); Witherspoon, *Reexamining Roe: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment*, 17 ST. MARY'S L.J. 29 (1985); Comment, *Roe v. Wade and the Traditional Legal Standards Concerning Pregnancy*, 47 TEMP. L.Q. 715 (1974).

One recent article organized much of the critical literature into no less than twelve different lines of attack. See Horan, Forsythe & Grant, *supra*, at 230 n.8. Another article reports that "[t]he Index to Legal Periodicals through May 1984 lists 107 law review articles largely devoted to substantive criticism of *Roe v. Wade*. This does not encompass commentary in books or in articles which cover *Roe* along with other topics." Horan & Balch, *Roe v. Wade: No Justification in History, Law, or Logic*, in ABORTION AND THE CONSTITUTION: REVERSING ROE V. WADE THROUGH THE COURTS, *supra*, at 79 n.2.

Even scholars identified as supporters of *Roe* resort to rewriting the opinion because they, too, find the actual opinion flawed. See, e.g., Heymann & Barzelay, *The Forest and the Trees: Roe v. Wade and Its Critics*, 53 B.U.L. REV. 765, 784 (1973) ("Sadly, the court failed to relate the body of long-emerging precedent it recognized as significant . . . to those articulable, widely shared principles that the precedents reflect. . . . This failure leaves the impression that the abortion decisions rest in part on unexplained precedents, in part on an extremely tenuous relation to provisions of the Bill of Rights, and in part on a raw exercise of judicial fiat."); Perry, *Abortion, the Public Morals, and the Police Power: The Ethical Function of Substantive Due Process*, 23 UCLA L. REV. 689, 690 (1976) ("[I]t is difficult to find a case that raises methodological problems as severe as those left in the wake of *Roe*."); Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569, 1569 (1979) ("The result in the case . . . was controversial enough. Beyond that, even people who approve of the result have been dissatisfied with the Court's opinion. Others before me have attempted to explain how a better opinion could have been written."); Tribe, *Foreward: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 7 (1973) ("One of the most curious things about *Roe* is that, behind its own verbal smokescreen, the substantive judgment on which it rests is nowhere to be found."); Wheeler & Kovar, *Roe v. Wade: The Right to Privacy Revisited*, 21 U. KAN. L. REV. 527, 527 (1973) ("Unfortunately, the decisions themselves fail to yield a reasonable justification of the constitutional basis for protection of the woman's interest in terminating her pregnancy."). Others "repackage" the opinion. See, e.g., Cheremin-

doctrine stem from several sources. The first is the existence of a *constitutional* abortion right itself. Since the days of the common law and the first American statute in 1821, "[a]bortion regulation was a matter exclusively for state legislatures."¹⁶ Such state regulation, paralleling the development of medical and general scientific knowledge of human conception and prenatal development, increasingly restricted abortion, abandoned the inaccurate "quickening" distinction, and increased penalties for performing abortions.¹⁷ In the climate of rapid social change occurring throughout the 1960s, at least one third of the states changed their long-standing abortion policies in response to public political pressure.¹⁸ A single Supreme

sky, *Rationalizing the Abortion Debate: Legal Rhetoric and the Abortion Controversy*, 31 BUFFALO L. REV. 107, 142 (1982). Significantly, Professor Tribe has recanted his defense of *Roe* cited *supra*. L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1349-50 (2d ed. 1988). Professor Wardle has called that article "the most influential article written in defense of the *Roe* decision." L. WARDLE, *supra* note 5, at xii.

16. George, *State Legislatures Versus the Supreme Court: Abortion Legislation in the 1980s*, in *ABORTION, MEDICINE, AND THE LAW* 23 (J. Butler & D. Walbert eds.) (3rd ed. 1986). The first American statute was passed by Connecticut in 1821. See generally Byrn, *supra* note 15, at 827-35 (discussing 19th century abortion statutes in America); Rosenblum, *supra* note 15; Quay, *Justifiable Abortion—Medical and Legal Foundations*, 49 GEO. L.J. 395, 399 (1961) (discussing historical roots of 19th century abortion statutes).

17. Justice Blackmun asserted in *Roe* that 19th century American statutes banning abortion, and the quickening distinction they incorporated but eventually abandoned, were for the purpose of protecting maternal health rather than fetal life. *Roe*, 410 U.S. at 151-52. He cited two articles by Cyril Means, legal counsel to the National Association for the Repeal of Abortion Laws, as evidence of "scholarly support for this view" and offered a single case citation to show that "[t]he few state courts called upon to interpret their laws . . . did focus on the State's interest in protecting the woman's health rather than in preserving the embryo or fetus." *Id.* at 151.

Extensive scholarship has shown Blackmun's conclusions to be false, the product of ignoring much of the evidence and misrepresenting much of the rest. See Byrn, *supra* note 15, at 827-35; Dellapenna, *Abortion and the Law: Blackmun's Distortion of the Historical Record*, in *ABORTION AND THE CONSTITUTION: REVERSING ROE V. WADE THROUGH THE COURTS* 137-58 (D. Horan, E. Grant & P. Cunningham eds. 1987); Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 U. PITT. L. REV. 359, 402-04 (1979); Destro, *supra* note 15, at 1278-82; Gorby, *supra* note 15, at 13-21; Horan & Balch, *supra* note 15, at 67-70; Horan & Marzen, *Abortion and Midwifery: A Footnote in Legal History*, in *NEW PERSPECTIVES ON HUMAN ABORTION* 199-204 (T. Hilgers, D. Horan & D. Mall eds. 1981); Krason & Hollberg, *supra* note 15, at 207-10; Rosenblum, *supra* note 15; Witherspoon, *supra* note 15. A British scholar writes (in direct reference to Means' work) that "[i]t would be a gross distortion, however, to believe that all or even most 19th century laws were mainly attempts to protect women's health. The medical profession was in the forefront of the drive for more restrictive laws, and . . . the main concern of doctors was with the safety of the foetus." Sauer, *Attitudes to Abortion in America, 1800-1973*, 28 POP. STUD. 53, 57-58 (1974). James Mohr, author of perhaps the best known historical analysis on abortion in America, notes the advocacy nature of Means' scholarship and asserts that "Means . . . was less than convincing on several points" and his conclusions "open to serious questions." J. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900* 29-30 (1978).

18. See generally S. KRASON, *supra* note 15, at 16-39 (a comprehensive survey of public

Court decision in 1973, however, negated those 150 years of state regulation and discovered a right to abortion¹⁹ that was deemed to be " 'implicit in the concept of ordered liberty' "²⁰ itself.²¹ This ex-

and legislative activity leading to reformation of abortion law); Roemer, *Legalization of Abortion in the United States*, in *THE ABORTION EXPERIENCE: PSYCHOLOGICAL AND MEDICAL IMPACT* 284 (H. Osofsky & J. Osofsky eds. 1973); Comment, *A Survey of the Present Statutory and Case Law on Abortion: The Contradictions and the Problems*, 1972 U. ILL. L.F. 177, 179.

19. See Sobran, *Pensees: Notes for the Reactionary of Tomorrow*, NAT'L REV., Dec. 31, 1985, at 54: "The abortion issue had been debated on its substantive merits, but never in terms of constitutionality. . . . 'Discovering,' in its way, a 'right of privacy,' which itself is nowhere explicit in the Constitution, the Court found the 'right' to abortion in the 'penumbra' of this phantom."

20. *Roe*, 410 U.S. at 152 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

21. The Supreme Court has used either of two tests to determine which rights are "fundamental" and, therefore, within the liberty protected against unjustified state deprivation by the due process clause of the Fourteenth Amendment. One test would include those rights that are "implicit in the concept of ordered liberty" in such a way that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937). The other, broader, test would include those rights that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.). See also *Bowers v. Hardwick*, 106 S. Ct. 2841, 2844, *reh'g denied*, 107 S.Ct. 29 (1986); *Thornburgh*, 106 S.Ct. at 2194 (White, J., dissenting).

In *Roe*, Justice Blackmun began the substantive portion of his majority opinion by surveying "the history of abortion, for such insight as that history may afford." *Roe*, 410 U.S. at 129-47. Commentators have since thoroughly demonstrated that this historical survey was fundamentally flawed. See *supra* note 17. They have also observed not only that Justice Blackmun failed entirely to connect the fruit of this survey with the substantive legal analysis, but also that this survey is entirely irrelevant to that analysis. See, e.g., Dellapenna, *The History of Abortion*, *supra* note 15, at 424 ("The Court's discussion of history is inaccurate and inconclusive, and, in any event, unrelated to its later conclusions."); Ely, *supra* note 15, at 925 n.42 ("The opinion does contain a lengthy survey of historical attitudes toward abortion. . . . The Court does not seem entirely clear as to what this discussion has to do with the legal argument . . . and the reader is left in much the same quandary. It surely does not seem to support the Court's position."); Epstein, *supra* note 15, at 167 ("Before Mr. Justice Blackmun was ready to deal with the constitutional issues, he found it necessary to burden his opinion with an exhaustive history of abortion from ancient times until the present day. It is difficult to see what comfort he could draw from his . . . [N]either the mass nor the antiquity of the sources can conceal their essential irrelevancy to the constitutional inquiry."); Note, *Roe and Doe: Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161, 1181 n.110 (1974) ("The exercise is most remarkable for its failure to relate the discussion to the Court's analysis.").

Such a survey could have even potential relevance only to the Court's assertion that abortion is a fundamental right. The only approach to answering this question to which an historical review could contribute is the broader "Nation's history and tradition" approach. Some commentators have suggested that this was Blackmun's unstated intention. See, e.g., Tribe, *supra* note 15, at 3 n.13 ("The Court's recitation of the history seems to be designed largely to support its view that 'at the time of the adoption of our Constitution . . . a woman enjoyed a substantially broader right to terminate a pregnancy than she does in most States today.' But the bearing of that proposition on the constitutional issue is unclear") (citation omitted); Note, *supra*, at 1181 ("[T]he Court's labored historical sketch of attitudes toward abortion may have been an attempt to bring that case within the tradition analysis."). However, not only was Justice Blackmun's survey seriously flawed and his connection of that survey to the

tra-constitutional right would form the basis for the continuing revision of state abortion regulation.

In addition to the existence of the right, the source of the right has been an area of confusion. In *Roe*, the Supreme Court itself was unsure whether the right emanated penumbally from the corpus of the Bill of Rights or derived from either the ninth or the fourteenth amendment.²² Although the abortion right is within the general constitutional "right to privacy,"²³ it is inherently different from the Court's previous privacy cases.²⁴ One lower court trying to sort out the Supreme Court's abortion doctrine, stated: "The fact that both procreation and abortion have been held to be fundamental rights is understandably confusing."²⁵

A further source of confusion, arising from the trimester system created by the Court in *Roe*, concerns the issue of when other interests can be recognized so as to limit the abortion right. *Roe* established the end of both the first and second trimesters of pregnancy as points when the state's interests in protecting maternal health and fetal life, respectively, become compelling.²⁶ Lower federal courts have used these guidelines as bright lines that initially seemed helpful in assessing constitutional challenges to abortion statutes.²⁷ Since *Roe*, however, the abortionist decides when the

legal issues entirely absent, but he explicitly based his finding of fundamentality on the "ordered liberty" test rather than this "history and tradition" test, the only one to which his survey could have had even the most tenuous connection! Nothing but a six-word quote from *Palko* provided the label for Justice Blackmun's actual assertion that the right to choose between alternative methods of ending a pregnancy is "implicit in the concept of ordered liberty" itself.

22. *Roe*, 410 U.S. at 152-53.

23. *Id.* at 153.

24. *Id.* at 159. As Justice White has observed:

However one answers the metaphysical or theological question whether the fetus is a "human being" or the legal question whether it is a "person," as that term is used in the Constitution, one must at least recognize, first, that the fetus is an entity that bears in its cells all the genetic information that characterizes a member of the species *homo sapiens* and distinguishes an individual member of that species from all others, and second, that there is no nonarbitrary line separating a fetus from a child or, indeed, an adult human being. Given that the continued existence and development—that is to say, the *life*—of such an entity are so directly at stake in the woman's decision whether or not to terminate her pregnancy, that decision must be recognized as *sui generis*, different in kind from the others that the Court has protected under the rubric of personal or family privacy and autonomy.

Thornburgh, 106 S. Ct. at 2195 (White, J., dissenting). See also Ely, *supra* note 15, at 925, 927.

25. *Poe v. Gerstein*, 517 F.2d 787, 796 (5th Cir. 1975), *aff'd sub nom.* *Gerstein v. Coe*, 428 U.S. 901 (1976).

26. *Roe*, 410 U.S. at 160, 163.

27. See, e.g., *Gary-Northwest Indiana Women's Services v. Bowen*, 496 F. Supp. 894, 899 (N.D. Ind. 1980), *aff'd sub nom.* *Gary-Northwest Indiana Women's Services v. Orr*, 451

state's compelling interest in fetal life exists because he alone may determine whether a preborn child is viable.²⁸ The state's interest in maternal health has been limited by the Court which, while claiming to affirm *Roe*, has shifted this line somewhere into the second trimester so as to conform to the "accepted medical practices" of abortion practitioners themselves.²⁹ Thus, the already minimal recognition given to state interests by *Roe* has been eroded by subsequent decisions, further demonstrating the slippery nature of the Court's abortion doctrine and the confusion of state legislatures as to the actual contours of legitimate regulation.

A fourth source of confusion is the question of whose right *Roe* established and subsequent cases supposedly vindicated. This question is of crucial importance in establishing the breadth of the Court's abortion doctrine and, more particularly, in properly assessing informed consent statutes. *Roe* spoke of "the abortion decision,"³⁰ "a woman's decision,"³¹ and "reasons for which a physician and his pregnant patient might decide that she should have an abortion."³² It also stated that "the attending physician, in consultation with his patient, is free to determine . . . that, in his medical judgment, the patient's pregnancy should be terminated"³³ and that "the abortion decision and its effectuation must be left to the medical judgment of the . . . attending physician."³⁴ Each of

U.S. 934 (1981); *Planned Parenthood v. Fitzpatrick* 401 F. Supp. 554, 574 (E.D. Pa. 1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

28. See *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979).

29. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 434 (1983). The Court emphasized that regulations furthering the state's interest in maternal health must not "depart from accepted medical practice." *Id.* at 431. Such standards are regularly derived from the statements or positions of the American Public Health Association and the American College of Obstetricians and Gynecologists (ACOG). *Id.* at 435-37. Both organizations have unbroken records of advocacy for virtually unlimited legal access to abortion. ACOG, of course, brought the successful constitutional challenge to Pennsylvania's abortion control statute in *Thornburgh*.

30. *Roe*, 410 U.S. at 154, 155.

31. *Id.* at 153.

32. *Id.* at 156.

33. *Id.* at 163.

34. *Id.* at 164. Dr. Alan Stone, Professor of Law and Professor of Psychiatry at Harvard University, finds this particular statement by Justice Blackmun very revealing. He writes: "Although we have come to know the abortion decision as freedom of choice versus right to life, we find Justice Blackmun writing not that the state must yield to the woman's choice but to the 'physician's medical judgement.'" Stone, *supra* note 5, at 579. Other writers have also acknowledged the substantive ambiguity of the Supreme Court's abortion doctrine on this particular question. Dr. Stone repeatedly refers to this reference to medical judgment as "misleading." *Id.* at 580, 581. It also is a criticism urged by some feminist writers. See, e.g., R. PETCHESKY, *ABORTION AND WOMEN'S CHOICE: THE STATE, SEXUALITY AND REPRODUCTIVE FREEDOM* 125-26, 289-93 (1984).

these formulations suggests a different location of the right. *Roe* spoke of "the right of the physician to administer medical treatment according to his medical judgment,"³⁵ and *Roe's* companion case spoke of "the physician's right to administer" medical care and "the physician's right to practice."³⁶ These suggestions of an independent physician's right have become central themes in the Court's analysis of informed consent statutes but, upon examination as in this article, are fundamentally flawed.

The question of whose right is implicated when states seek to regulate abortion is crucial to a proper analysis of a statute's constitutionality. While, upon first examination, the Supreme Court's abortion cases may not seem very confusing on this point, actual results and important dicta in some recent decisions strongly suggest that the Court actually bases its decisions on a different answer to this question. That is, although the Court states that the abortion right is the woman's right of choice, it invalidates certain kinds of abortion regulations, like informed consent statutes, on the basis of their impact on the physician and his freedom to practice medicine.³⁷ The Court's failure to properly and consistently address this issue has led to flawed and confusing analysis and, therefore, to improper results. It has produced an inherently nebulous abortion doctrine, lacking manageable and articulable boundaries, and has allowed the Court to achieve whatever results it wants in individual cases and to thwart legitimate state efforts to both improve the woman's decision-making process and to protect preborn human life.

35. *Roe*, 410 U.S. at 165.

36. *Doe v. Bolton*, 410 U.S. 179, 197, 199 (1973).

