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INFORMED CONSENT, ABORTION, AND REPRODUCTIVE AUTONOMY

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A DISSERTATION

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

(Interdisciplinary in Women's, Gender, and Sexuality Studies and Philosophy)

The Graduate School

The University of Maine

May 2015

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DISSERTATION ACCEPTANCE STATEMENT

On behalf of the Graduate Committee for Heather Dawn Lakey I affirm that this manuscript is the final and accepted dissertation. Signatures of all committee members are on file with the Graduate School at the University of Maine, 42 Stodder Hall, Orono, Maine.

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INFORMED CONSENT, ABORTION, AND REPRODUCTIVE AUTONOMY

By Heather Dawn Lakey

Dissertation Advisor: Dr. Jessica P. Miller

An Abstract of the Dissertation Presented
in Partial Fulfillment of the Requirements for the
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May 2015

Abortion is an inimitable experience that poses a host of unique ethical and philosophical questions not generated by other medical procedures. In spite of a massive amount of literature discussing abortion, there is little theoretical work examining the relationship between abortion and informed consent. This is a problematic oversight because informed consent plays a prominent role in contemporary abortion practices. In an effort to address this lacuna, my dissertation explores the concept of informed consent as it functions within abortion discourse.

Informed consent and abortion are both interdisciplinary terms and thus a robust critique of their intersection requires an interdisciplinary analysis. Therefore, I critically track the concept of informed consent across four unique discourses: traditional informed consent literature, Supreme Court rulings on abortion regulations, state-sponsored informed consent materials distributed to women seeking an abortion, and women's first-person narratives. As a contribution to feminist and bioethics scholarship, I argue that informed consent is a deeply inadequate concept in the context of abortion. Importantly, however, the reasons for this inadequacy change relative to the discourse in question.

Thus, Chapters One, Two, Three, and Four each take as their focus a distinct discursive engagement of informed consent. In Chapter Five, I confront a series of questions generated by my interdisciplinary survey.

In bridging the gaps between informed consent theory and abortion discourse, I demonstrate two important points. First, I illustrate how popular articulations of informed consent are ill-equipped to address the moral and medical issues particular to abortion. Secondly, I illuminate cases where the rhetoric of informed consent is, in fact, being used to undermine and jeopardize women's reproductive autonomy. This dissertation concludes with a plea for a revised conception of informed consent within the abortion context, one that deploys the subjective standard of disclosure and recognizes the value of flexible dialogue between the woman and her abortion provider.

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INTRODUCTION AND OVERVIEW

“Might it not be necessary to do two things at once: to emphasize both the permanent value of the philosophy of rights, and, simultaneously, the inadequacy, the limits of the breakthrough it represented?” Helene Cixous (1993, p.202)

Although abortion is shrouded in stigma and controversy, it is a common procedure. According to the Guttmacher Institute, one half of all pregnancies in the United States are unintended (Finer & Zolna, 2014). Of these, forty percent will end in abortion (Finer & Zolna, 2014). In 2011, over a million women had abortions in the United States alone (Jones & Jerman, 2014). Given abortion rates in 2008, three in ten women will have had an abortion by the age of forty-five (Jones & Kavanaugh, 2011).[1]

Abortion has been legal in the United States since the Supreme Court’s landmark 1973 ruling in *Roe v. Wade*. Over the last forty years, however, access to abortion has diminished as states have found creative ways to regulate and restrict the abortion procedure. In the first half of 2011, state legislators introduced a record number of antiabortion bills. In nineteen states alone, eighty antiabortion laws ranging from mandatory counseling and waiting periods to gestational laws and bans on insurance coverage were passed, a legislative testimony to the incremental successes of the antiabortion campaign (Guttmacher Institute, July 13, 2011). According to the Guttmacher Institute (July, 2014), at least half of the states have now passed some form of legislative restriction on abortion.

Of the many restrictive regulations imposed by antiabortionists in recent years, one of the most troubling comes in the form of "informed consent" laws. In traditional form, informed consent is at once a legal requirement that governs medical decision-making and an ethical ideal that aims to enhance and protect patient autonomy in the clinical and medical-research settings. An emancipatory concept designed to service individual rights, informed consent is a child of liberal humanist thought and its concomitant ideals of freedom and equality.

Despite its liberatory origins, however, informed consent practices are increasingly being used to subvert and undermine women's reproductive autonomy.[2] More specifically, antiabortion politicians are infiltrating the informed consent process to further an antiabortion agenda and, consequently, a number of states have passed laws that require healthcare providers to share misleading and fraudulent information to women seeking an abortion.[3] According to the Guttmacher Institute (February, 2015a), seventeen states currently advise women of at least one of the following scientifically unsubstantiated claims in their "informed consent" materials: a link between abortion and breast cancer; the ability of the fetus to feel pain; the possibility that abortion will cause long-term mental health consequences for the woman (p.1). Concurrently, five states require providers to tell women that personhood begins at conception, twenty-seven states include information on fetal development throughout the entire course of pregnancy despite the fact that third-trimester abortions have never been legal on demand, and five states inaccurately claim abortion causes infertility (Guttmacher Institute, February, 2015b). In each case, the information provided to women is scientifically unsupported, ideologically biased, or medically unnecessary (Richardson &

Nash, Fall 2006). Although some states' informed consent requirements continue to accord with the standard format of the informed consent process—a basic description of the abortion procedure and its purpose, a description of the risks or benefits associated with the procedure, a list of alternative procedures, and an opportunity for the patient to ask questions (Berg et al., 2001, p.12)—the information provided in other states' "informed consent" materials is medically deceptive and designed to reinforce antiabortion ideology.

Inspired and troubled by the antiabortion appropriation of bioethics rhetoric, this dissertation unpacks the concept of informed consent as it functions within the contemporary abortion context. Separately, the topics of informed consent and abortion have received extensive theoretical attention. However, there is little theoretical work that considers the troubling interplay between informed consent and abortion practices, and the ideological co-option of a concept originally intended to enhance patient autonomy has received minimal attention in bioethics literature. Operating with a feminist perspective, I aim to rectify such oversights by critically theorizing the problematic intersection of informed consent and abortion. This work is necessary because contemporary "informed consent" law jeopardizes women's reproductive autonomy and these laws institutionalize sexist ideologies that aim to efface women's moral agency.

Although I am certainly not the first person to notice that antiabortion forces are perverting the liberal rhetoric of informed consent, I am the first to offer a comprehensive analysis of informed consent as it functions within contemporary abortion rhetoric. To complete this task, I critically track the concept of informed consent across four discourses: traditional informed consent literature; Supreme Court rulings on abortion regulations; state sponsored "informed consent" materials given to women seeking an abortion; and women's first-person narratives relating their encounters with "informed consent" laws. I contend that this interdisciplinary survey of informed consent will better equip scholars and activists to recognize and confront the background normative assumptions and social beliefs that contribute to the institutionalization of antiabortion ideology under the pretext of bioethical ideals. That is, in order to successfully challenge and overthrow "informed consent" laws, it is necessary to understand how the concept of informed consent functions across different strands of abortion and bioethics rhetoric. One of the major tasks of this work is to provide a map of this functioning.[4]

In the course of tracking informed consent across multiple discourses, this work will demonstrate that informed consent is a deeply inadequate concept in the context of abortion. Importantly, however, the reason for this inadequacy changes relative to the discourse in question, whether be it bioethics, Supreme Court rulings, clinical materials, or anecdotal reports. Thus, Chapters One, Two, Three, and Four each take as their focus a specific discursive enactment of informed consent. In Chapter Five, I confront a series of concluding questions generated by the previous four chapters. The scope of my argument proceeds as follows.

Synopsis of Chapter One

I begin this work with a critical overview of traditional theories of informed consent. More specifically, my goal in Chapter One is to illuminate a series of theoretical deficiencies that haunt early articulations of informed consent. Even as I recognize the many ways that informed consent practices have improved medical decision-making during the preceding decades, I argue that mainstream conceptions of informed consent suffer from a series of theoretical blind spots that carry consequences for minority or subjugated patient-groups, such as women seeking an abortion.

A secondary goal of this chapter is to problematize the claim that abortion-specific "informed consent" laws are tantamount to a misappropriation or deformation of standard informed consent practices, an argument commonly made by Guttmacher Institute policy analysts and women's reproductive rights advocates. Although not untrue, the problem with this argument is that it falsely presumes that informed consent is an ethically ideal practice that invariably protects all subjects equally, and it overlooks how dominant articulations of informed consent fail to protect and enable women's reproductive autonomy. Counter to other critics of abortion-specific "informed consent" practices, I propose that the traditional doctrine of informed consent is a limited concept articulated from a position of social privilege, one that is insensitive to the moral issues generated by unwanted pregnancy. My critique, in turn, suggests that to adequately support women's reproductive autonomy, not only must we overturn "informed consent" laws that deliver false information to women, but we must revisit and revise dominant informed consent paradigms, as well.

In order to develop my argument, I construct a mode of critique unique to informed consent scholarship. More specifically, I use feminist insights to analyze three traditional formulations of informed consent. At its heart, informed consent is an interdisciplinary concept, one that emerges across a series of unique disciplines. In order to sufficiently illuminate the shortcomings of mainstream informed consent theory, I critique informed consent as it is articulated within early judicial rulings, founding texts of biomedical ethics, and government reports. By grouping these three articulations together, my analysis respects the interdisciplinary character of informed consent even as it casts this character into critical light.

Importantly, my point is not that informed consent practices should be discarded, as the concept of informed consent has indubitably benefited medical decision-making in many ways. I agree with Berg et al (2001) who argue that despite theoretical and practical flaws, "the process of informed consent is still the most promising path to patients' receiving care that is for their own good, as they themselves define it" (p.35). Rather, my argument is that informed consent theory requires feminist revision if it is to operationalize women's autonomy in the abortion-care context.

Synopsis of Chapter Two

In Chapter Two, I commence my critique of informed consent as it functions within abortion discourse specifically, beginning with a look at judicial rhetoric. More specifically, the purpose of Chapter Two is to critically track the evolution of informed consent across United States Supreme Court rulings on abortion, and to demonstrate how the Supreme Court opened the door to the tsunami of punitive abortion regulations that define the current era in the pivotal decision *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992).

To clarify the Court's deployment of informed consent, I offer an historical overview of Supreme Court rulings that concern medical decision-making in the abortion context. I focus my attention on the following pre-*Casey* Court decisions*: Roe v. Wade* (1973), *Planned Parenthood of Central Missouri v. Danforth* (1976), *Akron v. Akron Center for Reproductive Health* (1983), and *Thornburgh v. American College of*

Obstetricians (1986). Pointedly, my historical narrative will show that abortion jurisprudence routinely proffers an impoverished vision of women's moral and epistemic capacities, despite the legal advances precipitated by *Roe.* Consequently, the Supreme Court fails to advance an articulation of informed consent that promotes women's reproductive autonomy.

My primary argument is that the Court's failure to recognize women's moral authority vis-à-vis the abortion decision positions the Court to interpret informed consent as a means to monitor women's reproductive decisions, rather than as a mechanism that enhances and safeguards women's autonomy. Although the *Casey* decision marks a turning point in the Court's view of abortion-specific "informed consent" laws, the Court's logic from *Roe* onwards ignores or depreciates women's epistemic and moral capacities. When it comes to the abortion decision, the Court is either a) concerned with protecting the physician's autonomy, or b) concerned with defending a state's right to inject information into the informed consent process. In both instances, the Court configures women as secondary decision-makers whose abortion decision requires public surveillance.

Chapter Two develops my argument in Chapter One that the Court operates with an ethically frail conception of informed consent. Given the Court's failure to produce a patient-centered paradigm of informed consent practices in general, it is unsurprising that the Court would also fail to advance a vision of informed consent practices that underscore women's moral autonomy within the abortion context. This chapter provides a unique perspective on informed consent literature as it shows how the Court's failure to articulate a robust jurisprudence of informed consent carries added consequence for women seeking to terminate an unwanted pregnancy.

Synopsis of Chapter Three

In Chapter Three I focus on state-sanctioned “informed consent” materials to demonstrate the troubling deployment of “informed consent” within the clinical context. Informational content varies state by state, and states rely upon different mediums to transfer misleading and manipulative information regarding abortion, ranging from printed materials to verbal recitations to websites. Although a wide-range of information is discussed across the states, I focus specifically on information trends that I find particularly disturbing for their scientific falseness and ideological agendas.

Researchers at the Guttmacher Institute have compiled data on the existence of abortion-specific “informed consent” materials across the states, but there is a dearth of theoretical work analyzing the rhetoric of these materials. In this chapter I expand upon preliminary research carried out by the Guttmacher Institute to delineate three rhetorical strategies that operate within “informed consent” materials: a) the adoption of methodologically flawed and discredited research studies that falsely suggest a causal relationship between abortion and breast cancer; b) an embellished and empirically reductive discussion of post-abortion emotional response; c) the careful construction of a fetal subject that sanctions antiabortion ideology. By outlining these strategies I demonstrate with detail how antiabortion forces deform and reform bioethics lexicon to suit their political program. To discuss the first two rhetorical strategies, I draw upon policy papers and current scientific research to explain why warnings detailing the psychological and health “risks” of abortion are medically misleading, empirically reductive, and scientifically unsound. To discuss the construction of fetal subjectivity, I turn to medical embryology and feminist scholarship and I show how antiabortion ideology permeates and drives mandatory discussions of fetal subjectivity.

Chapter Three departs from the approach taken in the previous two chapters where I criticized the theory and practice of informed consent within bioethics and judicial rhetoric. Although I remain mindful of the theoretical problems that jeopardize dominant articulations of informed consent, my primary purpose in Chapter Three is to illuminate the dramatic perversion of informed consent practices by antiabortion politicians. In general, Chapter Three will explain why the antiabortion appropriation of informed consent bears little resemblance to informed consent doctrine as originally espoused by the Courts, bioethicists, and clinicians.

"Informed consent" materials assault and jeopardize women's reproductive autonomy, they displace the autonomy of healthcare providers, and they bypass professional standards of information provision. In this sense, "informed consent" laws are deforming standards of medical practice to align with antiabortion dogma. This deformation should be viewed as alarming, no matter one's personal views regarding the ethics of abortion. The explicit politicization of a healthcare practice originally designed to benefit patients and improve patient-provider dialogue demands immediate redress.

Synopsis of Chapter Four

The focus of Chapter Four is the impact of "informed consent" laws upon women's lives. Currently, there is limited research on "informed consent" laws, and little is known about women's idiosyncratic experiences with these regulations. Despite this paucity of research data, I argue that it is possible to illuminate some of the disturbing ramifications of “informed consent” laws and to show how these laws harm women’s reproductive autonomy.

In section one, I summarize limited research on women’s perceptions of “informed consent” laws in order to delineate the current research scene. Although empirical research indicates that “informed consent” laws are not impacting abortion demand, I argue this research nevertheless contains clues that suggest “informed consent” laws hurt women’s autonomy. More specifically, I draw on structured interviews to propose that optional-ultrasound laws engender negative emotional responses in some women. In addition, I explore a common opinion surfaced by Cockrill and Weitz’s (2010) research on women’s perceptions of “informed consent” laws: “I do not require heightened regulation, but other women, do.” I suggest that this opinion is both a cause and an effect of antiabortion ideology.

In section two, I turn to the story of Carolyn Jones whose first-person account of “informed consent” laws in Texas has received wide-ranging press. To help theorize an under-theorized field of human experience, I recount Carolyn Jones’ distressing experience with abortion laws. Jones’ narrative is useful as it provides rich insight into both the psychological and administrative dimensions of abortion regulation in Texas.

In section three, I couple Jones’ story with feminist theories of intersectionality and relational autonomy to hypothesize the obstacles women from other social locations may encounter during the “informed consent” process. In addition to providing important insights into the “counseling” experience, Jones’ story also affords the opportunity to imagine the impact of “informed consent” laws on women who are further disadvantaged along economic, sexual, or racial lines. Drawing on these insights, I argue that “informed consent” laws undermine, assault, and diminish women’s reproductive autonomy, although not in any uniform way.

By considering the empirical impact of “informed consent for abortion” laws upon women, this chapter brings together two arguments developed in earlier chapters. First, Jones’ story demonstrates how deeply “informed consent” laws pervert the doctrine of informed consent. Secondly, Jones’ encounter with the Texas sonogram law problematizes bioethics’ facile equation of information with autonomy, and it demonstrates the need to supplement mainstream bioethics with feminist insights. Overall, this chapter weaves together women’s first-person narratives with theoretical perspectives to offer a fresh perspective on the antiabortion appropriation of bioethics lexicon.

Synopsis of Chapter Five

I can neither anticipate nor answer all of the issues and questions raised by my research on “informed consent” laws. Nevertheless, this concluding chapter explores three questions that especially warrant further address. These questions include: 1) Who is resisting “informed consent” laws, and what form does this resistance take? 2) How have professional medical associations, like the American Medical Association or the American Woman’s Medical Association, responded to the politicization of the informed consent process? 3) Given that current informed consent practices are unacceptable and inadequate, how should informed consent practices proceed for women seeking an abortion?

To begin, I theorize resistance to antiabortion hegemony. Though “informed consent ” laws are an abusive instance of power, it is important to remember that women and abortion care givers are not simply victims; they are also agents capable of critical response and counter-action. This section suggests some of the ways resistance to “informed consent” laws may be occurring or could occur. More specifically, I consider four modes of resistance: legal challenges, provider strategizing, first-person narratives, and academic and research publications.

Secondly, I raise questions regarding the relationship between professional medical organizations and “informed consent” laws. In earlier chapters, I argued that traditional formulations of informed consent disproportionately defend and promote physician authority. Given that “informed consent ” laws invasively override medical authority and assault physician autonomy, it is not surprising that professional medical associations have issued formal responses to “informed consent” laws. I suggest that the policy statements of the American College of Gynecologists (ACOG), the American Woman’s Medical Association (AWMA), and the American College of Physicians (ACP) are important initial volleys against “informed consent” laws. However, I critique the American Medical Association’s (AMA) official policy on abortion for its tepidity and rhetorical imprecision. Given that the AMA wields the most social power of any medical organization, the AMA’s silence on “informed consent” laws is particularly troubling.

Finally, I return to the issue of informed consent in the abortion context. Although this work is clearly critical of the doctrine and practice of informed consent, I do not mean to suggest that informed consent practices should be discarded in the abortion context. Rather, informed consent practices must be redesigned in light of the inimitable phenomenology of unwanted pregnancy and the moral particularity of abortion. In this concluding section, I draw upon feminist clinical practice to espouse a positive vision of what informed consent practices should offer to women seeking an abortion.

CHAPTER ONE

A CRITICAL REVIEW OF INFORMED CONSENT

I begin this work with a critical overview of mainstream conceptions of informed consent in order to demonstrate two important points. First, I aim to illuminate a number of theoretical flaws that compromise traditional conceptions of informed consent. Although I recognize the many ways that informed consent practices have improved medical decision-making, I argue that dominant paradigms of informed consent are compromised by a series of theoretical weaknesses that carry consequences for minority or subjugated patient-groups, such as women seeking an abortion.

A secondary aim of Chapter One is to complicate a common claim made by feminists who challenge abortion-specific "informed consent" laws. More specifically, some feminists argue that "informed consent" laws violate the traditional doctrine and practice of informed consent. For example, Richardson and Nash (Fall, 2006) write in the *Guttmacher Policy Review* that abortion-specific "informed consent" laws " . . . do not always measure up to the gold standard of informed consent" (p.6). According to Richardson and Nash (Fall, 2006), "policymakers and public health officials frequently disregard the basic principles of informed consent in favor of furthering a highly politicized antiabortion goal" (p.11). Likewise, Jessica Mason Pieklo (July 25, 2012) observes in a *RH Reality Check* article that abortion-specific "informed consent" laws compel doctors to "go from being an advocate of the patient and a representative of the best possible medical consensus to an advocate for the anti-choice cause. It's nothing short of a perversion of the doctrine of informed consent" (para 10). In both cases, the authors view "informed consent" laws as a political deformation of standard informed consent practices.[5]

Although the observations made by Richardson and Nash (Fall, 2006) and Pieklo (July 25, 2012) are not untrue, I break away from their approach to highlight the theoretical weaknesses that compromise founding articulations of informed consent. Whereas thinkers like Richardson and Nash (Fall, 2006) and Pieklo (July 25, 2012) assume that informed consent is an invulnerable ethical ideal that invariably protects all subjects equally, an ideal that abortion-specific "informed consent" laws derange and deform, I contend that mainstream conceptions of informed consent are insensitive to issues of social oppression as they manifest within the medical setting and that this insensitivity carries added consequences for women seeking an abortion. Thus, I argue, a successful renovation of abortion-specific "informed consent" laws will also require a deep rethinking of the practices and policies of informed consent in general.