37. The Court has invalidated informed consent requirements for two "equally decisive" reasons. The first is the Court's conclusion that "much of the information required is designed not to inform the woman's consent but rather to persuade her to withhold it altogether." *Akron*, 462 U.S. at 444. The Court has gone so far as to suggest that it deems the woman's choice already informed, her decision already made, at the time she consults with the physician whom the statute requires to convey certain information, stating that "*Danforth's* recognition of the State's interest in ensuring that this information be given will not justify abortion regulations designed to influence *the woman's informed choice* between abortion or childbirth." *Id.* at 443-44 (emphasis added). The second reason for invalidation is that these requirements intrude upon the discretion of the physician, thereby placing him in an "undesired and uncomfortable straitjacket." *Id.* at 445 (quoting *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 n.8 (1976)). See also *Thornburgh*, 106 S. Ct. at 2179.

This Article analyzes both these reasons. First, it examines the notion that physicians have some kind of right to be free from government regulation in their practice of medicine. It then looks at the nature of the abortion right, the nature of abortion, and the context in which the abortion right is sought to be exercised, in order to assess the claim that informed consent requirements are undue burdens on the woman's right of choice.

Another source of confusion contributing to this malleability of doctrine stems from the Court's failure to delineate and consistently apply the precise nature of the abortion right itself. Is it a right to terminate pregnancy³⁸ or a right to kill the fetus?³⁹ Is it an abstract right to an abortion or the freedom to choose between abortion and childbirth?⁴⁰ Is it a right to control one's own body⁴¹ or the right to make certain kinds of decisions?⁴²

In addition to the issue of whose right is implicated in the abortion context, a clear explanation of the nature of the abortion right is necessary to a properly confined, consistent analysis of state abortion regulations. Such an explanation is especially important because, as the Court has repeatedly declared, important interests other than the woman's are at stake. If, for example, the right is to an abortion itself, then state requirements for conveying information which could potentially make abortion a less desirable option would be suspect. If, however, the right is one of choice between

38. *Roe*, 410 U.S. at 153.

39. A three-judge federal court has held that there is no "constitutionally protected right to kill the fetus." *Wynn v. Scott*, 449 F. Supp. 1302, 1321 (N.D. Ill. 1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979). The Supreme Court has never confronted this precise question. However, the Court invalidated measures prescribing a standard of care by the physician toward the fetus in *Planned Parenthood v. Danforth*, 428 U.S. 52, 81-84 (1976), *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979), and in *Thornburgh v. American College of Obstetricians & Gynecologists*, 106 S. Ct. 2169 (1986), but upheld a requirement that a second physician be present when abortions are performed after viability in *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 482-86 (1983). As such, the Supreme Court's view on this issue is at least ambiguous.

40. The Supreme Court has held that the right to choose *not* to have an abortion is "at least as fundamental" as the right to choose to have one. *Maher v. Roe*, 432 U.S. 464, 472 n.7 (1977). At the same time, the Court has seemingly protected the right to choose the abortion option more than specifically enumerated individual rights like freedom of speech. *See Ely, supra* note 15, at 953. The Court's strong language in *Thornburgh* is the closest it has yet come to holding that anything even potentially tending to deemphasize the attractiveness of the one option, abortion, is presumptively unconstitutional.

41. Although the Supreme Court specifically rejected this argument in *Roe*, 410 U.S. at 154, the popular media and abortion proponents (even some law school professors) continue to discuss the abortion right in these terms.

On this point, juvenile court Judge Randall J. Hekman has written:

Two basic points need to be made in responding to this argument. First, no one—man or woman—has the unqualified right to the control over his or her own body. For example, a person may legally be punished for taking or using an illicit or nonprescribed drug with his or her body. A person who unsuccessfully attempts suicide can be punished. A woman is not legally free to sell her sexual services even to a consenting adult man.

....

Second, medical facts show that abortion involves the deliberate taking of *another* person's life.

R. HEKMAN, JUSTICE FOR THE UNBORN 49-50 (1984).

42. *See Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

abortion or childbirth, then the presentation of information germane to that decision rather than the likely side of the decisional scale on which that information may appear for most women is more important.

These doctrinal and analytical problems are particularly acute concerning the Supreme Court's analysis of informed consent to abortion statutes. The issue of the role of the physician constitutes one of the most ambiguous features of the abortion doctrine. When confronting statutes implicating this role, most notably informed consent statutes, the Supreme Court has consistently failed to analyze the issues raised with reference to the nature of the right purportedly established in *Roe* or to traditional jurisprudence concerning public control of the medical profession. Rather, the Court has used vague references to the "rights" of physicians and has failed to specify either the source and nature of these rights or, more importantly, how the statute involving the physician under consideration violates or burdens the woman's right of choice. One commentator has observed that "no consistent policy toward informed consent in the abortion context has emerged."⁴³ Instead, the Court has suggested that informed consent statutes violate the woman's right to abortion by affecting the discretion of her physician.⁴⁴ In addition to ignoring the nature of the abortion right and

43. Note, *Abortion Regulation: The Circumscription of State Intervention by the Doctrine of Informed Consent*, 15 GA. L. REV. 681, 685 (1981).

Commentators examining informed consent and the physician's role in the abortion context also have failed to examine either the nature of the abortion right or the state's traditional power to regulate the medical profession, both of which bear directly on the constitutional room that must be given to physician's discretion. See, e.g., Marcin & Marcin, *The Physician's Decision-Making Role in Abortion Cases*, 35 JURIST 66 (1975); Wood & Durham, *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U. L. REV. 783; Note, *Abortion Regulation: The Circumscription of State Intervention by the Doctrine of Informed Consent*, *supra*; Note, *The Abortion Alternative and the Patient's Right to Know*, 1978 WASH. U.L.Q. 167.

44. In *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the Supreme Court laid the foundation for subsequent invalidation of statutes which burden a woman's rights by interfering with her physician's discretion. The Court defined informed consent as "the giving of information to the patient as to just what would be done and as to its consequences." *Id.* at 67 n.8. It added the dictum that "[t]o ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Id.* The Court has never explained why the desire and comfort of the physician is the touchstone for assessing the constitutionality of these statutes.

Courts picked up on this theme and have invalidated informed consent statutes because they constituted such a "straitjacket." See, e.g., *Thornburgh*, 106 S. Ct. at 2179; *Akron*, 462 U.S. at 445; *Charles v. Daly*, 749 F.2d 452, 461 (7th Cir. 1984), *appeal dismissed sub nom.* *Diamond v. Charles*, 106 S. Ct. 1697 (1986).

Other commentators see this theme as stemming directly from *Roe* itself. See, e.g., Stone, *supra* note 5, at 579-82.

the state's traditional power to regulate the medical profession, this method of analysis prevents the state from properly asserting its interest in protecting the woman's exercise of her fundamental right by ensuring that her choice of whether *or not* to terminate her pregnancy by abortion is truly informed. This interest is especially great in the abortion context where the reasons for undergoing the medical procedure, and many of its consequences, are not medical at all.⁴⁵

Rather, the Court has taken increasingly extreme and logically incoherent positions. By 1986, simply informing women that certain written factual information was available *if they chose to view it* was an unconstitutional "wedge . . . into the privacy of the informed-consent dialogue between the woman and her physician."⁴⁶ At the same time, the Court has ruled that the state may not ensure that such a dialogue exists by requiring *any physician* to actually convey information to women contemplating abortion.⁴⁷ The Court has held that the state may not require that information about agencies available to assist a woman should she choose the childbirth option be given to *any* women because it *might* not be relevant to *all* women.⁴⁸ Astonishingly, the Court has even held that requiring physicians to tell women contemplating abortion about the detrimental effects of abortion or the particular medical risks of the abortion procedure she would undergo "is the *antithesis* of informed consent."⁴⁹ These bizarre results are products of a fundamentally flawed method of analysis and were cited by former Chief Justice Burger as prompting his departure from the majority ranks and his belief that *Roe* itself should be reexamined.⁵⁰

The Court's treatment of informed consent provisions is incon-

45. One commentator put it this way: "Admittedly abortion is a medical *procedure*. But the question remains why the Court in *Roe* insisted that it was a medical *decision*." Moore, *Moral Sentiment in Judicial Opinions on Abortion*, 15 SANTA CLARA LAW. 591, 626 (1975) (emphasis in original). Abortion is as much a medical matter as capital punishment is an electrical engineering matter. Implementation requires the knowledge and technical skill of third-party professionals, but the decision itself is another matter altogether.

46. *Thornburgh*, 106 S. Ct. at 2179.

47. *Id.* at 2180; *Akron*, 462 U.S. at 447. The Court bases this contention on its conjecture that a physician taking the time (the Court never says how much) to furnish the limited information required by informed consent statutes may (the Court never shows that it will) increase the cost of an abortion (the Court never says by how much). The Court never explains how a minimal increase in cost is a constitutionally undue burden on a woman's right to choose between abortion and childbirth such that it alone overcomes the important state interest in ensuring that the decision is informed.

48. *Thornburgh*, 106 S. Ct. at 2179-80.

49. *Id.* at 2180 (emphasis added).

50. *Id.* at 2190-92 (Burger, C.J., dissenting).

sistent with its other holdings within the abortion context and to jurisprudence on informed consent to medical treatment outside that context. In short, because its analysis is flawed, the Court's decisions concerning informed consent to abortion have produced improper results, overly hostile to important interests and even to the right of choice that *Roe* itself established. In this area, the Court's decisions have been inconsistent with three other areas of jurisprudence: public control of the medical profession generally, informed consent to medical treatment outside the abortion context, and other aspects of the abortion doctrine itself. These inconsistencies have produced a scheme of ad hoc activist judgments by the Court which have been overly hostile to important interests implicated when the abortion decision is made.⁵¹ A new framework, presented herein, is possible once these inconsistencies are highlighted.

Assuming, for present purposes, that *Roe* "seems like a durable decision,"⁵² this Article will attempt to put the role of the physician with respect to informed consent in better perspective. After briefly reviewing the Court's decisions in this area, it will examine the two reasons given by the Court for invalidating informed consent provisions. First, this section will address the Court's point about interference with physician discretion by noting federal court jurisprudence regarding public regulation of the medical profession in the non-abortion context. Next, it will address the Court's second point about interference with the woman's right by delineating the nature of the abortion right and realistically appraising both the nature of abortion and the context in which the abortion right is

51. In *Roe*, the Supreme Court acknowledged that the state has increasingly important interests in both maternal health and fetal life. At some point in pregnancy, these interests become compelling. *Roe*, 410 U.S. at 162-63. The source and weight of the state's interest in the integrity of a woman's abortion decision is unclear, though it stems at least in part from the state's interest in maternal health generally. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 443 (1983). This consideration cannot be the sole source of the interest, however, because the Court has held that a state may not regulate abortion in the interest of maternal health during the first trimester. *Roe*, 410 U.S. at 164. The court has, at the same time, upheld a state requirement that physicians obtain written informed consent before performing abortions during the first trimester. *Planned Parenthood v. Danforth*, 428 U.S. 52, 66-67 (1976). The Court so held in *Danforth* because "it is desirable and imperative that [the decision whether or not to abort] be made with full knowledge of its nature and consequences." *Id.* at 67. Therefore, the state interest in the integrity of the abortion decision is separate, at least in part, from the acknowledged state interest in maternal health that becomes compelling at the end of the first trimester or the state interest in fetal life that becomes compelling at the end of the second trimester. This result is not so much a product of the rules the Court laid down in *Roe* as of its ad hoc judgment in *Danforth*.

52. Ely, *supra* note 15, at 947.

sought to be exercised. In conclusion, it will present a more consistent framework for evaluating the constitutionality of informed consent to abortion statutes.

II. THE SUPREME COURT'S INFORMED CONSENT DECISIONS: A REVIEW AND PRELIMINARY CRITIQUE

The Supreme Court held in *Roe* that the constitutional right of privacy encompasses "a woman's decision whether or not to terminate her pregnancy."⁵³ This prerogative is a constitutionally protected interest "in making certain kinds of important decisions" free from unjustified government interference.⁵⁴ "A woman has at least an equal right to choose to carry her fetus to term as to choose to abort it."⁵⁵

In *Planned Parenthood v. Danforth*,⁵⁶ the Court upheld a Missouri statutory provision requiring that women certify their consent to an abortion in writing and that such consent be "informed and freely given and not the result of coercion."⁵⁷ The district court had upheld that provision, stressing that such a requirement gave the woman control over her physician's discretion and ensured that the person constitutionally empowered to make the abortion decision was, in fact, the one who truly made it.⁵⁸ The Supreme Court, upholding the provision despite its application in the first trimester of pregnancy and its application to abortion but not to other surgical procedures, emphasized that "it is desirable and imperative that [the decision] be made with full knowledge of its nature and consequences."⁵⁹ The Court accepted the definition of "informed" as "the giving of information to the patient as to just what would be done and as to its consequences"⁶⁰ but cautioned that "[t]o ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession."⁶¹

The same year it decided *Danforth*, the Court summarily affirmed a three-judge district court decision upholding a Pennsylvania informed consent provision. In *Planned Parenthood v.*

53. *Roe*, 410 U.S. at 153.

54. *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

55. *Maher v. Roe*, 432 U.S. 464, 472 n.7 (1977).

56. 428 U.S. 52 (1976).

57. *Id.* at 65.

58. *Id.* at 66.

59. *Id.* at 67.

60. *Id.* at 67 n.8.

61. *Id.*

Fitzpatrick,⁶² the court applied “the rational relationship test”⁶³ rather than strict judicial scrutiny because it found that the information the statute required to be given did not “chill the exercise of the abortion option.”⁶⁴ Requiring that this information be conveyed, the court noted, “is suggested . . . by the realities of the system that provides abortions.”⁶⁵ The physician remains free to add anything he chooses to make the standardized information required by the statute more relevant to a particular patient’s situation.⁶⁶ The statute required that each woman be advised: “(i) that there may be detrimental physical and psychological effects which are not foreseeable, (ii) of possible alternatives to abortion, including childbirth and adoption, and (iii) of the medical procedures to be used.”⁶⁷

The Court next reviewed an informed consent provision in 1983. The ordinance at issue in *Akron v. Akron Center for Reproductive Health*⁶⁸ required the attending physician to present a woman contemplating abortion with several categories of information including the status of her pregnancy, the development of the fetus, the date of possible viability, the physical and emotional consequences of abortion, and the availability of agencies providing assistance and information on birth control, adoption, and childbirth. It required the physician to tell the woman of the particular risks associated with both her own pregnancy and the abortion technique to be employed.⁶⁹ Consistent with the court’s observation in *Fitzpatrick*, the ordinance in *Akron* explicitly allowed the physician to make standardized information more relevant to an individual patient by imparting “other information which in his own medical judgment is relevant to her decision.”⁷⁰

The Court invalidated every part of the informed consent provision in *Akron*. The court in *Fitzpatrick* had first determined the general nature of the burden that the informed consent provision under review placed on the woman’s decision whether or not to abort. Finding first that it would not “chill the exercise of the abor-

62. 401 F. Supp. 554 (E.D. Pa. 1975), *aff’d mem. sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

63. *Id.* at 587.

64. *Id.*

65. *Id.*

66. *Id.* at 587-88.

67. *Id.* at 583.

68. 462 U.S. 416 (1983).

69. *Id.* at 442.

70. *Id.*

tion option," the court then determined that strict judicial scrutiny was not appropriate and upheld the provision under the rational relationship test.⁷¹ The Court in *Akron*, however, made no such analysis to determine the appropriate standard of review but appeared to apply strict scrutiny immediately.

The Court struck down the informed consent provision for two "equally decisive"⁷² reasons. The first was based on its conjecture that "it is fair to say that much of the information required is designed not to inform the woman's consent but rather to persuade her to withhold it altogether."⁷³ Several problems with this apparent constitutional rule are immediately apparent. First, the Court had previously held that the state may legitimately pursue a policy preference of favoring childbirth over abortion to the extent of refusing to pay for abortions women could not otherwise afford.⁷⁴ In his opinion for the Court in *H.L. v. Matheson*,⁷⁵ Chief Justice Burger wrote that "[t]he Constitution does not compel a state to fine-tune its statutes so as to encourage or facilitate abortions" and held that encouraging childbirth over abortion was rationally related to a legitimate state interest.⁷⁶ Second, to invalidate an informed consent requirement because it may make some women less likely to choose the option of abortion violates the basic notion that *Roe* established a right to choose between options, not a right to choose only one. Third, the Court's holding in *Akron* begs a fundamental question: if such information is likely to have some persuasive force (in whatever direction), does this fact not argue even more for its introduction into the decision making process? Fourth, the Court professed to base its inclusion of the abortion decision within the right to privacy in *Roe* on a list of possible "detriments" that foreclosing the abortion option might impose on some women.⁷⁷ Why,

71. *Fitzpatrick*, 401 F. Supp. at 587.

72. *Akron*, 462 U.S. at 445.

73. *Id.* at 444.

74. See *infra* note 185 and accompanying text.

75. 450 U.S. 398 (1981).

76. *Id.* at 413.