Of course, I am not the first to argue that traditional theories of informed consent are limited or that informed consent requires theoretical redress. According to Manson and O'Neil (2007) informed consent "is now the most discussed theme in Western medical ethics and research ethics" (p.1). By way of example, a MedLine database search reveals the publication of over 1,800 English articles addressing the subject of informed consent in the years 2002 and 2003 alone (Manson & O'Neil, 2007, p.1). Critical discussions of informed consent are legion, and bioethicists and medical practitioners perpetually breathe analytic life into one of American bioethics' most entrenched subjects.[6]

Nevertheless, I argue that a particular mode of critical review is still missing from informed consent scholarship, despite the existence of a colossal library of informed consent literature. More specifically, a critique of informed consent that exposes informed consent's theoretical deficiencies through a feminist lens while simultaneously minding its interdisciplinary, rhetorical character has yet to be thoroughly developed. Insofar as founding articulations of informed consent proliferate across a series of unique discourses, it is imperative for any analysis of informed consent to demonstrate a similar interdisciplinary mobility. Likewise, a feminist reading of informed consent will highlight the impact and import of gender oppression within bioethics' discourse and practice, modes of oppression that carry particular consequences in the abortion context.

In order to develop such a critique, this chapter uses feminist insights to track the rhetorical inception of informed consent across three discourses. In demarcating three different discourses for survey, I take my cue from Berg et al. (2001) who argue there "are at least three distinct senses of informed consent" (p.15): legal conceptions of informed consent; bioethical conceptions of informed consent; and thirdly, informed consent as "shared decision making." By grouping these articulations together I offer a unique analysis that recognizes and engages the interdisciplinary discursive character of informed consent while simultaneously foregrounding theoretical pitfalls and blind spots. Perhaps more importantly, however, my interdisciplinary critique will allow me to demonstrate the inadequacy of the argument that "informed consent" laws are simply a violation of standard informed consent practice and doctrine.

To be clear, this chapter is not intended as a comprehensive critique of informed consent, nor do I mean to suggest that the concept and practice of informed consent vis-à-vis abortion care should be discarded. As an ethical ideal, informed consent provokes us to reconsider the ethical dilemmas endemic to medical decision-making, and the institutionalization of informed consent policies have benefited patients on a number of fronts. The three iterations of informed consent that I consider in this chapter stress the importance of patient autonomy, and each iteration improves upon its predecessors in terms of advancing a theoretical framework to help operationalize patient autonomy—characteristics that mark important ethical advances within biomedical practices.

Nevertheless, I argue founding constructions of informed consent advance an impoverished model of informed consent. Thus, my aim in Chapter One is to trouble the assumption that informed consent is a finely tuned and beneficial concept, specifically in the context of abortion. Later on, in Chapter Five, I suggest an alternative model for informed consent practices, one that is sensitive to the complex interactions of social power and medical decision-making that shape reproductive healthcare. A general premise of this work is that informed consent practices continue to hold liberatory promise, but they require feminist supplement in order to effectively operationalize patient autonomy.

A Brief History of Informed Consent

In short form, informed consent is both an ethical and legal doctrine that governs decision-making in the medical context. More specifically, informed consent obligates healthcare providers to disclose and discuss information relevant to a patient's medical condition prior to an act of medical intervention. In contemporary models, healthcare providers are required to alert patients to the following information during the communication process:

> (1) those facts or descriptions that patients or subjects usually consider material in deciding whether to refuse or consent to the proposed intervention or research, (2) information the professional believes to be material, (3) the professional's recommendation, (4) the purpose of seeking consent, and (5) the nature and limits of consent as an act of authorization. (Beauchamp & Childress, 2009, p.121)

In this model, if the healthcare provider delivers the relevant and necessary information, if the patient is competent to make adequate decisions and understands the provided information,[7] and if the patient's decision is voluntary and free from coercion,[8] then an informed consent has occurred. Or arithmetically put: information + competency + voluntary choice = informed consent.

In American bioethics, informed consent is viewed as key to respecting, protecting, and enacting patient autonomy during the medical decision-making process. First articulated in court rulings during the 1950s, and then embellished in subsequent decades, informed consent was initially devised as a corrective measure to medical paradigms that promoted medical paternalism and as a remedy for lurid cases of medical malfeasance, such as the notorious Tuskegee Syphilis Study. As an alternative to the "doctor-knows best" mentality, informed consent policies were originally intended to protect and empower the individual patient.

In theory, informed consent policies help to institutionalize sensitivity to the ethical ambiguities that often accompany medical decision-making in the modern world. Beginning in the mid-twentieth century, the advent of new medical technologies irrevocably changed medical practices by proliferating treatment options and extending human life. In this brave new world, a model of unilateral medical decision-making that privileges the physician's viewpoint, or assumes that patients automatically share the same nonmedical values as their doctor, is inadequate for generating medical solutions (Jonsen, 1998, p.3). Inarguably, informed consent revolutionized medical ethics, as prior paradigms of medical decision-making were unambiguously paternalistic and assumed that medical practitioners alone should make medical decisions.[9] Risking platitude, one might say informed consent was articulated with the best of intentions.

Yet, if we turn to key articulations of "informed consent," if we look and see how informed consent is formulated across a variety of discourses, we will witness theoretical weaknesses that may interfere with some patients' autonomy, most notably those from oppressed or underrepresented social groups. In the following section, I begin with a critical look at early judicial conceptions of informed consent as developed in the court cases, *Salgo v. Leland Stanford Jr. University Board of Trustees* (1957) and *Natanson v. Kline* (1960). Next, I turn to Tom L. Beauchamp and James F. Childress' (2009) definitive text, *Principles of Biomedical Ethics*, in order to critically engage a widely accepted model of informed consent within bioethics literature. Finally, I spotlight theoretical inadequacies concealed within a 1982 government report published by The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which advances a potentially promising conception of informed consent as shared decision-making. I focus on these texts partly because they are widely recognized as inaugural articulations of informed consent and partly because each text exemplifies a unique approach to informed consent theory and practice. Although the theories of informed consent that I consider in this section are decades old, they continue to exert an indelible influence upon contemporary medical practice and theory.

The theoretical weaknesses I discuss below carry implications for all patients, in all medical contexts. However, my critique in this section is driven primarily by concerns regarding abortion care. Consequently, I draw on examples from abortion decision-making to help elucidate my argument.

Informed Consent in Judicial Discourse

In the United States, it is well recognized that the term "informed consent" first appeared within legal discourse. Faden and Beauchamp (1986) write,

> Informed consent was never the concern of the great writings and teachings in medicine, theology, or any discipline traditionally addressing the search for moral truths in medicine. Informed consent is a creature originally of law and later snatched from the courts by interdisciplinary interests and spearheaded by an ethics driven more philosophically than theologically. (p.92)

Although medical cases dealing with battery, disclosure, and consent have a long history in judicial discourse,[10] the term "informed consent" is first used in the 1957 decision *Salgo v. Leland Stanford Jr. University Board of Trustees* and is given greater specificity in the 1960 decision *Natanson v. Kline*.[11] In both cases, new medical technologies had been used without the disclosure or discussion of possible risks, and patients had experienced severe injuries.

The *Salgo* (1957) case concerned Martin Salgo, a patient who experienced permanent paralysis in his lower extremities after a physician decided to perform an aortography. At that time, aortography involved injecting a dye, sodium urokon, into a patient to locate a block in the abdominal aorta. Martin Salgo claimed he had not been warned of the risks associated with the procedure and he sued his physicians for negligence.

Alternatively, the *Natanson* (1960) case concerned Irma Natanson, a patient who suffered severe and disabling injuries after receiving cobalt radiation therapy, a relatively new procedure for breast-cancer treatment. After undergoing a mastectomy, Natanson was administered cobalt therapy and, consequently, she suffered severe radiation burns to her thorax. Although Natanson "consented" to the new procedure, she argued that her physician had not informed her of the risks and hazards of the treatment (Katz, 1984, pp.60-71).

In the *Salgo* ruling, Justice Bray of the California Court of Appeals argued that physicians have a duty to disclose "any facts which are necessary to form the basis of an intelligent consent by the patient to proposed treatment" (as cited in Faden & Beauchamp, 1986, p.125). In the first documented judicial use of "informed consent," Justice Bray explained, "In discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent" (as cited in Katz, 1984, p.6).[12] Although the courts had long recognized "consent" as a necessary requirement in medical practice, and the courts had historically argued that patients have a right to know a physician's medical intentions and physicians could be convicted of battery absent disclosure of their intentions, the *Salgo* ruling expanded the idea of "consent" to include the enabling condition of information provision (Faden & Beauchamp, 1986, p.126).

Subsequently, the *Natanson* case endowed the notion of informed consent with richer legal specificity. Here, the Kansas Supreme Court ruled that physicians have the obligation "to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body" (as cited in Katz, 1984, p.66). As we can see in the previous citations from the *Natanson* and *Salgo* rulings, the court articulates informed consent as a process of informational disclosure governed by medical knowledge.

The *Salgo* and *Natanson* cases awarded "informed consent" formal status in judicial discourse, and they established a new legal injunction in medical practice: physicians have an affirmative duty to disclose relevant information to their patients. Consequently, physician liability now exceeded harmful intent; if a physician neglected or overlooked certain domains of information they could face charges of malpractice.[13] Although the doctrine of informed consent spawned a litany of legal questions that the courts did not answer, it irrevocably changed the legal practice of medical decision-making.[14] A medical paradigm that promoted patient ignorance and safeguarded physician paternalism was no longer acceptable. Instead, in the words of Justice Schroeder, "each man was to be master of his own body" and "the law does not permit [the doctor] to substitute his own judgment for that of the patient by any form of artifice or deception" (as cited in Katz, 1984, p.66). Although the court does not develop a detailed account of the ethical relationship between information and self-determination (a development we will witness later in the landmark texts of bioethics), the court's rhetoric reflects a burgeoning belief that healthcare providers must recognize and respect patient autonomy and that information provision is a necessary component in implementing this respect.[15] In many ways, it is not surprising that the court defended patient autonomy; after all, individual autonomy had long been an important component of the American ethos.[16]

Despite the courts' defense of patient autonomy, the courts' articulation of informed consent overlooks key components necessary to the operationalization of patient autonomy. More specifically, the courts' articulation of informed consent reduces informed consent to an institutionalized formality driven by the fear of medical liability. In addition, the courts' view of informed consent over-idolizes physician authority and consequently reduces informed consent to a unilateral process of information disclosure. In the following paragraphs I expand upon each of these concerns, and I explain why the courts' anemic articulation of informed consent carries added consequences for minority groups, particularly women seeking an abortion.

My first concern pertains to the courts' view of informed consent as an institutional requirement. Although institutional requirements are not necessarily problematic, problems can arise if medical practice shapes itself primarily to accord with institutional requirements, rather than patient needs. In the legal articulation of informed consent, informed consent simply becomes a series of procedures and protocols that medical practitioners must follow under threat of liability. Although the courts recognized the need to institute legal provisions to protect patients, ultimately their articulation of informed consent is limited to the clarification of physician liability and tort law, rather than the enhancement of patient autonomy (Terry, 1993; Shultz, 1985). Of course, institutionalized laws may incite important medical dialogue necessary to patient autonomy, but there is nothing inherent to such protocols to guarantee that patient autonomy has been protected and operationalized.

In their critique of legal articulations of informed consent, Beauchamp and Childress (2009) argue that legal articulations refer "only to an institutionally or legally effective authorization, as determined by prevailing social rules . . . . 'Consent' under these circumstances is not bona fide informed consent" (p.119). As Beauchamp and Childress (2009) correctly note, legal articulations fail to adequately explore the conditions and criteria necessary to an act of autonomous consent. In a context of medical power, a patient may feel compelled to sign a form indicating that the doctor has supplied him or her with medical information, but a signature does not necessarily mean the patient understands the meaning and consequences of a medical procedure nor that the patient has exercised an autonomous decision.

Following the dictates of legal discourse, informed consent can easily become a mechanical and empty exercise of obtaining a patient's signature on a consent form. In this model, once a provider has disclosed medical "facts," to borrow the language from *Salgo*, and the patient has signed the informed consent form, the healthcare provider has secured a certain degree of legal impunity. But, what vision of patient autonomy does this model proffer? In this sense, informed consent is simply a symbolic procedure evidencing a litigious culture, rather than a practice that encourages autonomous decision-making.

A second problem with the courts' early articulation of informed consent pertains to the courts' idolization of physician authority and its underlying distrust of patient competency. Jay Katz (1977; 1984) famously calls attention to a contradiction that lies deep at the heart of the *Salgo* ruling. In *Salgo,* Justice Bray ruled that physicians must exercise "a certain amount of discretion" while simultaneously practicing "full disclosure," a difficult coupling that leads Katz (1977) to remark, "[o]nly in dreams or fairy tales can 'discretion to withhold crucial information' so easily and magically be reconciled with 'full disclosure'" (p.138). The concept of "full disclosure" poses a number of complex problems. First, how can full disclosure occur if physicians can withhold crucial information? Secondly, what counts as "full" disclosure in a situation where a physician does not plan to withhold information? How does a physician decide when a sufficient amount of information has been supplied, and how does a physician avoid overwhelming a patient with superfluous information? Moreover, how does a physician decide which information is most pertinent in light of patient values?

The issue of abortion, for example, troubles the notion of "full disclosure." For example, some women seeking an abortion may not want to view an ultrasound image or hear a detailed medical reading of the image, as we will see with the case of Carolyn Jones in Chapter Four. In the highly politicized climate of abortion, it is difficult to purvey medical information about pregnancy as neutral medical fact, and some women may experience excessive information about pregnancy as patronizing or punitive rather than helpful and informative. As I will discuss further in Chapter Four, too much information regarding fetal ontology may agitate some women's self-trust and consequently trouble their capacity for reproductive autonomy (McLeod, 2002; Graham, Ankrett, & Killick, 2010). In general, the deeply personal nature of the abortion decision means that the physician may not be best positioned to recognize the appropriate informational scope of "full disclosure."

In general, the court glosses over the practical ambiguities entailed by the concept of "full disclosure," an oversight that may be partially informed by the court's reluctance to override medical authority. Katz (1984) argues, for example, that the contradictory injunction to practice "full disclosure" with "discretion" testifies to a deep judicial ambivalence regarding the relationship between patient autonomy and medical expertise. Katz (1984) writes,

> Judges were hesitant to intrude on medical practices, and not only for reasons of unfamiliarity with the ways in which physicians worked. Their impulse to foster individual self-determination collided with an equally strong desire to maintain the authority of the profession, both for the sake of professionals and for the 'best interests' of patients. (p.59)

That is, even as the courts recognized the value of patient autonomy, they were unable to relinquish the long-reigning paradigm of medical ethics that 'the doctor knows best.' Thus, their vision of informed consent placed an onus on doctors to share some forms of medical information, but it failed to sufficiently recognize patient values or delimit space for patient voices.

According to Katz (1984), the courts' arguably anemic vision of informed consent is informed by the "deeply buried" bias that patients lack "capacities to make reasonable decisions" (p.71). If patients are viewed as poor decision-makers, then physicians must retain control of the decision-making process, an assumption that carries a number of problematic consequences for the practice of informed consent. For one, insofar as competency is a requisite element of an informed consent (Beauchamp & Childress, 2009, p.120), then the informed consent process will be derailed, if not completely abandoned, if competency is found lacking. Secondly, the courts' general distrust of patient competency positions the court to advance a model of informed consent that is predicated on the primacy of physician knowledge rather than patient values. For the courts, informed consent amounts to a monologue wherein one agent, the doctor, simply recites information to another agent, the patient, in order to deflect medical liability. Although information provision marks an advance over older models of medical paternalism that kept the patient in the dark, so to speak, information disclosure is not sufficient for autonomous decision-making, a point that will be developed in the following section. Katz (1984) contends that the courts' deference for physician authority led the courts to "[toy] briefly with the idea of patients' right to self-determination and largely cast it aside" (p.82).

Katz's argument that legal articulations silence patient voices is insightful, but it requires feminist supplement. If Katz is correct in his claim that the legal and medical worlds are undergirded by a fundamental distrust of patient competency, then it is important to remember that different patients are distrusted to different degrees. Insofar as individuals' rational and moral capacities are not uniformly recognized across social groups (Lloyd, 1984), then it follows that asymmetric distributions of distrust will occur within the medical context, as well. Although Katz's insights are instructive in understanding the court's conservative articulation of informed consent, Katz does not explicitly recognize that physician distrust may be magnified in situations where the patient is a member of a social group that is historically discredited or deemed epistemically incompetent.

For example, male paradigms of ideal patient competency can unconsciously alter healthcare providers' assessment of patient competency. Feminist philosophers have gone to great lengths to demonstrate the normalization of hostile tropes of women's inferior epistemic and moral capacity across various discursive practices. Deeply entrenched stereotypes of women as irrational, nervous, or hysterical, for example, can color the assessment of women's rational competency and epistemic credibility.[17] Genevieve Lloyd (1984) has famously argued that rationality in western discourse is articulated on the basis of women's exclusion. More specifically, women are excluded from rational activity on both a practical and a symbolic level; to be rational is to be other than woman. Drawing on Lloyd's argument, "rationality" is not a material capacity, but it is a construction driven by sexist standards. This insight is developed by Susan Dodds (2000) when she writes, "The rational competence of women and other oppressed groups is frequently questioned, insofar as they are thought to lack sufficient emotional distance and objectivity to act rationally" (p.224). As we will see in Chapter Three, abortion-specific “informed consent” materials rely heavily upon cultural tropes of female irrationality and epistemic incompetency to advance their narrative that women who choose to terminate a pregnancy may become hysterical and pathological. Arguably, antiabortion arguments have found traction in state legislatures and in the courts partly because our culture is already saturated with stereotypes of female incompetency.

Sociological research on medical discourse further confirms that gender, race, and class differences frequently shape medical dialogue, and that healthcare providers may experience problematic attitudes ranging from paternalism to outright hostility when interacting with patients who are from an oppressed class. For example, sociologist Alexandra Todd (1983) writes,

> The darker a woman’s skin and/or the lower her place on the economic scale, the poorer the care and efforts at explanation she received. Women of color and/or an economically poor background were more apt to be seen as ‘difficult’ patients when they asked questions.[18] (p.77)

In a frequently cited study (Roberts, 1996, p.123; Smith, 1996, p.194), Roger Shuy (1983) notes that “[c]onsciously or unconsciously, dialect speakers tend to get worse treatment, wait longer for service, are considered ignorant, and are told what to do rather than asked what they would like to do” (p.192). Such studies suggest that implicit biases may predispose healthcare providers to unfairly assess a patient’s competency.

If a physician believes a patient lacks competency, or if a physician has internalized nefarious stereotypes about certain patient groups, then the informed consent process may be negatively impacted and the patient's ability for autonomous action may be derailed from the onset.[19] As demonstrated by the studies cited in the above paragraph, physicians who doubt patient competency may feel less inclined to engage in a meaningful dialogue with their patients or to entertain patient questions, or a physician may adopt an overtly paternalistic attitude that discourages the patient from asking questions or critically considering treatment options in light of the patient's own values and beliefs.

In essence, the court's defense of physician authority fails to reckon with issues of medical paternalism, a problem that can carry added weight for oppressed groups. McLeod and Sherwin (2000) speak to this point when they write:

> The exercise of paternalism is especially problematic when applied to patients whose autonomy is reduced by virtue of their history of oppression. Oppression involves unjust distributions of power, and health-care settings are sites of very uneven power differentials. If health-care professionals, especially physicians, further consolidate their already disproportionate power in relation to patients, especially those from oppressed groups, they exacerbate a problematic power differential and further reduce the already limited autonomy of their patients. (p.267)

Insofar as informed consent is intended to diffuse physician paternalism and enhance patient autonomy, it is important to recognize the import of social bias when interacting with patients from oppressed social groups. Yet, this recognition is missing not only in legal formulations of informed consent, but in Katz's (1984) critique of legal discourse, as well.

In short summation, the courts' delimitation of informed consent in terms of disclosure and negligence produces an impoverished articulation of informed consent. More specifically, judicial articulations of informed consent disproportionately deify physician insight, they fail to recognize the value of patient perspectives, and they ultimately defend a paternalistic model of medical decision-making. In general, the courts' consideration of informed consent is primarily driven by the need to clarify the legal parameters of medical liability, and the court's articulation does more to shore up and protect the physician's authority than it does to facilitate patient involvement in the medical decision-making process.

Informed Consent in Biomedical Ethics

A second articulation of informed consent is found in biomedical ethics. Tom L. Beauchamp and James F. Childress (2009) best demonstrate this articulation in their text, *Principles of Biomedical Ethics*, where they define informed consent as "an individual's *autonomous authorization* of a medical intervention or of participation in research" (Beauchamp & Childress, 2009, p.119).[20] The second use of informed consent, informed consent "as autonomous authorization" (Faden & Beauchamp, 1986; Beauchamp & Childress, 2009), exceeds legal articulations by introducing a more comprehensive list of qualifying criteria that targets a specific set of actions within the clinical setting.

For Beauchamp and Childress (2009), the legal articulation of "informed consent" is inadequate, and they argue in favor of a definition that stresses patient competency, understanding, and voluntary action. More specifically, they argue that an informed consent occurs “if and only if a patient or subject, with substantial understanding and in absence of substantial control by others, intentionally authorizes a professional to do something quite specific” (p.119). For Beauchamp and Childress (2009), a physician who allows a patient to sign a consent form without the patient *adequately* understanding her medical condition, or without a sure sense that the patient’s decision is voluntary, may meet the legal or institutional requirements for informed consent, but the act of consent cannot be considered an “autonomous authorization.”