77. *Roe*, 410 U.S. at 153. The Court stated:

The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.

then, is it constitutionally impermissible to require the presentation of demonstrably accurate factual information about possible complications of abortion? Is it simply because the Court labels it a "parade of horrors"?⁷⁸ Can it be that only the Court is constitutionally entitled to use its imagination?

The Court's second basis for invalidating the *Akron* informed consent ordinance was "its intrusion upon the discretion of the pregnant woman's physician."⁷⁹ Although the *Akron* ordinance explicitly recognized that a physician is free to use standardized information from a perspective that is relevant to an individual case, the Court stated that a requirement to present such information places "'obstacles in the path of the doctor.'"⁸⁰ The Court failed to explain what these constitutionally significant obstacles were or, more importantly, how they burdened or interfered with *the woman's right of choice*. The issue of whether requiring a physician to present information burdens that physician affects neither the woman's need for information nor the relevance of such information to her. By 1983, the Court had yet to establish its apparent view that physicians have some right to practice abortion (they have no such right outside the abortion context) entirely free from regulation by the state.

The Court approved the substance of one category of information required by the *Akron* ordinance: "the particular risks associated with her own pregnancy and the abortion technique to be employed."⁸¹ However, the Court struck down even this provision because it required the attending physician, and no one else, to present this information.⁸² Thus, even though *Roe* and subsequent cases had emphasized the central role of the physician in both the making and the implementing of the woman's decision,⁸³ the state may not require that the physician perform this role. Ironically, the Court struck the requirement for the presentation of more general information about abortion complications because it intruded upon the physician's particular medical judgment regarding his individual patient, and yet invalidated the more individualized information about particular risks of the procedure to be employed in each case

78. *Akron*, 462 U.S. at 445.

79. *Id.*

80. *Id.* (quoting *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977)).

81. *Id.* at 446.

82. *Id.* at 447.

83. *Roe*, 410 U.S. at 153, 164. See also *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (stressing the central role of the physician, both in consulting with the woman about whether to have an abortion, and in determining how any abortion is to be carried out).

on the theory that the physician should not be required to speak at all.

Three years later, the Court again struck down a variety of informed consent provisions. The Pennsylvania statute at issue in *Thornburgh v. American College of Obstetricians and Gynecologists*⁸⁴ required the physician to provide five kinds of medical information:

- (a) the name of the physician who will perform the abortion,
- (b) the "fact that there may be detrimental physical and psychological effects which are not accurately foreseeable," (c) the "particular medical risks associated with the particular abortion procedure to be employed," (d) the probable gestational age, and
- (e) the "medical risks associated with carrying her child to term."⁸⁵

The statute also required that the woman be told that medical assistance might be available if she chose to continue her pregnancy and that the father of the child was liable to assist in the child's support.⁸⁶ Finally, the woman must be informed that printed material is available, should she choose to view it, describing the facts of prenatal development and listing agencies offering alternatives to abortion.⁸⁷

The Court struck down this entire scheme because not all of it is always relevant to every woman's individual decision⁸⁸ or some of it may be "out of step with the needs of the particular woman."⁸⁹ Such a scheme officially structures the dialogue between woman and physician, the Court said, and is only a means of "discouragement of the abortion decision."⁹⁰ Some of it is nonmedical information "beyond the physician's area of expertise."⁹¹

While the Court in *Akron* had approved in substance the requiring of information as to "the particular medical risks associated with [the woman's] own pregnancy and the abortion technique to be employed,"⁹² the Court in *Thornburgh* struck down the requiring of information as to "particular medical risks."⁹³ In *Danforth*, the Court had said "it is . . . imperative that [the decision] be made with

84. 106 S. Ct. 2169 (1986).

85. *Id.* at 2178.

86. *Id.* at 2179.

87. *Id.*

88. *Id.*

89. *Id.* at 2180.

90. *Id.*

91. *Id.*

92. *Akron*, 462 U.S. at 446.

93. *Thornburgh*, 106 S. Ct. at 2180.

full knowledge of its nature and consequences.”⁹⁴ For the Court in 1976, “the giving of information as to just what would be done and as to its consequences” was the very *definition of informed consent*.⁹⁵ For the Court in 1986, the giving of information as to the abortion technique to be used and the complications and risks of abortion and childbirth was the very “*antithesis of informed consent*.”⁹⁶ The Court in *Fitzpatrick* had approved the requiring of information on the “detrimental physical and psychological effects of abortion.”⁹⁷ The Court in *Thornburgh* struck down the requiring of information on “detrimental physical and psychological effects of abortion.”⁹⁸

Thus, the Court in *Akron* and *Thornburgh* assumed that informed consent provisions necessarily and unduly burden a woman’s right of choice and unconstitutionally infringe on the physician’s judgment and practice of the physician’s profession. Further, the Court now holds that the physician need not even be involved at all in the actual counseling with women contemplating abortion. This Article will proceed to address the question of physicians’ rights by examining the law with respect to regulation of the medical profession. It will address the question of whether statutes requiring that minimal information be given to ensure informed consent burden the abortion right by examining that right, the context in which it is sought to be asserted, and the nature of abortion itself.

III. ANALYZING THE COURT’S REASONS: INTERFERENCE WITH PHYSICIAN DISCRETION

The Supreme Court, in its abortion decisions, has always placed heavy emphasis on the importance of the physician’s role in the abortion context.⁹⁹ Indeed, the Court believes that abortion is inherently a medical procedure.¹⁰⁰ This heavy emphasis, combined with the Court’s invalidation of informed consent statutes because

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

95. *Id.* at 67 n.8.

96. *Thornburgh*, 106 S. Ct. at 2180 (emphasis added).

97. *Fitzpatrick*, 401 F. Supp. at 583.

98. *Thornburgh*, 106 S. Ct. at 2180.

99. See, e.g., *Akron*, 462 U.S. at 427, 429-30, 445; *Colautti v. Franklin*, 439 U.S. 379, 387, 394, 396 (1979); *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975); *Roe*, 410 U.S. at 163, 165-66; *Doe v. Bolton*, 410 U.S. 179, 191-92, 197 (1973); *Planned Parenthood v. Fitzpatrick*, 410 F. Supp. 554, 564, 569 (E.D. Pa. 1975), *aff’d sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

100. See *Colautti*, 439 U.S. at 387; *Doe*, 410 U.S. at 215.

of their interference with the physician's discretion,¹⁰¹ suggests that the Court, at least implicitly, recognizes an independent right of the physician to practice medicine, at least in the abortion context, free from such interference. The Court has occasionally made reference, in its abortion decisions, to the "rights" of physicians.¹⁰² Inasmuch as the Court has never explicitly held that such a right exists in the abortion context,¹⁰³ it is helpful to examine federal court jurisprudence outside the abortion context to determine whether such a physician's right with constitutional significance has been recognized.

A. *A Right to Practice Medicine?*

Attempts to assert an independent right to practice medicine have typically been made in the context of attacks on state regulations claimed to violate the due process clause of the fourteenth amendment. The right to practice, it is claimed, is part of the "liberty" or "property" protected by that clause against unjustified infringement by the state.

Such an argument was rejected in some of the early cases in which courts recognized broad latitude for the state's police power to operate in this area. For example, the Supreme Court rejected a fourteenth amendment due process claim of a property right in the practice of medicine in *McNaughton v. Johnson*,¹⁰⁴ stating: "It is established that a State may regulate the practice of medicine, using

101. See *supra* note 44.

102. See, e.g., *Doe*, 410 U.S. at 197, 199. See also Stone, *supra* note 5, at 579: "we find Justice Blackmun writing not that the state must yield to the woman's choice but to the physician's 'medical judgement.'"

103. In *Doe*, the Court suggested in dicta that such a right existed. 410 U.S. at 197-98, 199. This suggestion was taken seriously by the Chief Justice of the California Supreme Court who stated in a dissent that *Doe* "speaks specifically of the doctor's right to administer medical care." *People v. Privitera*, 23 Cal. 3d 697, 723, 591 P.2d 919, 935, 153 Cal. Rptr. 431, 447 (1979) (Bird, C.J., dissenting) (emphasis in original). However, the U.S. Supreme Court specifically rejected this notion that such cited passages from *Doe* establish a "right to practice medicine free from unwarranted state inference." *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977). Rather, the Court said that the doctor's right is derived entirely from the patient's. The regulation in *Doe* was invalidated because it encumbered *her* right by "placing obstacles in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision. If those obstacles had not impacted upon the woman's freedom to make a constitutionally protected decision, if they had merely made the physician's work more laborious or less independent without any impact on the patient, they would not have violated the Constitution." *Id.* The Court has never explained the contradiction between this holding and its subsequent elevation of physician discretion to constitutional significance, separate from and even equal to the female patients' right of choice. See *supra* notes 72-73, 79-80 and accompanying text.

104. 242 U.S. 344 (1917).

this word in its most general sense.”¹⁰⁵

This due process argument, however, eventually prevailed during the early part of this century, when the philosophy of substantive due process dominated the Court's approach to reviewing state economic regulations. In *Lochner v. New York*,¹⁰⁶ the Court said that if the regulation on bakers' hours at issue in that case was upheld, similar regulation of “doctors, lawyers, scientists, all professional men” would soon follow.¹⁰⁷ The court in *Baker v. Daly*¹⁰⁸ sustained a challenge to the state's Cosmetic Therapy Law on similar grounds, stating that the due process clause of the fourteenth amendment included the right to earn a living and to live and work where and how one wished.¹⁰⁹ Likewise, in *Liggett Co. v. Baldridge*,¹¹⁰ the Supreme Court invalidated a state law requiring that pharmacies be owned by pharmacists. While acknowledging that the state “undoubtedly may regulate the prescription, compounding of prescriptions, purchase and sale of medicines, by appropriate legislation to the extent reasonably necessary to protect the public health,”¹¹¹ the Court held that the mere ownership of a drug store bore no rational relationship to public health. Thus, the court concluded that the regulation infringed upon the appellant's property rights in the business of pharmacy.¹¹²

The demise of substantive due process brought an end to the recognition of a constitutionally significant liberty or property right to practice medicine. The Supreme Court overruled *Liggett* in 1973, the same year it decided *Roe*, and noted that the substantive due process philosophy had been rejected and replaced by the principle that “states have power to legislate against what are found to be injurious practices in their internal commercial and business affairs, so long as their laws do not run afoul of some specific federal constitutional prohibition, or of some valid federal law.”¹¹³

The Court rejected a due process claim in *Semler v. Oregon State Board of Dental Examiners*¹¹⁴ and described the special defer-

105. *Id.* at 348-49.

106. 198 U.S. 45 (1905).

107. *Id.* at 60.

108. 15 F.2d 881 (D. Or. 1926).

109. *Id.* at 882.

110. 278 U.S. 105 (1928).

111. *Id.* at 112.

112. *Id.* at 111, 116.

113. *North Dakota State Bd. of Pharmacy v. Snyder's Drug Stores*, 414 U.S. 156, 165 (1973) (quoting *Lincoln Union v. Northwestern Co.*, 335 U.S. 525, 536-37 (1949)).

114. 294 U.S. 608 (1935).

ence with which it would treat state regulation of the medical profession: "The legislature was not dealing with traders in commodities, but with the vital interest of public health, and with a profession treating bodily ills."¹¹⁵ In *Johnston v. Board of Dental Examiners*,¹¹⁶ the court upheld the Dental Act of 1940 and regulations promulgated under it, despite the appellant's claim that "unduly oppressive and unwarranted restrictions [had] been placed upon the conduct of his profession."¹¹⁷ In so doing, the court stated: "The courts have so often sustained identical legislative provisions that we are somewhat surprised at appellant's apparently serious re-presentation of this argument here."¹¹⁸

In summary, then, the federal courts no longer recognize an independent constitutionally significant "right to practice medicine" free from government interference.¹¹⁹ The Supreme Court provides no justification for apparently resurrecting this notion within the abortion context while maintaining its burial outside that context. The constitutional significance of the physician's desires and comfort¹²⁰ is simply stated as fact, rather than established. This notion is not only unsupported, but it has been affirmatively rejected elsewhere. As such, the Court's reliance on this notion is fundamentally flawed. To the extent that reliance on this notion is outcome-determinative, the Court's results are wrong as well. Moreover, the explicit elevation of interference with physicians' discretion to a criterion equally decisive with burdening the woman's right of choice for invalidating informed consent requirements¹²¹ shows that this flawed premise has indeed become outcome-determinative.

B. *State Regulation of the Medical Profession*

It would be erroneous to suggest that, because there exists no independent constitutional "right to practice medicine," any form of regulation by the state is permissible. Such regulation must still

115. *Id.* at 612.

116. 134 F.2d 9 (D.C. Cir. 1943).

117. *Id.* at 10.

118. *Id.* at 11.

119. See 70 C.J.S. *Physicians and Surgeons* § 6 (1987); 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 13 (1987).

120. In *Planned Parenthood v. Danforth*, the Court approved the general requirement of obtaining written informed consent but cautioned that the state could not define "informed" in a way that placed the physician in "an undesired and uncomfortable straitjacket in the practice of his profession." *Danforth*, 428 U.S. at 67 n.8.

121. See *Thornburgh*, 106 S. Ct. at 2179; *Akron*, 462 U.S. at 445.

conform to the dictates of the Constitution.¹²² In addition, permissible state regulation of the medical profession may in part be determined by the effect it has on the patient/consumer of medical care. It is important, however, to note that the practice of medicine falls squarely within the ambit of the state police power, perhaps more directly than any other profession.

1. *Basis for state regulation*

State regulation of the medical profession is grounded in the police power. As the Supreme Court stated nearly 100 years ago: "The power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud."¹²³ Likewise, in *Watson v. State of Maryland*,¹²⁴ the Court declared a recognized principle:

It is too well settled to require discussion at this day that the police power of the State extends to the regulation of certain trades and callings, particularly those which closely concern the public health. There is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine.¹²⁵

The "right to practice medicine," then, if it exists at all, is a conditional one, subject to the states' police power to safeguard the public health.¹²⁶

2. *Permissible forms of state regulation*

The police power of the state has justified several forms of permissible regulation of the medical profession. The most significant element of such regulation, for present purposes, is the degree to which such regulation touches the core of the physician's practice: his discretion and medical judgment in dealing with patients. The

122. The fact that constitutional decisions by the Supreme Court can have such a preemptory effect on policymaking by state legislatures in areas traditionally left solely to their discretion only heightens the need for careful, clear, consistent interpretation and application of constitutional provisions and cautions against creating new "rights" not clearly found in the text or history of the Constitution. It also cautions against ad hoc formulations to achieve desired results.

123. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889).

124. 218 U.S. 173 (1910).

125. *Id.* at 176.

126. See *Geiger v. Jenkins*, 316 F. Supp. 370, 373 (N.D. Ga. 1970) (three-judge court). See also *McNaughton v. Johnson*, 242 U.S. 344 (1917); 70 C.J.S. *Physicians and Surgeons* §§ 6-8 (1987); 61 AM. JUR. 2D, *Physicians, Surgeons, Etc.* §§ 131, 132, 134 (1987).

permissible forms of state regulation reviewed here increasingly approach that core; the law of informed consent to medical treatment affects it directly.

a. *Initial licensing.* Perhaps the most clearly recognized means of state provision for the general welfare and of safeguarding the public health through regulating the medical profession is requiring physicians and surgeons to obtain licenses or certificates before practicing and determining the qualifications for such licensure. As long as such requirements for licensure are related to the profession and are reasonably attainable, they are consistent with the police power and have repeatedly been upheld.¹²⁷ Through licensure, the state may define the practice of medicine and ensure the competence of those who follow that calling.¹²⁸ As will become apparent in the course of this discussion, however, simply because an individual meets the state's initial requirement for licensure does not mean he is free to practice entirely at his own unfettered discretion.

b. *Supervision and revocation.* Determination of qualifications for practice and the requirement of a license constitute only the bare minimum of permissible state regulation of the medical profession.¹²⁹ Related to the power to determine qualifications for initial licensing is the state's power to supervise the profession and to suspend or revoke the licenses of those failing to maintain the requisite qualifications.

An important case relating to the subject of this Article is *Missouri ex. rel. Hurwitz v. North*,¹³⁰ in which the Supreme Court upheld, on equal protection grounds, a statute vesting the state board of health with authority to revoke a physician's license for unlaw-

127. See *Semler v. Oregon State Bd. of Dental Examiners*, 294 U.S. 608 (1935); *Reetz v. Michigan*, 188 U.S. 505 (1903); *Dent v. West Virginia*, 129 U.S. 114 (1889); *Geiger v. Jenkins*, 316 F. Supp. 370 (N.D. Ga. 1970) (three-judge court).

128. See *Collins v. Texas*, 223 U.S. 288, 296 (1912). See also *Hawker v. New York*, 170 U.S. 189, 191 (1898); 70 C.J.S. *Physicians and Surgeons* §§ 11-13 (1981).

129. In *Doe v. Bolton*, 410 U.S. 179 (1973), the Supreme Court invalidated a state requirement that two doctors concur with the determination of a woman's physician that an abortion was necessary. In so doing, the Court stated: "If he fails in this, professional censure and deprivation of his license are available remedies." *Id.* at 199. In light of both the principles governing state regulation of the medical profession and the Court's later abortion cases, however, this cannot be seen as the infirmity requiring invalidation. Rather, invalidation of this provision was proper because it vested an *absolute* veto of an *adult* woman's fundamental right to decide whether or not to have an abortion in third parties. See *Bellotti v. Baird*, 443 U.S. 622, 639 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976); cf. *H.L. v. Matheson*, 450 U.S. 398 (1981).

130. 271 U.S. 40 (1926).

fully procuring an abortion.¹³¹ Such a statute would be invalidated today under *Roe* because of its direct impact on the availability of abortion. However, the physician's right in the abortion context can appropriately be viewed only as derivative from the woman's right to decide whether or not to terminate her pregnancy.¹³² Clearly, barring from practice those who would violate prohibitions on the performance of abortions would make effectuating the woman's abortion decision impossible and it is for this reason that the *North* statute would be struck down today. As such, that case's basic principle still retains its vitality:

A statute which places all physicians in a single class, and prescribes a uniform standard of professional attainment and conduct, as a condition of the practice of their profession, and a reasonable procedure applicable to them as a class to insure conformity to that standard, does not deny equal protection of the laws within the meaning of the Fourteenth Amendment.¹³³

The courts have long upheld statutes authorizing boards to determine what constitutes unprofessional conduct or to establish other criteria for the revocation of licenses to practice medicine.¹³⁴ In *Barsky v. Board of Regents*,¹³⁵ the Court said:

It is elemental that a state has broad powers to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health.¹³⁶

c. *Commercial aspects of practice.* In *Johnston v. Board of Dental Examiners*,¹³⁷ despite the appellant's claim that "unduly op-

131. Similarly, the U.S. Court of Appeals for the D.C. Circuit upheld an action by a state licensing committee revoking a physician's license for "misconduct" involving the performance of an abortion. *Ladrey v. Commission on Licensure to Practice*, 261 F.2d 68 (D.C. Cir. 1958). The court noted that it was not even argued "that practitioners of medicine may not be regulated." *Id.* at 70. As in *Missouri ex rel Hurwitz v. North*, 271 U.S. 40 (1926), this decision could not be made today, but only because of its impact on a woman's right to choose whether or not to have an abortion, not because physicians have an independent constitutional right to practice medicine.

132. *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977).

133. 271 U.S. at 43.

134. *See, e.g., Johnston v. Board of Dental Examiners*, 134 F.2d 9 (D.C. Cir. 1943); *Rit-holz v. Indiana Bd. of Registration*, 45 F. Supp. 423 (N.D. Ind. 1937).

135. 347 U.S. 442 (1954).

136. *Id.* at 449. The Court in *Barsky* also stated: "The practice of medicine in New York is lawfully prohibited by the State except upon the conditions it imposes. . . . It is equally clear that a state's legitimate concern for maintaining high standards of professional conduct extends beyond initial licensing. Without continuing supervision, initial examinations afford little protection." *Id.* at 451. *See also* 70 C.J.S., *Physicians and Surgeons* § 16 (1987).

137. 134 F.2d 9 (D.C. Cir. 1943).

pressive and unwarranted restrictions [had] been placed upon the conduct of his profession,"¹³⁸ the court upheld the Dental Act of 1940 which regulated the advertisement of dental services. In that case, the court suggested that such regulations were virtually presumed to be within the police power. The court stated that "[r]egulations preventing the commercialization and exploitation of the medical professions have repeatedly been held to bear a reasonable relationship to the public health and safety."¹³⁹ The same court also found that the practice of medicine constituted a "trade" for purposes of the Sherman Anti-Trust Act.¹⁴⁰ In that case the court said: "The practice of medicine in the District of Columbia is subject to licensing and regulation and, we think, may not lawfully be subjected to 'commercialization and exploitation.'"¹⁴¹ In another form of commercial regulation, the Supreme Court has sustained a state law prohibiting the practice of optometry under a trade name.¹⁴²

d. *Content of practice.* The just described areas of permissible state regulation of the medical profession are still rather far removed from the actual content of the practice or the discretion of the physician. Yet, getting closer to the heart of the practice itself, the state has the power to establish the very definition of the practice of medicine.¹⁴³ The state may determine what constitutes a particular branch of medical practice. Thus, in *Williamson v. Lee Optical Co.*,¹⁴⁴ the Supreme Court upheld a regulation that permitted only licensed optometrists or ophthalmologists to fit frames, lenses, or other optical appliances. In assessing the due process claim in *Williamson*, the Court emphasized that "[t]he day is gone when this Court uses the Due Process Clause of the Fourteenth Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought."¹⁴⁵ Rather, the deferential test the Court applies is that "[i]t is enough that there is an evil at hand for correction, and that it might be thought that the

138. *Id.* at 10.

139. *Id.* at 12.

140. *United States v. American Medical Ass'n*, 110 F.2d 703 (D.C. Cir. 1940).

141. *Id.* at 714.

142. *Friedman v. Rogers*, 440 U.S. 1 (1979). See 70 C.J.S. *Physicians and Surgeons* § 32 (1987); 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 143 (1987).

143. *Collins v. Texas*, 223 U.S. 288 (1912).

144. 348 U.S. 483 (1955).

145. *Id.* at 488.

particular legislative measure was a rational way to correct it."¹⁴⁶ For this reason the California Supreme Court has held that the state can ban the distribution of drugs not recognized as effective for their intended use.¹⁴⁷

C. *Informed Consent to Medical Treatment*

The areas of pervasive government regulation of the medical profession discussed above, licensing and revocation, commercial aspects, and definition of practice, begin to approach the heart of the physician's practice of his craft, his discretion and medical judgment in dealing with his patients. The law governing informed consent to medical treatment, however, goes directly to the core of the physician's practice. Determining whether the law in this area recognizes a specially protected role for the physician's discretion and judgment, much less an actual right to unfettered practice, requires review of three factors: the cases and statutes themselves, their trends, and some of the recent Supreme Court decisions in the area of commercial speech. When these pieces are viewed in combination, the picture that emerges is that, even at the heart of the physician's practice, he does not enjoy a "right" to practice at his own discretion. The state retains considerable authority to ensure the integrity of medical care decision-making and to make substantive judgments about the minimal amount of information that patients need to receive.

1. *Cases and statutes*

a. *The reasonable physician model.* The cases and statutes concerning informed consent to medical treatment fall into two groups, which can be distinguished by the standard against which the physician's disclosure is to be measured. Since actions against physicians for failing to obtain informed consent are now based on a

146. *Id.*

147. *People v. Privitera*, 23 Cal. 3d 697, 591 P.2d 919, 153 Cal. Rptr. 431 (1979). In *Privitera*, a medical doctor and four others had been convicted of conspiracy to sell and distribute laetrile, an unapproved drug intended for the alleviation or cure of cancer, in violation of state statutory law. *Id.* at 697. The Supreme Court of California found that "a fundamental privacy right is not at stake here" because the constitutional right of privacy protects only "independence in making certain kinds of 'important decisions.'" *Id.* at 702. "But the kinds of 'important decisions' recognized by the high court to date as falling within the right of privacy . . . do not include medical treatment." *Id.*

For an example of an attempt to extend the right of privacy to include use of such unapproved or unproven medical treatments, see Comment, *The Right to Choose an Unproven Method of Treatment*, 13 LOY. L.A.L. REV. 227 (1979).

negligence theory,¹⁴⁸ and not the old battery theory,¹⁴⁹ this model is described in terms of the physician's duty of disclosure.

The first group of cases and statutes uses the standard of the "reasonable physician," and holds that the duty of the physician to disclose information to his patient is measured "with reference to the general practice customarily followed by the medical profession in the locality."¹⁵⁰ Under this model, the physician's duty to disclose "is limited to those disclosures which a *reasonable medical practitioner* would make under the same or similar circumstances."¹⁵¹ The courts generally require expert medical testimony to show what the reasonable practitioner in the local community would do under the circumstances.¹⁵² Statutes reflecting the reasonable physician standard have required that this contention be proven by a preponderance of the evidence.¹⁵³ The reasonable physician model emphasizes the complexity of the issues, the physician-patient relationship, the physician's special training and knowledge, and the patient's lack of such knowledge.¹⁵⁴

148. See, e.g., *Congrove v. Holmes*, 37 Ohio Misc. 95, 98 (1973):

Informed consent consists of a duty imposed by law upon a physician to inform his patient of the nature of the surgery he intends to perform, the probable consequences, risks and hazards of this procedure, and the benefits that can be anticipated from this procedure. . . . Breach of this duty is recognized as tortious misconduct actionable as medical negligence where harm proximately results therefrom.

149. The shift away from the battery theory of recovery for invasion of bodily integrity by an unauthorized operation began with *Salgo v. Stanford Univ. Bd. of Trustees*, 317 P.2d 170 (1957). Since then, the physician not only had to gain permission to treat but had to affirmatively make certain disclosures to the patient. See generally *Trojun v. Fruchtman*, 58 Wis. 2d 569, 595-96, 207 N.W.2d 297, 311 (Wis. 1973); *McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Comment, *New Trends in Informed Consent?*, 54 NEB. L. REV. 66 (1975). Some courts still cling to the battery theory, however. See, e.g., *Karlsons v. Guerinot*, 57 A.D.2d 73, 81, 394 N.Y.S.2d 933, 937 (N.Y. App. Div. 1977); *Shetter v. Rochelle*, 2 Ariz. App. 358, 373, 409 P.2d 74, 86 (1965).

150. *Roberts v. Young*, 369 Mich. 133, 140, 119 N.W.2d 627, 630 (1963). See *Bly v. Rhoades*, 216 Va. 645, 652, 222 S.E.2d 783, 789 (1976) (rejecting a national standard in favor of a local standard).

151. *Natanson v. Kline*, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960) (emphasis added).

152. See *Hamor v. Maine Coast Memorial Hosp.*, 483 A.2d 718, 722 (Me. 1984); *Bly v. Rhoades*, 216 Va. 645, 652, 222 S.E.2d 783, 788 (1976); *Aiken v. Clary*, 396 S.W.2d 668, 674 (1965).

153. See, e.g., ARK. STAT. § 34-2614 (1985 Supp.); DEL. CODE ANN. tit. 18 § 6852 (1984); ME. REV. STAT. ANN. tit. 29 § 2905 (1985-86 Supp.); NEB. REV. STAT. § 44-2816 (1984); TENN. CODE ANN. § 29-26-118 (1984 Supp.).

154. See, e.g., *Longmire v. Hoey*, 512 S.W.2d 307, 310 (Tenn. 1974); *Natanson v. Kline*, 186 Kan. 393, 409, 350 P.2d 1093, 1106 (1960) ("How the physician may best discharge his obligation to his patient in this difficult situation involves primarily a question of medical judgment.").

Therefore, the reasonable physician model generally places great emphasis on the discretion and judgment of the physician. Such judgment forms the basis of the standard for determining whether a physician has breached the duty to disclose. However, since the shift from the battery theory to the negligence theory, this standard has imposed a duty, as measured by the standards of the profession, to disclose information to the patient. The state can enforce this duty through the common law or statutes.

b. *The reasonable patient model.* The second group of cases and statutes, in contrast, uses the standard of the "reasonable patient," and generally holds that "[t]he physician is bound to disclose . . . those risks which a *reasonable man* would consider material to his decision whether or not to undergo treatment."¹⁵⁵ Underlying this model is an emphasis on the individual dignity and autonomy of the patient who has the right to make decisions regarding his or her own body.¹⁵⁶

The reasonable patient line of cases emphasizes that the "patient's right to make his decision in the light of his own individual value judgment is the very essence of his freedom of choice."¹⁵⁷ Under this model, the materiality of the information to the patient's decision, rather than the physician's medical judgment, is the measure of the physician's duty to disclose.¹⁵⁸ Statutes reflecting the reasonable patient model require that physicians disclose information about the intended procedure, its risks, and alternatives.¹⁵⁹ Some states have recently enacted statutes based on the reasonable patient model for specific contexts or conditions like breast can-

155. *Cooper v. Roberts*, 220 Pa. Super. 260, 267-68, 286 A.2d 647, 650-51 (1971) (emphasis added).

156. *See Schloendorff v. Society of N.Y. Hosps.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Schloendorff* represents the old battery theory. For a similar emphasis underlying the negligence theory, see *Sard v. Hardy*, 281 Md. 432, 439, 379 A.2d 1014, 1019-20 (1977); *Congrove v. Holmes*, 37 Ohio Misc. 95, 104 (1973); *Natanson v. Kline*, 186 Kan. 393, 410, 350 P.2d 1093, 1106 (1960).

157. *Wilkinson v. Vesey*, 110 R.I. 606, 624, 295 A.2d 676, 687 (1972). *See also* Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172, 174 (1981): "Today most courts recognize that the patient's right to decide is the *sine qua non* of informed consent."

158. *See Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); *Holland v. Sisters of Saint Joseph of Peace*, 270 Or. 192, 137, 522 P.2d 208, 211 (1974); *Miller v. Kennedy*, 11 Wash. App. 272, 282, 522 P.2d 852, 860 (1974) ("The scope of the duty to disclose information . . . is measured by the patients' need to know.").

159. *See, e.g.*, ALASKA STAT. § 09.55.556 (1983 Supp.); KY. REV. STAT. ANN. § 40:1299.40 (1977); MINN. STAT. ANN. § 144.651 (1987 Supp.) (very detailed statute); OR. REV. STAT. § 677.097 (1981).

cer.¹⁶⁰ The diversity of such statutes demonstrates that, outside the abortion context, states take an active role in making judgments about the minimum amount and kinds of information that patients should be told. By making such judgments, states protect the public health and the integrity of medical care decision-making. Although such statutes do not always conform to the precise informational needs of every individual patient in every possible setting, the state unquestionably has the authority to make judgments, based on a reasonable patient perspective, about what patients generally need to know in order to make a minimally informed decision about medical treatment. Dissenting in *Thornburgh*, Justice White observed: "Legislators are ordinarily entitled to proceed on the basis of rational generalizations about the subject matter of legislation, and the existence of particular cases in which a feature of a statute performs no function [or is even counterproductive] ordinarily does not render the statute unconstitutional or even constitutionally suspect."¹⁶¹

Clearly, under the reasonable patient model, the physician's judgment and discretion are less important than the patient's need to know. This statement is true even in those medical contexts in which the indications for and consequences of certain medical procedures or treatments are strictly medical in nature. The physician's duty to disclose strictly medical information in these situations is still conditioned upon the patient's decisional needs. Common sense suggests that the less medical the patient's decision is, the less the patient will need the physician's expert knowledge. Room for legislative judgments as to the amount and kinds of information necessary for minimally informed consent only increases.

The reasonable patient model, then, suggests an orientation focused more on the patient's rights and a consumer/contract style of medical care delivery.¹⁶² While there exist some narrowly defined

160. See, e.g., CAL. HEALTH & SAFETY CODE § 1704.5; GA. CODE ANN. § 43-34-21(g) (1984); FLA. STAT. § 458.324(2) (1984); N.Y. Public Health Law § 2404 (McKinney 1985); VA. CODE ANN. § 54-325.2-2 (1987 Supp.).

161. *Thornburgh v. American College of Obstetricians & Gynecologists*, 106 S. Ct. 2169, 2199 (1986) (White, J., dissenting).

162. See *Cooper v. Roberts*, 220 Pa. Super. 260, 267, 286 A.2d 647, 650 (1971). It is this reality of the changing nature of the doctor-patient relationship which the Supreme Court in *Roe* seems to ignore. Professor Stone writes: "In [*Roe*], Blackmun had used the phrase 'attending physician' to describe the doctor who would make the abortion decision. This language conjures up an earlier time when patients actually had a personal physician who attended them at bedside both at home and in the hospital, but is certainly an inapt phrase for describing doctors who perform abortion procedures in clinics." Stone, *supra* note 5, at 581. See *infra* notes 247-52 and accompanying text.

exceptions in some reasonable patient jurisdictions, including emergencies, incompetency, or therapeutic reasons,¹⁶³ the basic rule under the reasonable patient model is that "a physician . . . has a . . . duty to disclose all facts, risks, and alternatives that a reasonable person in the patient's situation would deem significant in determining whether to undergo treatment."¹⁶⁴ The state may codify this rule and make substantive judgments about the minimum amount of information patients generally should receive. The less a medical procedure's indications and consequences are purely medical, the greater the need for and legitimacy of such state judgments.