Whereas the legal formulation of informed consent focused almost exclusively on the disclosure of risks and benefits, Beauchamp and Childress (2009) analyze informed consent in terms of seven constitutive elements. They outline these elements as follows:

I. Threshold Elements (preconditions)
    1. Competence (to understand and decide)
    2. Voluntariness (in deciding)
II. Information Elements
    3. Disclosure (of material information)
    4. Recommendation (of a plan)
    5. Understanding (of 3 and 4)
III. Consent Elements
    6) Decision (in favor of a plan)
    7) Authorization (of the chosen plan) (pp.120-121)

In general, Beauchamp and Childress’ list can be read as a double effort to expand informed consent beyond their legal predecessor’s focus on disclosure, and to formulate the conditions requisite to an “autonomous authorization.”

Beauchamp and Childress (2009) address the ethical dimensions of the doctor-patient relationship more deeply than legal formulations of informed consent, and their framework reflects a richer understanding of the dynamics that structure and complicate practices of medical decision-making. Yet, their understanding of informed consent continues to pose a number of problems. More specifically, their articulation is problematic for at least two reasons that I will consider here: a) they reduce patient autonomy to a momentary and episodic choice, and b) they focus primarily on the actions of the healthcare provider and fail to adequately consider and engage the value and import of patient perspectives. Consequently, the articulation of informed consent advanced by Beauchamp and Childress overlooks the impact of socio-political power upon episodic choices, and it privileges the perspective of the healthcare provider over that of the patient.

To begin, Beauchamp and Childress (2009) delimit autonomy to a specific choice. In terms of autonomy, they state that their focus is on "autonomous choice rather than on general capacities for governance and self-management" (p.100). To flesh out this distinction, they call attention to the possibility that it is possible for a person who is "self-governing" to make a nonautonomous choice, as in cases of coercion or "other conditions that restrict their options" (p.100). Conversely, it is also possible for a person who lacks a general capacity for autonomy to make a momentary autonomous choice. A prisoner, for example, can still make decisions that reflect a certain degree of autonomy—like "making a phone call" (Beauchamp & Childress, 2009, p.100)—even if the general structure of their life lacks autonomy. According to Beauchamp and Childress, it makes sense to delimit their focus to specific choices because a general capacity for autonomy does not necessarily guarantee an autonomous choice, and their point of concern is the one-time choice that occurs in the clinical arena when a patient authorizes a medical procedure. Thus, they evaluate informed consent in terms of "autonomous choice" rather than "general capacities."

Importantly, my argument is not that Beauchamp and Childress' distinction between autonomous choice and a general capacity for autonomy is faulty. They are correct that it is possible for someone who generally lacks autonomy to make an autonomous choice, or vice-versa.[21] Rather, my problem with their articulation of informed consent as a specific episodic choice is that they fail to consider the impact of wider social structures upon that choice. As Anne Donchin (2000) observes, "in Beauchamp and Childress' account, respect for autonomy is constructed around micro-level considerations and isolated . . . from macro-level, societal issues" (p.238). That is, restricting their analysis of autonomy to a single choice prevents Beauchamp and Childress from adequately recognizing the relationship between an individual's medical choice and the wider political structures within which such choices occur.

Here, feminist theories of relational autonomy are useful in illuminating the theoretical weaknesses associated with Beauchamp and Childress' constricted focus.[22] In a nutshell, to argue that autonomy is relational is to argue that the capacities and skills that facilitate autonomous actions are engendered, nurtured, and exercised in a social environment (Sherwin, 1998, p.36).[23] Put more simply, relational autonomy means autonomy is socially constituted (McLeod, 2002, p.37). Although there are important differences that distinguish distinct relational approaches to autonomy, feminist models of relational autonomy agree that understanding an individual's capacity for autonomous choice requires some understanding of that individual's social location.[24] Natalie Stoljar (2011) astutely captures this point: "Relational conceptions emphasize that agents are situated in historical, social, class, race and gender contexts. The agent's social situation has an impact not only on her identity and self-conception but also on the nature of important capacities like autonomy" (p.376). If autonomy is dependent on social relationships, then recognizing and analyzing autonomy requires sensitivity to the practices and dynamics that structure social relationships, and to the ways race, gender, class, and other aspects of identity intersect with social prejudices to create barriers to autonomy.

In general, a feminist model of relational autonomy broadens the range of what is necessary for an autonomous medical decision, and it suggests that respecting and operationalizing a patient's autonomy requires a more panoramic view than what is allotted in Beauchamp and Childress' (2009) account. Although cognitive capacities such as rationality, deliberation, reflection, and understanding are necessary skills for autonomy, feminist thinkers have demonstrated that the functionality of these skills depends upon other socially learned capacities. For example, Natalie Stoljar (2011, p.378) and Carolyn McLeod (2002) argue that "self-referring attitudes" such as self-trust or self-esteem, are also foundational to autonomous choices.

In *Self-Trust and Reproductive Autonomy* Carolyn McLeod (2002) defines self-trust as “an attitude of optimism about our own competence and moral integrity” (p.5). According to McLeod, to reflect on what ones “truly believes,” one must have some degree of self-trust.[25] If an agent distrusts herself, she may be unable to recognize the value of her beliefs and goals, and she may lack the confidence to articulate and act upon her own desires. Moreover, without the capacity for self-trust, patients may be unable to direct other capacities like understanding and voluntariness in the direction of an autonomous choice.

According to McLeod (2002), self-trust is constituted and cultivated through social interaction. Insofar as individuals are positioned asymmetrically in society, it follows that capacities like self-trust, and consequentially autonomy, develop asymmetrically as well. Living in a social environment that discourages practices of self-contemplation for some agents may interfere with that agent’s autonomy skills. Likewise, such erosive factors as sexism, racism, classism, ableism, and homophobia can dissolve one’s self-trust and diminish one’s confidence in their own moral competency.

It is, therefore, important to recognize a patient’s social position over and beyond the momentary clinical encounter, particularly when dealing with patients who have been negatively impacted by gender socialization. Even in cases where adequate and accurate information has been provided, and the agent has met standards of competency, an agent’s autonomy skills may be frustrated or short-circuited if they lack self-trust. Given that women’s decisions have faced historical hostility and disdain from a variety of sources, their capacities for self-trust may be particularly vulnerable. For poor women, queer women, or women of color these vulnerabilities may be compounded by other axes of oppression.

As way of specific example, a woman may desire an abortion because she is disinterested in parenthood. However, if she has been socialized to doubt her own moral capacities then she may have difficulty explaining or defending her choice to her physician. If she inhabits a social context riddled with pronatalist stereotypes, then she may worry that her doctor will meet her abortion decision with derision or scorn. She may feel uncomfortable discussing abortion with an unknown professional in a clinical setting, and her discomfort may translate into disquietude or brusqueness. Consequently, she may come across as confused and uncertain, despite a deep desire to avoid parenthood. In order to recognize that the patient's uneasiness stems from a lack of self-trust, however, the provider will need a richer understanding of the patient's interpersonal relationships and social context. Otherwise, the provider may misinterpret the patient's lack of self-trust for deep moral conflict over the abortion decision, a misreading that could further frustrate the patient's ability to exercise her autonomous medical decision.[26]

Yet, provider insight regarding self-trust is unlikely to occur when the domain of concern is a mico-level choice, as in Beauchamp and Childress'(2009) account. Of course, time and resources perennially limit practices of informed consent, and it is unreasonable to expect every healthcare provider to work up a comprehensive evaluation of a patient's social and psychological profile. But at the very least, more attention to macro social-structures is necessary than what is allotted in Beauchamp and Childress's model of informed consent as a micro-level authorization.

A second shortcoming of Beauchamp and Childress' (2009) model of informed consent stems from their narrow focus on provider conduct. Of course, their book was written for healthcare providers, so it is understandable that their discussion would focus primarily on provider conduct. The problem, however, is that they fail to adequately discuss the unique issues that structure patient conduct during the medical decision-making process. In general, they articulate informed consent almost exclusively in terms of the healthcare provider's actions and responsibilities, and they are mostly silent on matters specific to the patient's decision-making process. As way of example: "Respect for autonomy," they argue, "obligates professionals in health care and research involving human subjects to disclose information, probe for and ensure understanding and voluntariness, and to foster adequate decision-making" (p.104). By delimiting the principle of autonomy to professional obligations in the clinical context, Beauchamp and Childress restrict their understanding of autonomy to the comportment of the physician: Has the provider disclosed the proper information? Has the provider refrained from coercive influence? Has the provider assessed patient competency? Susan Dodds (2000) notes that "bioethics is primarily concerned with the proper moral conduct of health-care providers" (p.216) and tends to overlook "the decision-making process *of the patient*" (p.214). Although provider conduct is surely a necessary ingredient to patient autonomy, it is only one part of the equation.

One of the issues with Beauchamp and Childress' (2009) limiting focus is that it forecloses the ability to recognize how various social forces may interfere with or limit a patient's ability to make autonomous medical decisions. The decision-making processes of the patient can be complicated and problematized by a number of elements, as discussed above with the example of self-trust. A provider may supply adequate information, adopt a stance of noninterference, and be confident that the patient is competent to make a medical decision, but if the patient lacks self-trust, for example, then her autonomy may be thwarted (McLeod, 2002). In order to recognize this obstacle, however, the provider will need to focus on the patient's actions and comportment in addition to their own, a focus that is not adequately recognized in Beauchamp and Childress' model.

Another problematic consequence of Beauchamp and Childress' (2009) focus is that it obscures the valuable insights that patients themselves bring to the informed consent process. Although focusing on the actions of healthcare professions is certainly necessary, this focus becomes precarious when the patient is conceptualized as an object that is acted upon, rather than a subject who brings a privileged perspective to the decision-making process. Insofar as the informed consent process aims to bring the patients' values to voice during the medical decision-making process, the informed consent process is predicated on the principle that the patient holds an epistemic advantage in terms of recognizing what those values are. By focusing primarily on provider conduct, however, Beauchamp and Childress replicate one of the problems with legal articulations of informed consent: their focus eclipses the epistemic specificity of the patient, a major oversight for a model whose founding purpose was to bolster patient autonomy and amplify patient involvement.

To be fair, Beauchamp and Childress (2009) do recognize the “moral” (p.124) benefits of tailoring information disclosure to the individual needs of the patient, a method that requires providers to attend to patient perspectives. In bioethics, this standard of disclosure is known as the “subjective standard,” and it “judges adequacy of information by reference to the specific informational needs of the individual person” (Beauchamp & Childress, 2009, p.123). One of the values of the subjective standard is that it requires providers to acquaint themselves with patients’ unique values and circumstances. However, Beauchamp and Childress (2009) also argue that the subjective standard “does not suffice for either law or ethics,” (p.124). In dismissing the subjective standard as impractical, they miss an opportunity to advance a theoretical framework that encourages providers to recognize, respect, and engage patients’ specific informational needs and personal values, an oversight that carries added consequences in the reproductive context.