2. *The doctrinal trend*

The second factor to consider in assessing the relative importance of physician discretion in the area of informed consent to medical treatment is the trend of the doctrine. Without question, the trend is away from the reasonable physician model and toward the reasonable patient model.¹⁶⁵ Commentators have documented this trend from the old battery theory to the negligence theory.¹⁶⁶ Within the negligence area, the trend is toward the reasonable patient model. Moreover, most commentators have noted this shift with approval.¹⁶⁷ Jo Anne Morrow writes:

Doctors have not been permitted to act totally without review for a quarter of a century. . . . It seems unreasonable that the person most concerned, the patient, should have only that information the doctor, no matter how well-intentioned, decides she should have. . . . By retaining the authoritative role in the doctor-patient relationship, the doctor denies the patient the right to make decisions that affect her body.¹⁶⁸

This contention closely parallels the emphasis of the district court in *Planned Parenthood of Missouri v. Danforth* that a statutory informed consent requirement "insures that the pregnant woman re-

163. See Meisel, "The Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 WIS. L. REV. 413.

164. Note, *The Abortion Alternative and the Patient's Right to Know*, 1978 WASH. U.L.Q. 167, 184.

165. Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980); Comment, *New Trends in Informed Consent*, 54 NEB. L. REV. 66 (1975).

166. See, e.g., Comment, *supra* note 165, at 67-72.

167. Some commentators would see the trend continue beyond mere information disclosure to actual patient participation in the decisionmaking. See Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172 (1981).

168. Note, *Women's Health Care and Informed Consent: Who Should Decide What is Best for Women—Patients or Doctors?*, 9 GOLDEN GATE U.L. REV. 553, 575 (1978-79).

tains control over the discretions of her consulting physician.'"¹⁶⁹ Among the reasons commentators cite for approving this trend are its emphasis on personal dignity and control over one's own body,¹⁷⁰ the unequal information status of the physician and patient,¹⁷¹ and the "danger that physicians will exploit patients by subjecting them to treatment that is not in their best interests."¹⁷²

In sum, while a number of jurisdictions continue to adhere to the reasonable physician standard, a substantial and growing number have opted for the reasonable patient standard.

3. *Commercial speech*

Finally, consistent with the spirit of the trend toward fuller disclosure based on the materiality of the information to the patient's decision about medical treatment, some recent Supreme Court decisions in the area of commercial speech make clear the Court's preference for fuller disclosure, so long as the information is not false or deceptive. The public's lack of information and the inability or refusal of the professions to police themselves has prompted the Court to adopt an attitude leaning toward fuller disclosure.¹⁷³ Likewise, the Court has held that there is a only minimal interest in *not* providing particular factual information.¹⁷⁴ These concerns are relevant in the medical context, because of the contractual nature of the contemporary physician-patient relationship in general, and are even greater where important considerations and related information are non-medical in nature.

In cases involving commercial speech, a state restriction on the physician might be invalid because of its effect on the patient/consumer of health care. Significantly, however, the Court has corrected the perceived constitutional defect in these cases by requiring that *more*, not less, information be given to the patient/consumer so that he or she will be able to make a better decision. The Court has not required that more deference be given to the physician, nor has the Court contemplated the possibility of further restriction of relevant information. In contrast, the Court's

169. *Danforth*, 428 U.S. at 66 (quoting *Planned Parenthood of Central Mo. v. Danforth* 392 F. Supp. 1362, 1369).

170. Comment, *supra* note 165, at 74; Note, *supra* note 168, at 575-76.

171. Comment, *Informed Consent in Washington: Expanded Scope of Material Facts That the Physician Must Disclose to His Patient*, 55 WASH. L. REV. 655, 657 (1980).

172. Comment, *supra* note 168, at 175.

173. See, e.g., *Virginia Pharmacy Bd. v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976).

174. See, e.g., *Zauderer v. Office of Disciplinary Council*, 471 U.S. 626 (1985).

abortion cases suggest that the Constitution somehow forbids the expansion of information for the patient within this particular context. The Court has never explained or justified this fundamental inconsistency.

Although physician disclosure of information to patients involves a physician's discretion and judgment, the trend of informed consent law and the Supreme Court's commercial speech cases suggest that the medical profession can be legitimately subject to extensive public control. Therefore, a claim of a constitutionally significant "right" to practice medicine by one's unfettered discretion is unfounded.

The Court fails to explain why the Constitution itself apparently mandates the application of an extreme version of the outdated reasonable physician model in the abortion context, while states remain free to choose their preferred approach outside that context. The Court does not even explain how the Constitution is related to this inquiry. Rather, the Court's conclusion is merely stated. Even assuming that the preference for one approach over the other is of constitutional import, many arguments support the application of the reasonable patient model in the abortion context.

D. Summary

Outside the abortion context, physicians do not enjoy a constitutionally protected right to practice medicine by their own unfettered discretion. Even "an undesired and uncomfortable straitjacket in the practice of his profession" as asserted in *Danforth*¹⁷⁵ or "unduly oppressive and unwarranted restrictions . . . upon the conduct of his profession" as asserted in *Johnston*¹⁷⁶ have not been held to be constitutionally forbidden. Rather, the police power of the state has traditionally justified many such controls on the profession.

In addition, the law of informed consent to medical treatment outside the abortion context is shifting from the reasonable physician model, with its heavy emphasis on the physician's discretion, to the reasonable patient model. Under this standard, the materiality of information to the patient's decision, rather than the physician's discretion, is the measure of the physician's disclosure duty. Recent decisions by the Supreme Court on commercial speech likewise support the emphasis on greater knowledge by the patient/consumer and downplay interests in non-disclosure of information by physi-

175. *Danforth*, 428 U.S. at 67 n.8.

176. 134 F.2d at 10.

cians. The state has authority to make judgments, based on the reasonable patient model, about the minimum kinds and amount of information patients must be told for their consent to be informed. The state's role increases when the strictly medical nature of the indications and consequences of medical procedures decreases.

The fact that, in the abortion context, the Supreme Court finds informed consent statutes unconstitutional because of their effect on the discretion of the physician is at odds with traditional jurisprudence. This approach fails to establish why the Constitution requires any particular model and why an increasingly outmoded and inappropriate model is the Constitution's substantive choice. Justice White, dissenting in *Danforth*, stated that traditional rules and methods of constitutional interpretation should not be discarded merely because the case before the Court concerns abortion.¹⁷⁷ However, the Court seems to take just this approach when reviewing informed consent provisions.

The first of the Supreme Court's two "equally decisive" reasons for invalidating informed consent to abortion statutes, their effect on the physician's discretion, is totally unjustified. The second is that such statutes actually interfere with the woman's right of choice between abortion and childbirth. The next step in this analysis will be to examine the abortion right itself, the nature of abortion, and the context in which the abortion right is sought to be exercised. This investigation will provide further insight into the proper method for evaluating the constitutionality of informed consent to abortion statutes. Although the Court bases its abortion decisions on the reasonable physician model, the reasonable patient model is clearly more appropriate. Not only should states be free to select the model on which to base their statutes, but compelling reasons argue in favor of the model they have indeed chosen in the abortion context: the reasonable patient model.

IV. ANALYZING THE COURT'S REASONS: INTERFERENCE WITH THE WOMAN'S RIGHT

A. *The Abortion Right*

Despite the confusion in the Supreme Court's abortion doctrine noted at the outset, a careful analysis of the Court's abortion decisions reveals an underlying framework. The Court's language, if not its holdings, lends itself to some kind of organization. This

177. *Danforth*, 428 U.S. at 98 (White, J., dissenting).

analysis makes clear that the core of the abortion right is a woman's freedom to decide whether to terminate her pregnancy by abortion or continue it to childbirth. The Court's abortion decisions are replete with expressions of the basic notion that *Roe* established freedom of choice between alternative ways of ending a pregnancy: abortion or childbirth.¹⁷⁸ At the very least, therefore, state action that literally proscribes either choice, for example, by making it criminal for a physician to perform abortions, is clearly unconstitutional.¹⁷⁹ This unconstitutionality does not arise because a physician has an affirmative constitutional right to perform abortions; it arises merely because the involvement of a third party, in this case a physician, is necessary for the woman to exercise and effectuate her constitutional right of choice. State regulations directed at the physician should not be invalidated unless they improperly infringe upon or burden *the woman's constitutional right*. The physician has no such right independent of the patient. Because the nature of the abortion right is freedom of decision, the state may not foreclose either option.

The Supreme Court has, at the same time, held that this right is not absolute.¹⁸⁰ Indeed, the abortion right has been limited, at least rhetorically, in a variety of ways. For example, a woman does not have a right to an abortion performed by anyone other than a licensed physician.¹⁸¹ Also, the state may require that the physician

178. See, e.g., *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 427 (1983); *Harris v. McRae*, 448 U.S. 297, 312, 313, 314-15, 316, 317-18 (1980); *Bellotti v. Baird*, 443 U.S. 622, 639 (1979); *Maier v. Roe*, 432 U.S. 464, 473-74 (1977); *Whalen v. Roe*, 429 U.S. 589, 600 n.26 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 80, 95 (1976); *Roe v. Wade*, 410 U.S. 113, 153, 165-66 (1973); *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 563, 564, 565, 580 (E.D. Pa. 1975), *aff'd sub nom.* *Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

179. Courts have repeatedly said that actual state-created obstacles to the woman's choice are unconstitutional. See, e.g., *H.L. v. Matheson*, 450 U.S. 398, 409, 411 (1981); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Whalen v. Roe*, 429 U.S. 589, 603 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 70-71 n.10, 74; *Akron Center for Reproductive Health v. City of Akron*, 479 F. Supp. 1172, 1200 (N.D. Ohio 1979); *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 565, 568 (E.D. Pa. 1975), *aff'd sub nom.* *Franklin v. Fitzpatrick*, 429 U.S. 901 (1976).

180. See, e.g., *Maier v. Roe*, 432 U.S. 464, 472 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 83 (1976); *Connecticut v. Menillo*, 423 U.S. 9, 10 (1975) (per curiam); *Doe v. Bolton*, 410 U.S. 179, 201 (1973); *Roe v. Wade*, 410 U.S. 113, 153 (1973); *Gary-Northwest Indiana Women's Services v. Bowen*, 496 F. Supp. 894, 900 (N.D. Ind. 1980), *aff'd sub nom.* *Gary-Northwest Indiana Women's Services v. Orr*, 451 U.S. 934 (1981); *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 565 (E.D. Pa. 1975), *aff'd sub nom.* *Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

181. See *Connecticut v. Menillo*, 423 U.S. 9, 10 (1975); *Doe v. Bolton*, 410 U.S. 179, 216 (1973) (Douglas, J., concurring).

obtain the written consent of a woman before performing an abortion.¹⁸² The abortion funding cases¹⁸³ make clear that the woman does not enjoy such an abstract "right to an abortion" that the state must pay for them whenever she cannot. To the contrary, the state is under no obligation to pay for abortions, and can legitimately encourage the alternative choice of childbirth, in which the Court has acknowledged the state has a particularly strong interest.¹⁸⁴ Such a policy is permissible even when restriction of public funds "results" in unavailability of abortions services for some women.¹⁸⁵

The abortion option may not be foreclosed nor may the choice of that option be unduly burdened. Nevertheless, abortion is not a positive "good" that the state is obliged to encourage or make more attractive. In *Roe*, inclusion of abortion in the right to privacy was apparently based on its being a way to avoid certain "detriments" that childbirth and childrearing might involve.¹⁸⁶ Chief Justice Burger, in his *Thornburgh* dissent, noted the majority's "astounding rationale" for striking down the informed consent provisions that some of the required information "might have the effect of 'discouraging abortion' . . . as if abortion [was] something to be advocated and encouraged."¹⁸⁷ He countered that the Constitution does not require states to facilitate or encourage abortion but instead permits states to promote the alternative choice by encouraging childbirth.¹⁸⁸ Likewise, Justice White observed:

[P]recisely because *Roe v. Wade* is not premised on the notion that abortion is itself desirable (either as a matter of constitu-

182. *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

183. *Harris v. McRae*, 448 U.S. 297 (1980); *Williams v. Zbaraz*, 448 U.S. 358 (1980); *Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977).

184. *H.L. v. Matheson*, 450 U.S. 398, 412-13 (1981); *Harris v. McRae*, 448 U.S. 297, 324-25 (1980); *Beal v. Doe*, 432 U.S. 438, 445 (1977); *Maher v. Roe*, 432 U.S. 464, 473, 477 (1977); *Poelker v. Doe*, 432 U.S. 519, 521 (1977).

185. See *Maher v. Roe*, 432 U.S. 464, 474 (1977). In *Maher*, Justice Powell acknowledged that "some" women might not be able to have abortions when the funding restrictions under the Hyde Amendment were enforced. The Alan Guttmacher Institute, the research arm of the Planned Parenthood Federation, estimates that approximately 100,000 women were unable to obtain abortions in 1978 because of the funding restrictions under the Hyde Amendment. See Trussell, Mentum, Lendheim & Vaughan, *Impact of Restricting Medicaid Financing for Abortion*, 12 FAM. PLAN. PERSP. 120, 120 (May-June 1980). It should be noted, however, that none of the predictions by abortion proponents of increased maternal morbidity or mortality resulting from the funding restrictions came true. See 129 CONG. REC. S9255, 9286 (daily ed. June 28, 1983); J. BURTCHAELL, RACHEL WEeping AND OTHER ESSAYS ON ABORTION 67 (1982).

186. *Roe*, 410 U.S. at 153.

187. *Thornburgh*, 106 S.Ct. at 2191 n.* (Burger, C.J., dissenting)

188. *Id.*

tional entitlement or of social policy), the decision does not command the States to fund or encourage abortion, or even to approve of it. Rather, we have recognized that the States may legitimately adopt a policy of encouraging normal childbirth rather than abortion so long as the measures through which that policy is implemented do not amount to direct compulsion of the woman's choice regarding abortion."¹⁸⁹

This array of limitations on a woman's right to choose her method of pregnancy termination shows that a state, even if it theoretically could,¹⁹⁰ does not need to remain entirely neutral with respect to the particular choice being made.

Abortion is unlike any other situation implicating the "right to privacy" because of the presence and development of the preborn child,¹⁹¹ in which the state retains at all times at least an "important" interest. As such, the state has a set of interests entirely absent in other contexts. The significance of these state interests in the abortion context means, as the Court explicitly recognized in the funding cases, that the state can seek to further its preference for childbirth through a variety of means.

This situation naturally leads to two observations. First, consistent analysis emphasizing information relevant to the decision rather than the relatively "encouraging" or "discouraging" nature of such information is necessary for the true nature of the right to be maintained and for these important state interests not to be unduly limited by the Court's policy preferences.¹⁹² Second, the Court's recent decision in *Thornburgh* is wholly unjustifiable because it is based on the Court's negative view of Pennsylvania's presumed statutory motive rather than the relevant impact and demonstrative unconstitutionality of its statutory scheme. Chief Justice Burger's defection to the dissenters' ranks is perhaps the

189. *Id.* at 2198 (White, J., dissenting).

190. Even information "as to just what would be done and as to its consequences," *Danforth*, 428 U.S. at 67 n.8, that the Court approved is not neutral. Such information alone could readily tip the decisional balance in either direction, depending on the knowledge, preferences, values, and other characteristics of the woman. One commentator, making the same mistake as the Court, spoke of "neutral information relevant to a woman's decision." George, *supra* note 16, at 35. However, "neutral" information can hardly be relevant. It is precisely because information is material, that is, can influence the decision, that it is relevant and should be considered.

191. *Roe*, 410 U.S. at 159.

192. Justice White stated in his *Thornburgh* dissent that "the unrestrained imposition of [the Court's] own, extraconstitutional value preferences" began in *Roe* with denominating the liberty to choose abortion as fundamental. *Thornburgh*, 106 S.Ct. at 2196 (White, J., dissenting). See *supra* note 21.

most poignant evidence of just how far afield the Court has gone in mandating preferred results without reasoned or consistent analysis.

The Supreme Court has also rejected the argument that the abortion right means an absolute "right to control one's own body." Indeed, the Court has held that this notion has little, if anything, to do with the privacy cases at all.¹⁹³ Because of the presence and development of the preborn child, this argument has even less relevance in the abortion context. A three-judge federal panel has likewise rejected the notion that the abortion right means a constitutional right, in any particular case, to actually kill the fetus.¹⁹⁴

The nature of the abortion right cannot be described merely by reference to other medical procedures or treatment, even though abortion is undeniably a medical procedure. Just as the abortion right is inherently different from other privacy rights because of the presence and development of the preborn child, so abortion is different from other medical procedures because it involves the termination of the life of the preborn child. Although the Court's early decisions seem to suggest otherwise,¹⁹⁵ a state may treat abortion differently from other medical procedures.¹⁹⁶ In *Danforth*, for example, the Court upheld the requirement of written informed consent for abortion even though such consent is not required for any other surgical procedure.¹⁹⁷

The abortion right is further limited by the state's interests in maternal health and fetal life, which become compelling at certain

193. *Roe*, 410 U.S. at 154.

194. *Wynn v. Scott*, 449 F. Supp. 1302, 1321 (N.D. Ill. 1978), *appeal dismissed*, *Carey v. Wynn*, 439 U.S. 8 (1978) (per curiam), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979).

195. The Supreme Court, in *Doe v. Bolton*, 410 U.S. 179 (1973), invalidated a requirement that the decision by a physician that an abortion was necessary be reviewed by a committee and stated: "We are not cited to any other surgical procedure made subject to committee approval as a matter of state criminal law." *Id.* at 197.