Here, abortion is an excellent example of how patients can have insights or informational needs that exceed the providers’ expertise. The deep personal nature of abortion means that many women choose to terminate a pregnancy for reasons that physicians can neither immediately know nor anticipate. For example, a woman may be struggling economically, or a woman may be working to end an abusive relationship. In such situations, childbirth could carry insufferable consequences, yet this relevant information falls outside of the physician’s epistemic purview. Although physicians’ professional expertise certainly awards them a unique insight on many matters, specialized knowledge does not amount to medical omniscience, and there is a particularly clear limit to provider insights in the case of abortion where patient values are often the determining factor in choosing an abortion. The necessity of engaging patient values in the abortion context, as well as the value and benefit of deploying the subjective standard in determining informational disclosure, are topics that will be further discussed in Chapter Five. For the time being, however, my primary point is that the framework advanced by Beauchamp and Childress (2009) in *Principles of Biomedical Ethics* does not adequately attend to the experiences and perspectives specific to the patient within the clinical context, an oversight that could potentially frustrate the autonomy of some patients.

In conclusion, Beauchamp and Childress (2009) set a higher bar for autonomy than what is offered in legal discourse. Yet, their account of informed consent, and consequently their account of autonomy, is still too lean. Like their legal forefathers (sic), Beauchamp and Childress perpetuate the valorization of physician authority and they fail to situate informed consent within the context of kyriarchy, to use a term that is gaining popularity with third-wave feminists.[27] Although they inarguably highlight many of the moral pitfalls that threaten practices of informed consent, and they certainly broaden the moral meaning of informed consent beyond its initial legal interpretation, their analysis ultimately limits informed consent to a one-time action that focuses primarily on the actions of the provider. Consequently, their focus overlooks the import of social oppression upon patient perspectives and devalues the specificity of patient insight. When theories of informed consent fail to contextualize medical decisions in the context of greater social structures, then minority groups suffer added consequences. We should expect more from liberatory concepts designed to enhance the autonomy of all patient groups.

Informed Consent and Shared Decision Making

A third articulation of informed consent is informed consent as “shared decision making” (Berg et al., 2001, p.15). More than the previous two articulations, this sense of informed consent is concerned with neutralizing, or at least diminishing, the power imbalance inherent to medical dialogue and ensuring that the medical decision is a collaborative process that balances “the rights and responsibilities of patients and health care professionals” (The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, October 1982, p.35). Informed consent as shared decision making conceptualizes informed consent as a specific form of dialogical exchange, one that differs from previous articulations with its emphasis on the normative dimensions of patient-physician collaboration. In the words of Jay Katz (1984), this model views informed consent as “a joint undertaking that depends more on the nature and quality of the entire give-and-take process than on whether a particular disclosure has or has not been made” (p.84). Of the three articulations of informed consent that I consider in this section, I find this model the most promising in terms of abortion care because it recognizes and underscores the indispensible value of patient participation.[28]

Although informed consent as shared decision making shares some features with other articulations of informed consent, it also departs from those articulations in important ways (Whitney, McGuire, & McCullough, 2004, p.55). According to some theorists, "informed consent cannot be reduced to shared decision making" (Beauchamp & Childress, 2009, p.118; Faden & Beauchamp, 1986, p.279), primarily because shared decision making demands a collaborative model of dialogical interchange that is not appropriate for all medical decisions. Sometimes physicians will provide patients with medical information and patients will autonomously authorize a medical intervention without engaging in the collaborative partnership that is the hallmark of shared decision making. According to Whitney et al. (2004), shared decision making is only appropriate in situations of medical uncertainty where multiple options exists; informed consent, on the other hand, is appropriate in situations of medical risk where only one viable option exits. Other theorists worry that shared decision making may compel patients to sideline their own desires in an effort to find common ground with their physician (Berg et al, 2001, p.17), or vice versa. In short, informed consent as shared decision making envisions a particular mode of medical dialogue that the other articulations of informed consent do not promote.

In this section, I focus on the idea of shared decision making as articulated by The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982). First authorized by Congress in 1978, the Commission was tasked with unpacking the ethical dimensions of various issues endemic to the clinical and treatment realms. The Commission published its work in nine reports (Faden & Beauchamp, 1986, p.97), and its 1982 report *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* addressed the issue of informed consent explicitly. In their first chapter, “Informed Consent as Active, Shared Decisionmaking” (p.15) the Commission (1982) draws on the work of Jay Katz to argue that shared decision making “is the appropriate ideal for patient-professional relationships that a sound doctrine of informed consent should support” (p.30).

Commonly recognized as the “earliest mention” (Elwyn et al., 2012, p.1361) of shared decision making, the Commission’s influential report advanced a robust model of dialogical interaction between providers and patients. Since the publication of the Commission’s report, bioethicists have developed and expanded the idea of shared decision making beyond its discursive inception, in many cases offering detailed strategies and guidelines for implementation (Charles, Gafni, & Whelan, 1997; Charles, Gafni, & Whelan, 1999; Elwyn et al., 2000; Elwyn et al., 2012; Towle et al., 1999). Although the Commission’s report marks an older instance of informed consent as shared decision making, their underlying values and goals are consistent with contemporary discussions; in general, the Commission’s report is a touchstone for discussions of shared decision making, and it provides one of the most comprehensive overviews of shared decision making to date.

In their report, the Commission continues to develop the ethical implications of informed consent beyond its legal origins. Throughout the course of their report, the Commission deploys liberal humanist language of individual rights and self-determination to justify the institutionalization of informed consent policies. For example, the Commission (1982) explains:

> Current requirements for informed consent owe much to the legal system, but the values underlying these requirements are not merely legal artifacts.

> Rather, they are deeply embedded in American culture and the American character; they transcend partisan ideologies and the politics of the moment. Fundamentally, informed consent is based on respect for the individual, and, in particular, for each individual's capacity and right both to define his or her own goals and to make choices designed to achieve those goals. (p.17)

By locating the values that underwrite informed consent in "American culture," the Commission amplifies the ethical-political implications of informed consent. The concept is not simply a tool to assess medical liability; it is now part of the institutional machinery that reflects and facilitates cultural norms.

In many ways, the Commission demonstrates a heightened sensitivity to patient individuality and informational needs. For example, the Commission (1982) argues that the substantial content and scope of what constitutes "appropriate information" will vary in relation to context (p.70), and the Commission stresses the need for physicians to tailor the disclosure process to "the special needs of particular patients" (p.70) and "to elicit and discuss the values of their patients" (p.71). Likewise, the Commission (1982) recognizes that both the patient and the healthcare professional bring "to the relationship special knowledge and perspectives that can help to clarify for both parties what is actually at issue in any decision to be reached" (p.39). Thus, informed consent as shared decision making is sensitive to the fact that ethical problems change relative to unique patient needs. For all of these reasons, I find informed consent as shared decision making to be the most promising and liberatory articulation of informed consent.

Nevertheless, the Commission's (1982) report poses a number of theoretical concerns, specifically in the context of abortion. Like Beauchamp and Childress (2009), the Commission employs general criteria to demarcate the informed consent process. More specifically, the Commission (1982) believes that the following three criteria are necessary for "effective patient participation": decision-making capacity, voluntariness, and information (p.55). Although the Commission (1982) recognizes complicated cases, it continuously treats these criteria as stalwart sentinels of patient autonomy. Although a formulaic approach to informed consent is not necessarily problematic, it can become problematic when it fails to consider how models premised on universalized criteria can shadow specific issues relevant to vulnerable patient groups.

Once again, theorists of feminist relational autonomy are instructive in considering the theoretical deficiencies that threaten the demarcation of informed consent with generalized criteria. In this section I focus my critique on the Commission's (1982) use of "information" and "voluntariness," as I have already unpacked some of the problems with the criteria of "decision-making capacity" during my discussion of legal articulations of informed consent. In the course of doing so, I intend to demonstrate what is missing from the Commission's articulation of informed consent as shared decision making.

To begin, information is clearly a necessary ingredient to patient autonomy and to practices of informed consent. Yet, an uncritical use of "information" can be problematic if healthcare providers forget that "information" itself is a constructed concept. The processes through which information is identified and the manner in which information is delivered are subject to number of social forces, and in the ethically complex world of medical care there is no single equation to determine the correct content and purveyance of informational exchange.

Although some of the informational content physicians need to share with their patients may be straightforward, such as the statistical likelihood of success of a certain medical procedure, other pieces of information desired by the patient may not be as obvious. In such cases, problems can arise if the information only reflects, or is only relevant to, the lives of the socially privileged. As Susan Dodds (2000) who draws on the work of Susan Sherwin (1998) writes:

> [I]nformation made available to patients is inevitably that information deemed relevant by the health professionals who care for them; but the large gap between the life experience of health professionals, who are relatively privileged, and their sometimes seriously disadvantaged patients makes the likelihood that the former will provide information that meets the specific needs of their patient rather slim. (p.224)

As way of specific example, a woman of color who is trying to decide between an abortion or an adoption may be influenced by the fact that children of color are disproportionately represented in the foster are system (U.S. Department of Health and Human Services, September 2013, p.2, p.6; Summers, Wood, & Donovan, May 2013, p.1). However, it may not occur to economically privileged white physicians to share this information with their patient while they discuss her unplanned pregnancy; indeed, some physicians may not even be aware of the racial inequalities that shape foster care in the United States. Yet, for some women this fact may be particularly relevant as they decide how to manage an unwanted pregnancy.

It is important to note that the failure to provide relevant information should not be attributed solely to a physician's lack of perception. Indeed, the information the physician encounters is also the product of various political forces. Susan Sherwin (1998) speaks to this point when she writes, "research, publication, and education policies largely determine what sorts of data are collected and, significantly, what questions are neglected; systematic bias unquestionably influences these policies" (p.27). If patient autonomy centers on the process of information purveyance, however, and if the information itself is limited in scope and content, then the patient's autonomy may be jeopardized from the outset.

Recent work in feminist bioethics also raises concerns about the exchange of information in the course of medical dialogue. Janet Farrell Smith (1996) has argued, for example, that the "information-transfer" model of communication that dominates medical discourse is problematic because it treats information as transparent fact and, thereby, fails to account for the normative tones that are inevitably wrapped up with any informational package (p.188).[29] Smith (1996) argues that the meritorious goal of communication may be compromised by the healthcare provider's preoccupation with transferring information, as well as the prescriptive elements that significantly and sometimes subtly shape dialogical interaction. As Smith (1996) writes, "patients may perceive 'what the doctor says' as factual and final. Because of the authority physicians have in our society, a patient may hear as an imperative or command what the physician-speaker intends only as an factual assertion or one among many options" (p.189). In such cases, the discussion of information may exert counterproductive pressures upon the patient's ability to assess information. For example, a physician's statement that a fetus has a "well-developed diaphragm" could code for the normative claim that the abortion decision is immoral because a being with a "well-developed diaphragm" has a "right to life." Although the Commission (1982) shows a heightened sensitivity to the variability of patient needs, it promotes an inadequate treatment of "information" by failing to robustly discuss how socio-political power impacts what gets recognized and demarcated as medical information.

A second problem that arises with the Commission's (1982) articulation of informed consent concerns their criterion of voluntary action. In general, the Commission (1982) fails to adequately reckon with the ways social forces can impose subtle limits and restrictions on voluntariness. Although the Commission (1982) recognizes that medical power can inadvertently intrude upon patient will (p.63, p.65) and that genuine choice may be foreclosed if the provider capitalizes upon "disparities in knowledge, position and influence" (p.66), they fail to robustly discuss how gender, race, and other social identities intersect with medical power to complicate concepts like voluntary choice.

Recent feminist work on "adaptive preferences," or cases where an individual molds her preferences to fit her available options, is instructive in illuminating shortcomings with the Commission's (1982) approach to voluntary action. Sometimes discussed under the rubric of psychological oppression (Bartky, 1990, pp.22-32), internalized oppression (Cudd, 2006), or deformed desires (Supersen, Spring 2014), adaptive preferences have received ample attention in feminist literature, perhaps most notably by Martha Nussbaum (2001) and Armartya Sen (1995). In general, feminist discussions are sensitive to the gendered dimensions of adaptive preferences.

As way of example, Nussbaum (2001) references conversations she had with two women while visiting Ahmedabad, Gujarat, India and Trivandrum, Kerala, India. One woman, Vasanti, tolerated domestic abuse at the hands of her husband for years because she believed it was "part of a woman's lot in life" (Nussbaum, 2001, p.68). Similarly, Jayamma did not protest discriminatory wages because "it was just the way things were . . . she did not waste time yearning for another way" (Nussbaum, 2011, p.69). In both cases, the women adapted their beliefs and choices to accord with the circumstances they found themselves in. Although all thoughts, desires, and values are socially formed, adaptive preferences develop in the context of social injustice and benefit a social order at the expense of the subject. In a just society, it is unlikely that these women would have voluntarily chosen domestic abuse or wage discrimination. Indeed, Nussbaum uses the fact that each woman later revolted against her specific circumstances as evidence that these "preferences" are adaptive, not autonomously chosen.

The phenomenon of "adaptive preferences" complicates the Commission's (1982) concept of autonomy and voluntary action. In their model, people's desires, beliefs, or choices are valuable just because they are that person's actual beliefs or desires. So long as the (competent) patient has been provided with accurate and sufficient information, and so long as there is no threat of external coercive forces, then the patient's choices are respected because they (purportedly) reflect the patient's own beliefs and desires. In the case of adaptive preferences, however, a patient may be unable to make distinctions between desires that promote her well-being and those that replicate and reproduce ideologies that undermine her well-being. She is not necessarily acting irrationally, incompetently, or under coercion insofar as her choices may be rationally perceptive (albeit subjugated) responses to an unjust situation. Yet, it would be incorrect to call the patient's decision "voluntary" insofar as it was driven by norms that reflect an unjust social order rather than her own well-being, even if she identifies these norms as "her own." Part of what makes adaptive preferences so problematic is that their deep integration into the agent's belief system makes it difficult for the agent, or others, to recognize them as socially constructed.

In the case of reproductive healthcare, for example, a woman who comes from a socially conservative family background that vilifies abortion and typecasts women as "mothers" may internalize the belief that carrying a pregnancy to term is necessary, even if the pregnancy jeopardizes her own health or life. Although she does not choose motherhood under threat of execution and she may claim she is freely willing to carry a life-threatening pregnancy to term, there is something strange in qualifying her choice as voluntary insofar as it was made to accommodate a system of gender oppression. In such cases, women may benefit from enhanced dialogue with a provider who is cognizant of her greater social circumstances and is willing to help the woman critically reconsider her medical choices in light of the influences exerted by social values that stigmatize abortion. In order for such a dialogue to even occur, however, the provider must be sensitive to the reality of gender subordination and to the fact that systems of gender oppression can subtly constrain and deform women's voluntary choices to align with sexist standards, a sensitivity that is missing in the Commission's (1982) report.

Of course, theories of adaptive preferences complicate all models of medical decision-making, including feminist ones. Insofar as all individuals are socially constituted, the ideal of voluntary choice is problematized. However, my point here is not that healthcare providers should incessantly worry about the sway of adaptive preferences, nor do I mean to suggest that women are incapable of making voluntary choices in the reproductive context. Rather my point is simply that in societies marked by social and political injustice, agents will adopt a variety of techniques to survive, and that a recognition of these techniques may require a familiarity with the realities of sexism. Consequently, healthcare providers should practice a more heightened sensitivity to the intersection of social oppression and patient choice than what is granted in the Commission's (1982) discussion of voluntary choice.

In general, the Commission (1982) relies upon and mobilizes a generic model of patient subjectivity, and it displays an excessive confidence in the principles that guide the demarcation of information. As feminists have long argued, purportedly gender-neutral models of both subjectivity and knowledge reflect and consolidate the perspectives and interests of white, heterosexual, middle-class, men. Although the

Commission's (1982) articulation of informed consent as shared decision making advances a more ethically sensitive concept of informed consent than what is proffered in legal discourse or Beauchamp and Childress' (2009) account, their failure to adequately wrestle with the import of social differences and social power ultimately attenuates their theoretical apparatus.

Conclusion to Chapter One

The objective of this chapter has been to illuminate various weaknesses inherent in the founding conceptions of informed consent. Rather than offering universal value for all social groups at all times, informed consent suffers from a series of theoretical deficiencies. When you mix abortion (an issue historically riddled with narratives of women's moral ignorance and inferior epistemic capacity) with the doctrine of informed consent, (a doctrine that presupposes and reinstates relations of power and authority even as it seeks to manage these), you have a perfect storm for practices that fail to recognize and operationalize women's reproductive decisions. Consequently, it is inadequate to simply argue that abortion-specific "informed consent" practices violate informed consent doctrine. If our goal is to restore full reproductive autonomy to women, then we must also recognize how the concepts of informed consent and patient autonomy have themselves been compromised by their founders' failure to recognize the import of social and political oppression.

Informed consent may originally have been devised to protect patient autonomy, but such good intentions are often insufficient or inadequate when it comes to enacting ethical goals. Margaret Urban Walker (2007) has insightfully argued that the very practice of moral theorizing can help to authorize the position of a few politically elite and facilitate an authoritarian politics that is rhetorically veiled by the very language of morality itself. In this sense, widespread ethical practices are often a function of those who have access to, or control over, the institutional structures that legitimate, broadcast, and reinforce moral theories. This is not reason to discard ethical concepts, but it is reason to reconsider ethical concepts from the perspective of marginalized or disenfranchised groups. Hopefully, the rhetorical cartography conducted in this chapter will have illuminated some of the shortcomings that have compromised dominant articulations of informed consent, thus pointing the way to more emancipatory practices of medical decision-making.

CHAPTER TWO

THE SUPREME COURT, INFORMED CONSENT, AND ABORTION

Chapter One explored the doctrine of informed consent as it is most broadly construed, but it did not address the intersection between informed consent and abortion discourses specifically. In Chapter Two, I turn my attention to abortion discourse, and I consider the United States Supreme Court's assessment of abortion-specific "informed consent" laws. This chapter's focus on judicial rhetoric will show how the Court problematically configures informed consent vis-à-vis abortion and it will help to explain the Court's creation of a legal environment that sanctions government intrusion upon women's abortion decisions.

In general, the judicial origins of abortion-specific "informed consent" regulations are typically located in the Supreme Court case, *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) (Cockrill & Weitz, 2010, p.12; Joyce, Henshaw, Dennis, Finer & Blanchard, April 2009, p.3; Manian, 2009, p.8; Richardson & Nash, Fall 2006, p.6). In this historic decision, the Court rejected the standard of strict scrutiny previously used to assess the constitutionality of abortion regulations and replaced it with the more lenient "undue burden" standard. Consequently, states were permitted to institute a wider range of abortion regulations, culminating in today's harmful abortion-specific "informed consent" laws.

Indubitably, the *Casey* decision ushered in a new era of abortion regulation. However, in this chapter I complicate the common claim that "informed consent" laws originate with the *Casey* decision. Although this is not untrue, and I do spend considerable time discussing *Casey* in this chapter, I argue a single focus on *Casey* is myopic because the Court's problematic treatment of informed consent within the abortion context begins long before the *Casey* decision. Therefore, I argue that a robust understanding of abortion-specific "informed consent" laws requires a more historical critique of judicial rulings on abortion regulations than what is generally recognized in the (limited) literature critiquing "informed consent" laws.

Chapter Two develops my argument begun in Chapter One that judicial discourse offers a theoretically underdeveloped account of informed consent. By tracking the Court's articulation of informed consent from *Roe* through *Casey*, I will demonstrate that the Court is either a) concerned with protecting the physician's autonomy, or b) concerned with defending a state's right to intrude upon the informed consent process. That is, the Court articulates the abortion decision as either a medical decision made by the physician or as a moral decision that requires state intervention. As we will see, women are never granted the status of primary decision-maker vis-à-vis abortion. Instead, the Court routinely configures women as secondary decision-makers who require some form of supervision, a configuration that problematically influences the Court to interpret informed consent as a means to monitor women's reproductive decisions. Thus, although the Court's interpretation of informed consent changes over time, their distrust of women remains a constant throughout abortion jurisprudence.

This chapter's focus on the Court's treatment of informed consent vis-à-vis abortion is important for several reasons. For one, spotlighting entrenched articulations of women's moral inferiority within judicial discourse will acquaint us with the background prejudices that shape the Court's assessment of "informed consent" regulations, thereby positioning us to better challenge the legal frameworks that compromise women's reproductive autonomy and justify punitive "informed consent" laws. Secondly, this chapter provides a unique perspective on informed consent literature as it shows how the Court's failure to articulate a robust jurisprudence of informed consent in general carries added consequence for women seeking to terminate an unwanted pregnancy. That is, the theoretical weaknesses that haunt early articulations of informed consent, weaknesses that were discussed in Chapter One, are amplified within abortion jurisprudence.

Roe v. Wade and Abortion Decision Making

The Court's weak configuration of women's decision-making capacity within the abortion context originates with *Roe v. Wade* (1973). In this landmark decision, the Court delimited abortion as fundamentally a "medical decision" and it stressed the physician's authority in making this decision. Although a thorough analysis of *Roe* is beyond the scope of this project, I provide a brief summary of the Court's 1973 divisive ruling in order to illuminate the origins of the Court's problematic analysis of informed consent and abortion decision-making.