196. See, e.g., *H.L. v. Matheson*, 450 U.S. 398, 412-13, 422-23 (1981); *Harris v. McRae*, 448 U.S. 297, 325 (1980); *Bellotti v. Baird*, 443 U.S. 622, 640-41, 643, 649 (1979); *Maher v. Roe*, 432 U.S. 464, 480 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 66-67, 103 (1976); *Bellotti v. Baird*, 428 U.S. 132, 149 (1976); *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 587 (E.D. Pa. 1975), *aff'd sub nom.*, *Franklin v. Fitzpatrick*, 428 U.S. 901 (1976). In contrast to its emphasis in *Doe*, see *supra* note 195, the Court in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), upheld a requirement that a physician obtain written informed consent from the patient before performing an abortion, despite the fact that such a requirement existed for virtually no other surgical procedure. *Id.* at 66. In *Maher v. Roe*, 432 U.S. 464 (1977), the Court said: "The simple answer to the argument that similar requirements are not imposed for other medical procedures is that such procedures do not involve the termination of a potential human life." *Id.* at 480.

197. *Danforth*, 428 U.S. at 66-67.

points during pregnancy and are then sufficient in themselves to justify more extensive regulation.¹⁹⁸ Another significant anomaly in the Court's abortion doctrine is that, while it defines "health" very broadly when that term is used to justify a woman's decision to have an abortion,¹⁹⁹ it utilizes a much more narrow definition of "health" when that term is used to justify state regulation after the first trimester in furthering its interest in maternal health.²⁰⁰ Because such statutes are justified by their relation to the state's interest in the preservation of maternal health, they affect the informed consent situation.²⁰¹ Consistent application of the broader definition would allow the state to protect the varied aspects of "health" implicated when the abortion decision is being made.²⁰² The state could ensure that the information relating to the broader, less medical, aspects of health that go into the decision whether to abort are provided so a better decision for many women will result.

Finally, as the previous section demonstrates, the abortion right is not a physician's right to practice medicine according to his unfettered discretion. Although some dicta exists suggesting the existence of such a right,²⁰³ the Court has specifically held that whatever "right" a physician may be said to possess in the abortion context is entirely derivative from the woman's right to have her decision effectuated.²⁰⁴ The Court's recent creation of an "equally decisive"

198. *Roe*, 410 U.S. at 163, 164-65.

199. Beginning with *United States v. Vuitch*, 402 U.S. 62 (1971), the Court has held that "health" should be understood, not in medical or strictly clinical terms, but in terms of "general usage and modern understanding" to include psychological as well as physical "soundness." *Id.* at 72. In *Doe v. Bolton*, 410 U.S. 179 (1973), the Court expanded on this idea to hold that, in the abortion context, "the medical judgement may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors relate to health." *Id.* at 192.

200. The state's interest in maternal health becomes compelling only when the mortality rate for abortion is no longer less than the mortality rate for normal childbirth. *Roe v. Wade*, 410 U.S. 113, 163 (1973).

201. *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 443 (1983).

202. It should again be noted that this argument for a consistent use of the Court's broad definition of "health" is premised on the assumption of *Roe's* continued existence. See *supra* note 52 and accompanying text. Those pursuing a litigation strategy to accomplish *Roe's* reversal, conversely, seek "to limit the scope of criteria which may justify an abortion on grounds of 'maternal health.'" Rosenblum & Marzen, *Strategies for Reversing Roe v. Wade* in *ABORTION AND THE CONSTITUTION: REVERSING ROE V. WADE THROUGH THE COURTS*, *supra* note 15, at 199.

203. See *supra* notes 35-37 and accompanying text.

204. *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977):

Nothing in [*Doe v. Bolton*] suggests that a doctor's right to administer medical care has any greater strength than his patient's right to receive such care. The constitutional right vindicated in *Doe* was the right of a pregnant woman to decide whether or not to bear a child without unwarranted state interference. The statutory restric-

and separate reason for invalidating informed consent provisions because of their effect on the physician's discretion is, therefore, quite astonishing. As the district court in *Danforth* had emphasized, it is vital that the woman retain control over her physician's discretion;²⁰⁵ coercion by a man in a white coat should be no less suspect than coercion by legislators in a state capitol.

When the Court in its abortion decisions discusses the physician's discretion or medical judgment, it always does so in the context of the woman's right of choice; usually in the same sentence.²⁰⁶ This observation provides more support for the view that there is no independent "right of the physician" but, rather, that any physician's "right" in the abortion context is derivative from and dependent upon the woman's right. It is only because the exercise of that right and its effectuation requires the technical services of a third-party professional that the physician is in the picture in the first place. Regulation of the physician should be held unconstitutional to the extent that it *impermissibly* affects the woman's right of choice. The Court's willingness to invalidate informed consent abortion statutes because of their effect on the discretion of the physician²⁰⁷ remains a fundamental flaw in its abortion doctrine.

The Court has developed an "unduly burdensome" standard which it uses to measure the constitutionality of state abortion regulations, and which can consistently reflect the true nature of the abortion right and also recognize, but not subordinate, the other important interests involved.²⁰⁸ Under this standard, strict judicial

tions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right. . . . If those obstacles had not impacted upon the woman's freedom to make a constitutionally protected decision, if they had merely made the physician's work more laborious or less independent without any impact on the patient, they would not have violated the Constitution.

See *supra* note 45.

205. *Danforth*, 428 U.S. at 66.

206. See, e.g., *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 429-30 (1983); *Bellotti v. Baird*, 443 U.S. 622, 639 (1979); *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975); *Doe v. Bolton*, 410 U.S. 179, 197, 199 (1973); *Roe v. Wade*, 410 U.S. 113, 163 (1973); *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 564, 569 (E.D. Pa. 1975), *aff'd sub nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976).

207. See *supra* notes 45, 102 and accompanying text.

208. See *Harris v. McRae*, 448 U.S. 297, 314 (1980); *Bellotti v. Baird*, 443 U.S. 622, 640 (1979); *Maher v. Roe*, 432 U.S. 464, 473 (1977); *Bellotti v. Baird*, 428 U.S. 132, 147 (1976); *Birth Control Centers v. Reizen*, 508 F. Supp. 1366, 1379-80 (E.D. Mich. 1981), *aff'd*, 743 F.2d 352 (6th Cir. 1984). This standard is not unlike the "unfair prejudice" test of the Federal Rules of Evidence. FED. R. EVID. 403. It allows burdens on the abortion right but finds *undue* burdens unconstitutional. This approach makes sense, since "burden" could easily be construed to mean any "effect" or interface at all. Likewise, Professor Wardle emphasizes

scrutiny is appropriate only when a regulation *unduly* burdens the right of choice and a compelling state interest is necessary to justify such scrutiny. Under this standard, actual foreclosure of the abortion option by statutory prohibition would unduly burden the choice. Strict judicial scrutiny would render such a regulation presumptively invalid unless it was supported by a compelling state interest. Under the *Roe* trimester framework, an interest sufficient to even potentially justify a prohibition on abortion exists only after viability, when the state's interest in fetal life becomes compelling.²⁰⁹ This conclusion holds whether the performance of an abortion is criminalized²¹⁰ or a unilateral veto power over the woman's decision is given to a third party.²¹¹ In either case, the state is literally acting to foreclose the abortion option without regard to other circumstances.

In her dissent in *Akron*, Justice O'Connor urged consistent application of the "unduly burdensome" test as a way of preserving the true nature of the fundamental right while not imposing the Court's particular value choices on state legislatures and frustrating important state interests.²¹² In his *Thornburgh* dissent, Justice White also argued that nothing in the dispute triggered strict judicial scrutiny because the informed consent provision "does not directly infringe the allegedly fundamental right at issue—the woman's right to choose an abortion."²¹³ The district court in *Fitzpatrick* applied the rational relationship test rather than strict judicial scrutiny because the informed consent provision at issue did not "chill the exercise of the abortion option."²¹⁴ The Supreme Court has applied this test in abortion cases involving issues other than informed consent.²¹⁵ Lower federal courts have applied it.²¹⁶ State

that the test is whether an informed consent requirement is detrimentally burdensome, not whether it merely effects the choice. L. WARDLE, *supra* note 5, at 103.

209. *Roe*, 410 U.S. at 163-64.

210. The statute invalidated in *Roe* made it a crime to perform all abortions except those that were to save the life of the mother. *Id.* at 118 n.1. Similar statutes had been enacted in a majority of states. *Id.*

211. *See, e.g.*, *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 439, 442 (1983) (parental consent); *Bellotti v. Baird*, 443 U.S. 622 (1976) (spousal and parental consent).

212. *Akron*, 462 U.S. at 453 (O'Connor, J., dissenting).

213. *Thornburgh*, 106 S.Ct. at 2199-200 (White, J., dissenting).

214. *Fitzpatrick*, 401 F.Supp. at 587 (Adams, J., concurring and dissenting).

215. *See, e.g.*, *Harris v. McRae*, 448 U.S. 297, 314-15 (1980); *Bellotti v. Baird*, 443 U.S. 622, 640 (1979); *Maher v. Roe*, 432 U.S. 464, 473-74 (1977); *Bellotti v. Baird*, 428 U.S. 132, 147 (1976).

216. *See, e.g.*, *Akron Center for Reproductive Health v. Akron*, 651 F.2d 1198, 1215 (6th

courts have applied it. In *Village of Oak Lawn v. Marcowitz*,²¹⁷ for example, the Supreme Court of Illinois stated: "The fundamental right here involved, of course, is a woman's privacy right to decide . . . whether to obtain an abortion. As to those abortion regulations which do not unduly burden that fundamental right, the Supreme Court has applied only a rational-basis test."²¹⁸ Commentators have also identified this scheme as a central part of the Court's abortion doctrine. Professor Mark Tushnet describes what he calls "a unified approach" this way: "[The Court] has prohibited regulations that unduly burden the decision to have or to refrain from having an abortion. The 'unduly burden' approach has been applied in three groups of cases."²¹⁹ Discussing the constitutionality of informed consent provisions in 1980, another writer emphasized that the burden on the abortion right must be "undue" to trigger strict scrutiny and that a compelling state interest is then required.²²⁰

Regulations that do not foreclose options but only indirectly affect the making of the choice in some way should be treated differently. The Court, in the funding cases,²²¹ has recognized this difference between the state affirmatively setting up a barrier and acting in other ways that only affect the decision itself indirectly. A relative burden is different from a total denial;²²² limited access is different from prohibited access.²²³

A statute is not unconstitutional if it merely deals with the subject of abortion.²²⁴ It is not unconstitutional if it merely affects the abortion decision. It is not unconstitutional if it can be said merely to "burden" that decision. Consistent use of the "unduly burdensome" standard would mean that those regulations that do not amount to *undue* burdens should be evaluated according to the so-called "rational relationship" test: as long as there is a problem in need of correction perceived by the legislature and the means chosen bears a rational relationship to that end, the statute is constitu-

Cir. 1981) (Kennedy, J., dissenting); *Birth Control Centers v. Reizen*, 508 F. Supp. 1366, 1379-80 (E.D. Mich. 1981), *aff'd*, 743 F.2d 352 (6th Cir. 1984).

217. 86 Ill. 2d 406, 427 N.E.2d 36 (1981).

218. *Id.* at 416-17, 427 N.E.2d at 40.

219. Tushnet, *supra* note 15, at 162.

220. Comment, *The Maine Abortion Statutes of 1979: Testing the Constitutional Limits*, 32 ME. L. REV. 315, 323 (1980).

221. *See supra* note 183.

222. *Bellotti v. Baird*, 428 U.S. 132, 151 (1976).

223. *Whalen v. Roe*, 429 U.S. 589, 603 (1977). *See also Akron Center for Reproductive Health v. City of Akron*, 479 F. Supp. 1172, 1200 (N.D. Ohio 1979).

224. *See supra* 177 note and accompanying text.

tional under the due process clause.²²⁵

Looking only at whether a statute "burdens" or "affects" the woman's freedom of choice, and not at the nature of the burden or the significance of the effect, and automatically applying de facto strict scrutiny, as the Court has begun to do in *Akron* and *Thornburgh* with respect to informed consent provisions, is inappropriate. It makes the imagination and policy preferences of the Court the measure of constitutionality at the expense of important state interests, consistently applicable analysis, and proper deference to legislative judgments.

The proper analysis requires focusing on the nature of the right and to whom it belongs. Achieving the proper outcome of that analysis with respect to informed consent statutes requires further attention to the nature of abortion and the reality of the context within which the abortion right is sought to be exercised.

B. *The Nature of Abortion*

Abortion is, of course, a medical procedure in that it is a procedure performed by physicians.²²⁶ It is the most commonly performed surgical procedure in the United States today²²⁷ but it is not medically indicated in at least ninety-eight percent of cases.²²⁸ That

225. *Williamson v. Lee Optical Co.*, 348 U.S. 483, 488 (1955).

226. See *Colautti v. Franklin*, 439 U.S. 379, 387 (1979); *Doe v. Bolton*, 410 U.S. 179, 192, 197, 199, 215, 220 (1973); *Roe v. Wade*, 410 U.S. 113, 148, 163, 166 (1973).

227. See generally STATISTICAL ABSTRACT OF THE UNITED STATES: 1987, at 98 (107th ed. 1987); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 33 (1985); T. MADDEN, I. TURNER & E. ECKENFELS, THE HEALTH ALMANAC 153 (1982). See also F. JAFFE, B. LINDHEIM & P. LEE, ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY 7 (1981) (By 1978, "[t]ermination of pregnancy had become the most frequently performed operation on adults in the United States."); L. WARDLE & M. WOOD, A LAWYER LOOKS AT ABORTION 8 (1982) ("Abortion is now the most frequently performed operation in the United States.")

228. This fact is accepted by both abortion proponents and opponents. In testimony before the U.S. Senate Subcommittee on the Constitution in October 1981, abortion advocate Dr. Irving M. Cushner of the U.C.L.A. School of Public Health and director of the women's health division of the School of Medicine's Department of Obstetrics and Gynecology, stated that "something on the order of 2 percent of all the abortions in this country are done for some clinically identifiable entity—physical health problem, amniocentesis, and identified genetic disease or something of that kind. The overwhelming majority of abortions in this country are performed on women who for various reasons do not wish to be pregnant at this time. . . . Their reasons are a mixture of social, economic, educational, or whatever." In response to the question of how often abortions are performed to save the life of the mother or to ensure her physical health, Dr. Cushner replied: "In this country, it is about 1 percent." *Hearings, supra* note 11, at 158.

Likewise, abortion opponent Dr. Bernard N. Nathanson, a practicing obstetrician/gynecologist and clinical professor at the Cornell University College of Medicine, testified that "there are only a few medical reasons for abortion. . . . I do not think there are

is, the procedure is not required for either physical²²⁹ or psychological health reasons.²³⁰ Rather, it more properly compares to elective surgery.²³¹ It was in this context that the shift in the informed consent doctrine from the reasonable physician model to the reasonable patient model first began.²³² Of course, abortion may be deemed significant or necessary for other, non-medical reasons. However, abortion, from the clinical or medical perspective, is not medically indicated. Therefore, the physician's special training and judgment

really any abortions designed for the mother's health." *Id.* at 172-73. Dr. Nathanson has personally performed more than 5,000 abortions, supervised the performance of at least 10,000 more, and was responsible for 60,000 more as director of the world's busiest abortion clinic in New York City in the early 1970s. *Id.* at 169. The Supreme Court has called Dr. Nathanson "a widely experienced abortion practitioner." *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 489 (1983).

See also *Hearings*, *supra* note 11, at 194 (statement of Dr. Thomas W. Hilgers, professor of obstetrics and gynecology at the Creighton University School of Medicine): "[T]he overwhelming number of abortions are not being performed for any medical reasons."; *id.* at 267 (statement of the late Dr. Jasper F. Williams, Sr., chairman of the department of obstetrics and gynecology at Chicago's Bernard Hospital and a practicing obstetrician/gynecologist): "[T]he number of medical cases in which abortion is an indicated and appropriate part of the treatment is practically nil"; Mecklenburg, *The Indications for Induced Abortion: A Physician's Perspective*, in *ABORTION AND SOCIAL JUSTICE* 39 (T. Hilgers & D. Horan eds. reprint 1980) ("[T]here are very rare and very individual circumstances which may require therapeutic abortion in order to save the life of the mother.").

James Burtchael surveyed the research and expert opinion on this subject and concluded that abortion is medically indicated in 1% of cases, or less. He writes: "Abortion, legal or criminal, serves no one's health, and is no medical matter—unless those words are stretched beyond their ordinary meanings. In perhaps 99% of present cases it is medical only in virtue of being performed by a physician." J. BURTCHAEEL, *supra* note 185, at 68.

229. See J. BURTCHAEEL, *supra* note 185, at 68-72; Mecklenburg, *supra* note 228, at 39-41.

230. This fact has been known for some two decades, and medical opinion has not changed. In 1963, Dr. Myre Sim noted that in 15 years' experience in Britain "there were no clear psychiatric indications for termination of pregnancy." Sim, *Abortion and the Psychiatrist*, *BRIT. MED. J.* 145 (20 July 1963). Irving C. Bernstein, a professor of both psychiatry and obstetrics/gynecology at the University of Minnesota, stated: "From the psychiatric point of view of the psychiatrist, there are no indications for recommending therapeutic abortions." *Abortion—Part 2: Hearings Before the Subcomm. on Constitutional Amendments of the Comm. on the Judiciary*, 93d Cong., 2d Sess. 335, 336 (1974). Dr. Sim has written more recently that "the 'mental' argument has no basis as an indication for abortion." Sim & Neisser, *Post-Abortive Psychosis: A Report From Two Centers*, in *THE PSYCHOLOGICAL ASPECTS OF THE ABORTION* 11 (D. Mall ed. 1979).

Dr. Bernard N. Nathanson, as founder of the National Abortion Rights Action League, was a leading advocate of using loopholes in liberalized state abortion laws to get abortions performed on what were claimed as "psychiatric" grounds. He now admits this practice was completely fraudulent. B. NATHANSON, *ABORTING AMERICA* 191, 240-41 (1979).

231. Dr. Nathanson has testified that abortion "can be likened best to cosmetic surgery where a woman will visit the plastic surgeon and tell him what she wishes to have done." *Hearings*, *supra* note 11, at 172.

232. See, e.g., *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd sub nom. Wilson v. Scott*, 412 S.W. 2d 299 (Tex. 1967).

are obviously less important within the abortion context than with most other medical procedures. For these reasons, the reasonable patient model is particularly appropriate.

The reasonable patient model suggests what courts have recognized in the past: the abortion decision is made on the basis of a whole host of factors that have essentially nothing to do with medicine. Justice Blackmun's majority opinion in *Roe* recognized this and listed some of the relevant factors,²³³ while Justice Douglas' concurring opinion in *Doe* listed others.²³⁴ Most of these factors are non-medical in nature. The Court has, therefore, adopted a definition of "health" as meaning "relating to well-being" in the broadest possible sense.²³⁵ This should not be taken, however, to mean, as the Court apparently has, that the physician's particular medical judgment and discretion is any more relevant or central. As one commentator has stated, the Court in *Roe* "justified the expansion of the right [of privacy] on the basis of the significant impact on the lifestyle of the woman if she were denied the choice to have an abortion."²³⁶

The Court's dichotomous definition of "health" lies at the heart of its inappropriate review of informed consent statutes. The Court defines "health," as it relates to a woman's decision whether to have an abortion, so broadly as to mean general well-being or lifestyle preference, thus including a broad array of non-medical considerations. However, the Court defines the same term, as it relates the state's interest in maternal health underlying certain regulations, very narrowly. This latter definition is limited to physical health and risk of death, thus encompassing only a small range of strictly medical factors. In *Roe*, the Court placed the point at which the state's interest in maternal health becomes compelling at the end of the first trimester "because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion *may be* less than mortality in normal childbirth."²³⁷ On its face, a "fact" that something "may be" true hardly seems sufficient as a basis for a constitutional rule. In the abortion context, this denies the state virtually any opportunity to safeguard maternal health (broadly or narrowly defined) during the period when more than ninety percent

233. *Roe*, 410 U.S. at 153.

234. *Doe*, 410 U.S. at 214-15 (Douglas, J., dissenting).

235. See *supra* note 199 and accompanying text.

236. Comment, *The Right to Choose An Unproven Method of Treatment*, 13 LOY. L. A. L. REV. 227, 230 (1979).

237. *Roe*, 410 U.S. at 163 (emphasis added).

of abortions are performed—the first trimester. Maternal mortality from abortion continues nonetheless,²³⁸ as does the real debate over which method of pregnancy termination, abortion or childbirth, is actually safer for most women.²³⁹ That abortion is safer for women in the first trimester can hardly be said to be the established medical fact the Court thought it was in 1973. More importantly, the Court's radical definitional dichotomy is nowhere justified in any of its abortion decisions. The Court's emphasis on the state's interest in maternal health as the basis for informed consent requirement, coupled with its failure to appropriately apply the "unduly burdensome" test, will severely limit the state's ability to ensure the integrity of the abortion decision-making process.

Medical complications in the physical,²⁴⁰ emotional/

238. See Kaunitz, *Causes of Maternal Mortality in the United States*, 65 OBSTET. & GYNECOL. 605 (1985).

239. Some researchers claim that abortion is safer than childbirth. See, e.g., LeBolt, *Mortality from Abortion and Childbirth*, 248 J.A.M.A. 188 (1982). As a rejoinder to this article, see Laska, *Mortality From Abortion and Childbirth*, 250 J.A.M.A. 361 (1983).

Several factors must be noted to put this issue in better perspective. First, evidence exists that abortion mortality is underreported. Eleven deaths from abortion were reported to the abortion surveillance unit of the Centers for Disease Control in 1978. *Hearings, supra* note 11, vol. 2, at 602. An investigation of just four Chicago abortion clinics in 1978, however, turned up 12 abortion deaths that had never been reported. Zekman & Warrick, *12 Die After Abortions in State's Walk-in Clinics*, Chicago Sun-Times, Nov. 19, 1978. Political scientist Hadley Arkes comments: "If, as we suspect, the experience in Chicago can find modest duplication in New York, Detroit, Los Angeles and other cities, the total deaths due to legal abortion may now exceed the number of deaths that were thought to occur each year as a result of illegal abortions." H. ARKES, *THE PHILOSOPHER IN THE CITY: THE MORAL DIMENSIONS OF URBAN POLITICS* 437 (1981). See also *Senate Comm. on the Judiciary, Human Life Federalism Amendment, S. No. 465*, 97th Cong., 2d Sess. 39-40 (1982).

Second, the formulas used to compare maternal mortality from childbirth and from abortion may be biased to show more favorable results for abortion. See 129 CONG. REC. S9270-71 (daily ed. June 28, 1983) (affidavit of Dr. Richard G. Moutvic M.D., Professor, Loyola University, Stritch School of Medicine). See also Hilgers & O'Hare, *Abortion Related Maternal Mortality: An In-Depth Analysis* in NEW PERSPECTIVES ON HUMAN ABORTION 90 (T. Hilgers, D. Horan & D. Mall eds. 1981): "In comparing the relative risk of natural pregnancy versus that of legal abortion, *natural pregnancy was found to be safer in both the first and second 20 weeks of pregnancy*. The data used in this comparison are thought to be more accurate than previously compiled comparisons done in the traditional fashion." Cf. Cates, Smith, Rochat, & Grimes, *Mortality from Abortion and Childbirth: Are the Statistics Biased?* 248 J.A.M.A. 192 (1982).

240. See A. SALTENBERGER, *EVERY WOMAN HAS A RIGHT TO KNOW THE DANGERS OF LEGAL ABORTION* 27-133 (3d ed. 2d printing 1983); Barrett & Guidotti, *Induced Abortion: A Risk Factor for Placenta Previa*, 141 AM. J. OBSTET. GYNECOL. 257 (1981); Beller, Douglas, Kulker & Rosenberg, *Consumptive Coagulopathy Associated with Intra-Amniotic Infusion of Hypertonic Salt*, 112 AM. J. OBSTET. GYNECOL. 534 (1972); Beric, Kupresanin & Kapor-Stanulovic, *Accidents and Sequelae of Medical Abortions*, 116 AM. J. OBSTET. GYNECOL. 813 (1973); Bulfin, *Complications of Legal Abortion: A Perspective From Private Practice*, in NEW PERSPECTIVES ON HUMAN ABORTION 145 (T. Hilgers, D. Horan & D.

psychological,²⁴¹ and reproductive capability²⁴² categories do occur

Mall eds. 1981); Bulfin, *A New Problem in Adolescent Gynecology*, 72 S. MED. J. 967 (1979); Burkman, Atlenza & King, *Culture and Treatment Results in Endometriosis Following Elective Abortion*, 128 AM. J. OBSTET. GYNECOL. 556 (1977); Ferrari & Shollenberger, *Abdominal Wall Endometriosis Following Hypertonic Saline Abortion*, 238 J.A.M.A. 56 (1977); Hilgers, *The Medical Hazards of Legally Induced Abortion*, in ABORTION AND SOCIAL JUSTICE 57-85 (D. Horan ed. reprint 1980); Iffy, *Letters: Second-Trimester Abortions*, 249 J.A.M.A. 588 (1983); Kimball, Hallum & Cates, *Deaths Caused by Pulmonary Thromboembolism After Legally Induced Abortion*, 132 AM. J. OBSTET. GYNECOL. 169 (1978); Lowensohn & Hibbard, *Laceration of the Ascending Branch of the Uterine Artery: A Complication of Therapeutic Abortion*, 118 AM. J. OBSTET. GYNECOL. 36 (1974); Nemeec, Prendergast & Trumbauer, *Medical Abortion Complications: An Epidemiologic Study at a Mid-Missouri Clinic*, 51 OBSTET. GYNECOL. 433 (1978); Panayotou, Kaskarels, Mettinen, Trichopoulos & Kalandidi, *Induced Abortion and Ectopic Pregnancy*, 114 AM. J. OBSTET. GYNECOL. 507 (1972); Rubin, Cates, Gold, Rochat & Tyler, *Fatal Ectopic Pregnancy After Attempted Legally Induced Abortion*, 244 J.A.M.A. 1705 (1980); White, Coe, Dworsley & Margolis, *Disseminated Intravascular Coagulation Following Midtrimester Abortions*, 58 ANESTHESIOLOGY 99 (1983); cf. Cates, *Legal Abortion: The Public Health Record*, 215 SCIENCE 1586 (1982); Grimes, Schultz, Cates & Tyler, *Mid-Trimester Abortion By Dilatation and Evacuation: A Safe and Practical Alternative*, 296 NEW ENG. J. MED. 1141 (1977); Wulff, *Elective Abortion: Complications Seen in a Free-Standing Clinic*, 49 OBSTET. GYNECOL. 351 (1977).

241. See A. SALTENBERGER, *supra* note 240, at 135-55; S. KRASON, ABORTION: POLITICS, MORALITY, AND THE CONSTITUTION 327-29 (1984); Sim, *Abortion and the Psychiatrist*, 20 BRIT. MED. J. 145 (July-Dec. 1963); Sim, *Abortion and Psychiatry*, in NEW PERSPECTIVES ON HUMAN ABORTION 151, 155-58 (T. Hilgers, D. Horan & D. Mall eds. 1981); Spaulding & Cavenar, *Psychoses Following Therapeutic Abortion*, 135 AM. J. PSYCHIATRY 3 (1978); Tishler, *Adolescent Suicide Attempts Following Elective Abortion: A Special Case of Anniversary Reaction*, 68 PEDIATRICS 670 (1981); cf. Ewing & Ravse, *Therapeutic Abortion and a Prior Psychiatric History*, 130 AM. J. PSYCHIATRY 37 (1973); Ford, Castenuovo-Tedesco & Lorg, *Abortion: Is It a Therapeutic Procedure in Psychiatry?*, 218 J.A.M.A. 1173 (1971); Greenglass, *Therapeutic Abortion and Psychiatric Disturbance in Canadian Women*, 21 CANADIAN PSYCHIATRIC A.J. 453 (1976).

242. See 129 CONG. REC. S9270-72 (daily ed. June 28, 1983) (affidavit of Dr. Richard Moutvic); Daling & Emanuel, *Induced Abortion and Subsequent Outcome of Pregnancy in a Series of American Women*, 297 NEW ENG. J. MED. 1241 (1977); Funderburk, Guttrie & Meldrum, *Suboptimal Pregnancy Outcome Among Women with Prior Abortions and Premature Births*, 126 AM. J. OBSTET. GYNECOL. 55 (1976); Harlap & Davies, *Late Sequelae of Induced Abortion: Complications and Outcome of Pregnancy and Labor*, 102 AM. J. EPIDEM. 217 (1975); Harlap, *A Prospective Study of Spontaneous Fetal Losses After Induced Abortions*, 301 N. ENG. J. MED. 677 (1979); Kline, Stein, Susuey & Warburton, *Induced Abortion and Spontaneous Abortion: No Connection?*, 107 AM. J. EPIDEM. 290 (1978); Kline, *Induced Abortion and Subsequent Outcome of Pregnancy in a Series of American Women*, 297 NEW ENG. J. MED. 1241 (1977); *Latent Morbidity After Abortion*, BRIT. MED. J. 506 (3 March 1973); Lembrych, *Fertility Problems Following an Aborted First Pregnancy*, in NEW PERSPECTIVES ON HUMAN ABORTION, 128, 128-34 (T. Hilgers, D. Horan & D. Mall eds. 1981); Levin, Schoenbaum, Marisun, Stubblefeld & Ryan, *Association of Induced Abortion with Subsequent Pregnancy Loss*, 243 J.A.M.A. 2495 (1980); Madore, *A Study on the Effects of Induced Abortion on Subsequent Pregnancy Outcome*, 139 AM. J. OBSTET. GYNECOL. 516 (1981); Pantelakis, Papadimitraus & Dexiadis, *Influence of Induced and Spontaneous Abortions on the Outcome of Subsequent Pregnancies*, 116 AM. J. OBSTET. GYNECOL. 799 (1973); Quick, *Liberalized Abortion in Orgeon: Effects on Fertility, Prematurity, Fetal Death, and Infant Death*, 68 AM. J. PUBLIC HEALTH 1003 (1978); Richardson & Dixon, *Effects of Legal Termination on Subsequent Pregnancy*, 29 BRIT. MED. J. 1303 (May 1976); Schoenbaum,

with some frequency, justifying a requirement that physicians inform their patients about the medical complications and risks of abortion. The common law imposes just such a requirement, even with respect to abortion. In *Reynier v. Delta Women's Clinic, Inc.*,²⁴³ for example, Mrs. Reynier sued an abortionist and an abortion clinic after having to undergo a hysterectomy following abortion complications. She alleged that the physician should have informed her that uterine perforation was a possible risk of suction abortion.²⁴⁴ The court described several elements which the plaintiff would have to prove for the doctrine of informed consent to apply, including the principle that the physician must describe "all risks which reasonably tend to affect the patient's decision."²⁴⁵ The court concluded that uterine perforation was a normal risk of abortion and, hence, should have been revealed.²⁴⁶ The astonishing result of the Supreme Court's decision in *Thornburgh* is that the common law can require, based on the reasonable patient model, that risks of abortion procedures be revealed, but that states are constitutionally forbidden from codifying the same requirement in a statute.

Abortion is not medically indicated but, rather, is prompted by non-medical factors. As Justice Stevens has observed, "the most significant consequences of the decision are not medical in character."²⁴⁷ Consequences of abortion indeed range far beyond the medical and, therefore, support the reasonable patient model of informed consent. Because indications for and consequences of abortion are largely non-medical, information relating to these considerations will likely be largely non-medical in nature. However, the non-medical nature of the information does not make it less important or less relevant. But if, as the Court held in the rather circular *Thornburgh* opinion, requiring that factual non-medical information is unconstitutional because it is beyond the physician's expertise, then information centrally relevant to the abortion decision will likely never reach the women who supposedly

Outcome of the Delivery Following an Induced or Spontaneous Abortion, 136 AM. J. OBSTET. GYNECOL. 19 (1980); Trichopoulos, Handanus, Danezis, Kalandidi & Kalaputhlzi, *Induced Abortion and Secondary Infertility*, BRIT. J. OBSTET. GYNAECOL.; Wynn & Wynn, *Some Consequences of Induced Abortion to Children Born Subsequently*, 4 MARRIAGE & FAMILY NEWSLETTER (Feb.-April 1973).

243. 359 So. 2d 733 (La. App. 1978).

244. *Id.* at 737.

245. *Id.* at 737-38.

246. *Id.* at 737.

247. *Planned Parenthood v. Danforth*, 428 U.S. 52, 103 (1976) (Stevens, J., dissenting).

have the right of choice in the first place. It is the reasonable patient model, with its touchstone of materiality, that allows for or can require the disclosure of relevant though non-medical information by the physician.

This discussion leads to two conclusions. First, the Court's insistence on the reasonable physician model is misplaced since so much of what goes into and results from the abortion decision is non-medical in nature. Second, the Court's hostility to state measures designed to ensure informed consent is inappropriate. This conclusion is true for several reasons. First, it prevents relevant non-medical information from entering into each woman's consideration. Second, it prevents medical information about factors relevant to the decision but not directly related to the woman's own health from being considered. Finally, it looks at the physician's discretion rather than the woman's decision. As Justice Stevens has stated:

even doctors are not omniscient; specialists in performing abortions may incorrectly conclude that the immediate advantages of the procedure outweigh the disadvantages. . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales. The overriding consideration is that the right to make the choice be exercised as wisely as possible."²⁴⁸

The nature of abortion, its indications, and consequences support the reasonable patient model of informed consent. The many non-medical factors involved and the nature of the right as one of personal choice also argue for this model. The Court's "unduly burdensome" standard is also fully consistent with this model, because it keeps the focus on the woman and her right of choice, and avoids making physicians' preferences or comfort the touchstone of constitutionality. The reality of the context in which the abortion right is exercised makes this all the more important.

C. *The Abortion Context*

The final piece to the puzzle is an assessment of the reality of the context in which the abortion right is sought to be exercised. The Supreme Court has placed obvious emphasis on real-life situations when creating the abortion right in the first place. Its broad definition of "health" testifies to this. This examination of the real context in which the abortion right is sought to be exercised is, then, particularly appropriate. It supports the developing conclusion that

248. *Id.* at 104.

the Court's assumption of thorough physician involvement in the abortion decision is illusory. Rather, the reality of this context supports the reasonable patient model of informed consent because the physician is rarely, if ever, involved in the decision-making. As the court in *Fitzpatrick* observed, informed consent requirements are suggested "by the realities of the system that provides abortions."²⁴⁹ Especially in free-standing abortion clinics, which perform a large majority of abortions, the physician is a technician only. Those settings are not places in which to decide whether or not to get an abortion; they are settings in which to have the actual abortion performed. No one goes to the grocery store to decide whether or not to buy groceries. People go to grocery stores to buy groceries after having made their decision to do so. Likewise, abortionists sell abortions. The Supreme Court's hostility to state measures protecting some minimal level of decision-making integrity is based on a skewed vision of reality.

The Court's abortion decisions repeatedly reflect a view that the physician either is or ought to be involved in both the making and the effectuating of the abortion decision.²⁵⁰ Reality is much different. The physician actually participates in the making of the abortion decision in perhaps only one percent of the cases.²⁵¹ Despite its professed preference for physician involvement in the 1983 *Akron* decision, the Court actually began to hold that no physician need be involved in the decision-making at all. Because other personnel can do this, the physician need only ensure that some disclosure is made.²⁵²

249. *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 587 (1975).

250. *See, e.g., Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 427 (1983); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 61 (1976); *Roe v. Wade*, 410 U.S. 113, 164 (1973). *See also* Stone, *supra* note 5, at 580: "The language of the [*Roe*] decision throughout misleadingly suggests that some crucial sort of medical judgement is involved not only in how the abortion is performed but whether the pregnancy 'should be terminated.'" *Id.*

251. 129 CONG. REC. S9124 (daily ed. June 27, 1983). *See also Hearings, supra* note 11, at 172 (Testimony of Dr. Bernard N. Nathanson: "The doctor is nothing more than an instrument of her will . . . There is no physician input into the decision making process in permissive abortion. . . . The physician is not involved in decision making here."); Nathanson, *Deeper Into Abortion*, 291 NEW ENG. J. MED. 1189, 1189 (1974) ("The phrase between a woman and her physician' is an empty one since the physician is only the instrument of her decision."); Stone, *supra* note 5, at 581 ("The physician is more appropriately characterized as a technician in an assembly line than an attending physician."); Zekman & Warrick, *The Abortion Lottery*, Chicago Sun-Times, Nov. 14, 1978, at 1, col. 1 ("When a woman goes to an abortion clinic, she entrusts her body to strangers—doctors she knows nothing about, doctors she has never met.").

252. *Akron*, 462 U.S. 416, 448-49 (1983).

The reality, again, is different. The problem is not so much *who* gives out information; the problem is that no one gives it out at all or, if someone does, inadequate information is given. Women receive little counseling or information when making the abortion decision, particularly in the many free-standing clinics which exist for the sole purpose of performing abortions for profit. This assertion should not surprise many people and some courts have actually recognized this fact. On the basis of stipulated facts, one court noted:

Women who undergo abortions are not always told of the alternatives to abortion or of the full nature and effect of the procedure they will undergo. . . . In fact, some of the women who undergo abortions would not have had an abortion if they were provided with all the information to be provided by the [statute being challenged].²⁵³

Dissenting from the invalidation of a rather detailed informed consent statute, a federal appellate judge wrote:

The evidence presented at trial showed that the decision to terminate a pregnancy was made not by the woman in conjunction with her physician, but by the woman and lay employees of the abortion clinic, the income of which is dependent upon the woman's choosing to have an abortion. The testimony disclosed that the doctors at [the] clinic did little, if any, counseling before seeing the patient in the procedure room.²⁵⁴

Similar situations have been cited in the popular media and well-documented by researchers.²⁵⁵

Under these conditions, disclosure of information making abortion a more attractive option is much more likely than disclosure of information making it less attractive. Again, this assertion should surprise no one. An abortion clinic sells abortions. Information downplaying the attractiveness of this product and suggesting that other options are more readily available than a woman might have thought are hardly likely to be presented absent some incentive. Informed consent statutes can play this role.

The picture that emerges is of a procedure performed by medical personnel, for their own profit, which is not medically indicated but is instead the product of many non-medical factors and about

253. American College of Obstetricians & Gynecologists v. Thornburgh, 552 F. Supp. 791, 799 (E.D. Pa. 1982).

254. Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198, 1217 (6th Cir. 1981) (Kennedy, J., concurring in part and dissenting in part).

255. In 1978, Pamela Zekman and Pamela Warrick conducted a five-month investigation of four abortion clinics in Chicago, sponsored by the Chicago Sun-Times and the Better Government Association. The results became a Pulitzer Prize-winning series, *The Abortion Profiteers*, appearing in the Sun-Times during November 1978.

which little information (especially information which would enhance other options, make abortion less attractive, or is largely non-medical) is voluntarily made available. This picture is fully consistent with, and even demands application of, the reasonable patient model of informed consent.²⁵⁶ This model increases, rather than decreases, the state's interest in ensuring the integrity of the abortion decision by having certain information considered when that decision is made.²⁵⁷ It decreases, rather than increases, the physician's involvement and the deference to be given his judgment. Finally, this model supports using the same broad definition of "health" to justify informed consent provisions as is used to describe a woman's reasons for choosing abortion. The former should respond to the latter.

V. A NEW FRAMEWORK

It is apparent that the Supreme Court's approach to informed consent statutes in the abortion context is inappropriate. By using the effect of informed consent requirements on the physician's discretion as the touchstone of constitutionality, this approach ignores traditional jurisprudence on public control of the medical profession as well as the role of the state and trend in the law of informed consent generally. By failing to apply the unduly burdensome test with proper reference to the true nature of the abortion right, the nature of abortion, and the reality of the abortion context, the Court improperly invalidates many legitimate informed consent provisions. Furthermore, this approach unnecessarily prevents states from protecting the integrity of the abortion decision-making process and from properly asserting important state interests in maternal health and preborn life.

A framework which takes these factors into account would include four basic elements. The first is a focus on the woman, rather than a focus on the physician. Physicians enjoy no independent

256. See *supra* notes 155-172 and accompanying text. Professor Stone writes that "to the extent [*Roe* and *Doe*] involved factual inferences about medical standards and medical practice—inferences which suggested a context for the decision, inferences which suggested more limited consequences of the decision, inferences which suggested the realities of medical practice—to that extent, the decision was quite misleading." Stone, *supra* note 5, at 581. He calls *Roe* and *Doe* "flawed decisions" and emphasizes that "[i]t was Blackmun and Burger who were out of touch with reality if they honestly believed what they wrote." *Id.* His references above to the context, consequences, and realities of the abortion decision closely resemble the approach taken in this article.

257. See *H.L. v. Matheson*, 450 U.S. 398, 421-23 (1981) (Stevens, J., concurring); *Planned Parenthood v. Danforth*, 428 U.S. 52, 103 (1976).

constitutional right to practice medicine free from state interference. Rather, the abortion right belongs solely to the woman and any physician "right" is solely derivative therefrom. The woman's right is one of choice, and informed consent provisions should be evaluated strictly with reference to their impact on *that* interest.²⁵⁸ In light of the fact that abortion is most often not medically indicated, the Court should emphasize criteria such as the autonomy of the woman, the integrity of her decision, and the materiality of information as relevant criteria.

Second, the test for evaluating an informed consent provision should be whether it unduly burdens the abortion right just described. The Court should maintain a distinction between absolute and relative burdens²⁵⁹ so that the physician's discretion does not again become the touchstone of constitutionality. Only when a regulation unduly burdens the abortion right should it be subjected to strict judicial scrutiny.²⁶⁰

Third, the determination of whether an informed consent statute unduly burdens the abortion right should be made on the basis of the reasonable patient model. Abortion is not medically indicated in most cases. The Supreme Court has held that a state need not treat abortion like other medical procedures because abortion involves the termination of preborn human life.²⁶¹ The materiality of information to the woman's decision is most important. In addition, because of the profit-making nature of the abortion context and many well-documented instances of manipulation and lack of adequate counseling in that context,²⁶² the concern over "the danger that physicians [or their surrogates] will exploit patients by subjecting them to treatment that is not in their best interests"²⁶³ is

258. *Maier v. Roe*, 432 U.S. 464, 473 (1977).

259. See *supra* notes 208-23 and accompanying text for an explanation of this distinction. See also Pearson & Kurtz, *The Abortion Controversy: A Story in Law and Politics*, 8 HARV. J.L. & PUB. POL'Y 427, 431, 433 (1985) (distinction drawn between "power investiture" and "burden creation"). Even though the Court does not consistently use the "unduly burdensome" test, it has used this formulation more often in its later cases. Cases involving either state-created obstacles or less burdensome regulations can be analyzed under this test.

260. Professor Wardle's conclusion is similar. He states that the standard should be that "since (or so long as) as informed consent requirement does not constitute an undue burden or barrier . . . to exercising the right of a pregnancy [sic] woman to choose her course of conduct, the particular statute should be upheld if it is rationally related . . . to a legitimate state interest . . . even if, on close examination, the statute may contain some ambiguous, questionable or unwise provisions." L. WARDLE *supra* note 5, at 92.

261. See *Maier v. Roe*, 432 U.S. 464, 480 (1977).

262. See generally *supra* notes 249-255 and accompanying text.

263. Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172, 175 (1981).

acutely real. The district court in *Danforth* upheld the general requirement of obtaining written informed consent because it "insures that the pregnant woman retains control over the discretions of her consulting physician."²⁶⁴

The Supreme Court's commercial speech decisions increasingly emphasize that more, rather than less, disclosure is necessary in a consumer/contract environment. Abortion services are sought and delivered in just such an environment. As long as information is not false or deceptive, it should be provided whether or not the professional involved would prefer otherwise. It may be that either the form or content of information required by a particular informed consent provision makes compliance unduly burdensome because the information is factually incorrect, deceptive, or inflammatory in nature. These may constitute *undue* burdens. But when information simply affects a decision, or has a potential for making one or the other option more or less attractive, no reason for constitutionally forbidding its disclosure exists. Physicians can remain free, as under the *Akron* ordinance, to make the required standardized information more relevant to individual patients' situations.

Finally, this framework should utilize a definition of "health" as a basis for informed consent provisions consistent with the breadth given to that term when used with reference to the exercise of the abortion right itself. Most of the indications for and many of the consequences of abortion are non-medical but yet are highly relevant to a woman's lifestyle and overall well-being. It makes no sense to continue imposing this unjustified radical dichotomy of definitions. The information about alternatives such as financial assistance for the childbirth option, risks, and the like required by the statutes the Supreme Court invalidated in *Akron* and *Thornburgh*, parallel quite closely some of the very concerns listed in the Supreme Court's opinions that might make women consider abortion.²⁶⁵ A workable doctrinal framework within which to decide

264. *Planned Parenthood v. Danforth*, 392 F. Supp. 1362, 1369 (E.D. Mo. 1975).

265. For example, information about the complications of abortion and the risks of the particular procedure to be employed, *Thornburgh*, 106 S. Ct. at 2178, could be weighed against the "harm medically diagnosable" that pregnancy might entail. *Roe*, 410 U.S. at 153. Information about medical assistance benefits for prenatal care, childbirth, and neonatal care, *Thornburgh*, 106 S. Ct. at 2179, would seem particularly relevant to the family concerned about financial inability to care for another child. *Roe*, 410 U.S. at 153. Information about alternatives to abortion like adoption, *Thornburgh*, 106 S. Ct. at 2179, may be very relevant to women who are faced with "a distressful life and future" with another child but who fear the same result were they to live with the knowledge that they have aborted a child. *Roe*, 410 U.S. at 153.

cases involving competing interests, rather than insisting on unprincipled results on the judicial force of *stare decisis* alone, will require a change in the Court's framework.

This framework will allow states to require disclosure of more kinds of information with more specificity than the Court has allowed to date. Accurate information about the preborn child, for example, would likely be permissible. One should again note that the presence of the preborn child makes abortion different from other medical procedures and from other situations involving the right to privacy.²⁶⁶ Polls consistently show that women believe life begins at an earlier point than do men²⁶⁷ and that new scientific information about the fetus has an impact on attitudes toward abortion.²⁶⁸ Whether the fetus is viewed as a "blob of jelly"²⁶⁹ or as a recognizable member of the human species with human characteristics and abilities is material to the decision whether to abort it or carry it to term. Such information may be more relevant to women who have not yet finally decided whether to obtain an abortion, but it is important to remember that the choice between abortion and childbirth is the core of the abortion right. The right not to have an abortion is at least as fundamental as the right to have one.²⁷⁰ Information about prenatal human development has been widely documented, is commonly understood throughout the medical community, and can readily be put into understandable layman's terms.²⁷¹ The Court's invalidation of the disclosure requirement in *Thornburgh*, because such information may not be relevant to *all* women, is without justification. The same conclusion may be made

266. *Roe*, 410 U.S. at 159.

267. See Blake, *The Supreme Court's Abortion Decisions and Public Opinion in the United States*, 4 HUMAN LIFE REV. 64, 73 (Winter 1978); R. Adamek, ABORTION AND PUBLIC OPINION IN THE UNITED STATES 6 (1982); S. Rep. No. 465, *supra* note 239, at 48.

268. See Beck, *America's Abortion Dilemma*, NEWSWEEK, Jan. 14, 1985, at 22 (results of Gallup poll also showing that 38% of Americans doubt their position on abortion).

269. This is how the fetus is described in many so-called "counseling" sessions at abortion clinics. See, e.g., *Eight Other Women's Stories*, PEOPLE, Aug. 5, 1985, at 83 (account by Larijo Nerad).

270. *Maher v. Roe*, 432 U.S. 464, 472 n.7 (1977).

271. See L.B. AREY, DEVELOPMENTAL ANATOMY (7th ed. 1975); G. BERGEL & C.E. KOOP, WHEN YOU WERE FORMED IN SECRET (1980); R. RUGH & L. SHETTLES, FROM CONCEPTION TO BIRTH: THE DRAMA OF LIFE'S BEGINNINGS (1971); L. SHETTLES & D. RORVICK, RITES OF LIFE: THE SCIENTIFIC EVIDENCE FOR LIFE BEFORE BIRTH (1983); Blechschmid, *Human Being From the Very First*, in NEW PERSPECTIVES ON HUMAN ABORTION 6-28 (T. Hilgers, D. Horan & D. Mall eds. 1981); Heffernan, *The Early Biography of Everyman*, in ABORTION AND SOCIAL JUSTICE 3-25 (T. Hilgers & D. Horan eds. reprint 1980); Koop, *The Right to Live*, 1 HUMAN LIFE REV. 70 (Fall 1975); *The Beginning of Human Life*, 10 STUDIES IN LAW & MEDICINE (1982).

concerning the holding of the court in *Planned Parenthood v. Bellotti*²⁷² that such information "is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement."²⁷³ Materiality to a woman's abortion decision is the heart of the requirement. Non-medical information, or medical information relating to non-medical factors, may yet be highly relevant, even vitally important. As such, a state should have the freedom to require that this information be disclosed so that it may also be considered.

VI. CONCLUSION

The Supreme Court's abortion doctrine is fraught with confusion, stemming from a variety of sources. This confusion is apparent in the area of informed consent to abortion statutes, particularly concerning the Court's willingness to strike down these requirements because of their impact on the physician's discretion. This approach ignores traditional jurisprudence on the public control of the medical profession and the Court's rejection of the notion that physicians have a constitutionally significant right to practice medicine free from state interference. It also ignores the law of informed consent outside the abortion context, and its trend away from the reasonable physician model, which the Court contends is constitutionally mandated within that context, and toward the reasonable patient model, which many compelling reasons support as appropriate for abortion information disclosure. The Court's view that these provisions interfere with the woman's right ignores the nature of that abortion right, the nature, and the abortion context. All of these factors support a framework other than that which the Court has used to date in evaluating the constitutionality of informed consent to abortion statutes. Consideration of these factors would probably produce different results.

Such a framework would focus on the woman rather than the physician, would consistently use the "unduly burdensome" test based on the reasonable physician model, and would use a definition of "health" underlying informed consent requirements which was broad enough to include the integrity of the decision.

This refinement would not only make some sense out of the confusion, and allow more consistent application of identifiable princi-

272. 641 F.2d 1006 (1st Cir. 1981).

273. *Id.* at 1021.

ples, but it would allow states more room to preserve the integrity of the choice between abortion and childbirth and to pursue its legitimately important interests implicated in that choice.