At issue in *Roe* was a Texas law that prohibited abortion except in cases to save the woman's life. At the time, similar laws governed a majority of states.[30] In its final ruling, the Court opined that criminal abortion statutes violate a woman's right to privacy as it flows from the Due Process Clause of the Fourteenth Amendment.[31]

In his majority opinion, Justice Blackmun argued that a categorical prohibition on abortion at any point in the pregnancy was unconstitutional, and that a state's right to regulate abortion depended, instead, on the stage of pregnancy. The Court explained:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.[32] (as cited in Shapiro 2007, p.43)

The three "stages" of pregnancy detailed above became known collectively as "the trimester framework," and this framework irrevocably changed the landscape of abortion regulation.

Prior to *Roe*, women could obtain legal abortions. To do so, however, women either had to find a sympathetic doctor who was willing to break the law, or plead their case before an authorized medical panel, requirements that essentially hinged the abortion decision upon physician power. *Roe*, therefore, unquestionably awarded women more latitude to govern their reproductive lives and *Roe* mitigated the power previously possessed by doctors.

Nevertheless, the Court's logic in *Roe* continued to stress medical authority, as evidenced in the above passage where the Court claimed, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician" (as cited in Shapiro 2007, p.43). Although *Roe* represents a pivotal victory in the women's liberation movement, legal scholars have correctly noted that the rhetoric of *Roe* says very little about women's moral autonomy per se (Atkinson, 2011, p.658; Daly, 1995; Manian, 2009, p.9). Instead, the Court continued to privilege the role of the physician over that of the woman (Daly, 1995, p3).

The Court's privileging of medical authority is evidenced, for example, when it argued, "The abortion decision in all its aspects is inherently, and primarily a medical decision, and basic responsibility for it must rest with the physician" (as cited in Shapiro, 2007, p. 44).[33] Likewise the Court purported, "For the period of pregnancy prior to [viability], the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated" (as cited in Shapiro, 2007, p.43). Although *Roe* defended a woman's right to abortion on the basis of privacy, the Court's concern was to protect the privacy of the medical relationship, rather than the personal privacy of a woman's reproductive decisions.

Clearly there is a substantive medical component to abortion. Physicians command specialized knowledge regarding the abortion procedure, as well as the risks and benefits of abortion relative to a woman's health. Yet, the abortion decision often exceeds medical concerns, an excess that challenges the Court's view that abortion is "inherently" a medical decision. For example, many women seek an abortion for non-medical reasons, such as economic strain or a disinterest in parenthood. Pregnancy and abortion are highly specific, embodied experiences, and the need for an abortion is often a matter of personal values rather than medical needs. In this sense, women enjoy epistemic privilege vis-à-vis the abortion decision. However, by delimiting abortion as "primarily a medical decision" (as cited in Shapiro, p.44) and granting women only auxiliary status, the Court overlooked women's unique epistemic insights.

Problematically, the Court's failure to recognize women's epistemic privilege reinforces and reproduces a long cultural narrative that discredits women's knowledge by subjecting their reproductive decisions to the surveillance of others.[34] Evelyn Atkinson (2011) has correctly observed, "the physician under abortion's legalization plays the same role as under abortion's criminalization: that of social and medical arbiter of the proper reasons for aborting a pregnancy" (p.660). In other words, the decriminalization of abortion was less about the promotion of women's autonomy and more about preserving medical authority, at least within judicial rhetoric.

Notably, the Court's valorization of physician authority in *Roe* echoed early court rulings on informed consent. That is, the Court's articulation of abortion as a medical decision is symptomatic of the Court's traditional reverence for the medical community. It is also important to locate the Court's decision within the socio-historical context of medical practice in which *Roe* was penned. At the time of *Roe,* medical practice was still very much governed by paternalistic models of medical decision-making, despite the introduction of informed consent laws in the 1950s. Given the historic predominance of paternalism within medicine, it is not surprising that the Court argued that the abortion decision ultimately belonged to the doctor, or that the woman's right to abortion was "not absolute" (as cited in Shapiro, 2007, p.36). In this sense, the paternalism of *Roe* mirrors the paternalism that governed medical decision-making in general.

In terms of reproductive rights, a further problem followed from the Court's articulation of abortion as a "medical decision." Insofar as medical practice is itself subject to state regulation, then abortion could be subjected to state regulation, as well. If antiabortionists could infiltrate standard medical protocol, such as the informed consent process, then it would be possible to impose legal hurdles to abortion without directly violating the logic of *Roe*.[35]

It is, therefore, not surprising that in the wake of *Roe*, states immediately began testing the limits of abortion regulation, an experiment that emerged under pressure from antiabortion groups. Judith Blake (1977) reports that 260 abortion bills were introduced in state legislatures in the first year of legalization, and 189 bills were introduced in 1974 (p.46). Craig and O'Brien (1993) explain, "[i]nstead of pushing for legislation that would directly challenge the principle that women have a right to choose an abortion, pro-life groups won many states over to adopting regulations that would simply cut back on the availability of abortion" (p.80). Although *Roe* prohibited regulations that interfered with medical judgment during the first trimester of pregnancy, *Roe* did not address every regulative possibility, and antiabortion forces began to exploit these silences (Kurtz, Pearson, Douglas & David, 1986).

For example, on the grounds that *Roe* did not require hospitals to perform abortions, states passed laws that banned the use of public facilities for abortions (Craig & Obrien, 1993, p.78), thereby limiting the number of facilities that could provide abortions, particularly for poor women.[36] In addition, states passed laws requiring abortions to be performed by licensed physicians and in a licensed setting (Craig & O'Brien, 1993, p.79). States also passed laws that prohibited the advertisement and promotion of abortion, as well as laws that dictated strict reporting requirements (Craig & O'Brien, 1993, p.79).

It is within this climate of enhanced regulation that early abortion-specific "informed consent" laws should be understood. Along with the other restrictive laws discussed above, states also introduced laws that required parental consent, spousal consent, and a woman's written consent. Evelyn Atkinson (2011) reports that half of the states passed informed consent statutes in the first five years following *Roe* (p. 661). Abortion rights groups quickly challenged many of these laws, thereby requiring the Supreme Court to clarify its position on abortion regulation.

In the following pages I will review three Court decisions that directly addressed "informed consent" laws*:* *Planned Parenthood of Central Missouri v. Danforth* (1976), *Akron v. Akron Center for Reproductive Health* (1983) and *Thornburgh, Governor of Pennsylvania v. American College of Obstetricians* (1987). In each of these cases, the Court's articulation of abortion as a "medical decision" played a pivotal role in its early assessment of "informed consent" laws, and the Court assessed "informed consent" laws in terms of proper medical protocol. In *Danforth,* the Court upheld a Missouri "informed consent" statute because it viewed the Missouri law as complying with standard medical practice. In *Akron* and *Thornburgh*, however, the Court rejected "informed consent" statutes that invaded and dictated physician speech. Although the Court initially overturned aggressive "informed consent" regulations, the Court articulated informed consent primarily as a tool of physicians, not as an ethical mechanism to recognize the woman's perspective and enhance her role in the decision-making process. Consequently, the Court's focus on physician autonomy eclipsed and displaced women's epistemic insight vis-à-vis abortion, and thereby, mitigated the ethical potential of informed consent within the abortion context.

Informed Consent and the Danforth Decision

The issue of informed consent vis-a-vis abortion makes its first appearance in the Court's 1976 decision *Planned Parenthood of Central Missouri v. Danforth* (1976). At issue in this decision was a Missouri abortion law that instituted a series of abortion regulations and banned certain practices (Missouri An Act Relating To Abortion With Penalty Provisions and Emergency Clause, 1974). The bill prohibited the use of saline amniocentesis, it required detailed record keeping of abortions, it dictated standards of "professional care" for the aborted fetus, and it defined the meaning of "viability."[37] In terms of the consent process, the Missouri bill required the women's written consent, her spouse's consent, and parental consent for unmarried minors. The original text of the legislation read:

> Section 3. No abortion shall be performed prior to the end of the first twelve weeks of pregnancy except:
>
> (1) By a duly licensed, consenting physician in the exercise of his best clinical medical judgment.
>
> (2) After the woman, prior to submitting to the abortion, certifies in writing her consent to the abortion and that her consent is informed and freely given and is not the result of coercion.
>
> (3) With the written consent of the woman's spouse, unless the abortion is certified by a licensed physician to be necessary in order to preserve the life of the mother.

> (4) With the written consent of one parent or person *in loco parentis* of the woman if the woman is unmarried and under the age of eighteen years, unless the abortion is certified by a licensed physician as necessary in order to preserve the life of the mother. (as cited in Legal Information Institute, n.d.a, Appendix to the Opinion of the Court, para 7)

Challengers of the Missouri law argued that it violated *Roe* by "imposing an extra layer and burden of regulation on the abortion decision" and that the meaning of the informed consent provision was "overbroad and vague" (as cited in Shapiro, 2007, p.59).

Notably, this early abortion-specific "informed consent" law did not include scripted information, nor did it compel physicians to recite antiabortion propaganda. Wood and Durham (1978) note it demanded "only a general expression of consent" and it did "little if anything beyond codifying common law rules" (p.818). In a footnote, the Court determined that informed consent in this case simply meant "the giving of information to the patient as to just what would be done and as to its consequences" (as cited in Shapiro, 2007, p.131). Notably, the Court's definition of informed consent in *Danforth* reflected the Court's traditional treatment of informed consent as a process of unilateral informational purveyance determined by the physician.

In their majority ruling, delivered by Justice Blackmun, the Supreme Court struck down the spousal and parental consent provisions, the provision that prohibited the use of saline amniocentesis, and the provision that specified the care of the fetus. However, the Court ruled that the informed consent provision was constitutional because it did not "restrict the decision of the patient and her physician" (as cited in Shapiro, 2007, p.59).

In his concurring opinion, Justice Stewart reasoned that “informed consent” regulations did not violate the Court’s trimester framework as it was established in *Roe*. Even though the Court ruled in *Roe* that the abortion decision was to be free from state regulation during the first trimester, Justice Stewart argued,

> . . . that statement was made in the context of invalidating a state law aimed at thwarting a woman's decision to have an abortion. It was not intended to preclude the State from enacting a provision aimed at ensuring that the abortion decision is made in a knowing, intelligent, and voluntary fashion. (as cited in Legal Information Institute, n.d.a, Concurrence, para 7)

In short, the Court did not believe Missouri’s “informed consent” law restricted or interfered with medical decision-making.

The Court dismissed the charge that the “informed consent” provision was too vague by arguing that vagueness was, in fact, an important part of the informed consent process. In the appendix to the majority opinion, the Court reasoned, “To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession” (as cited in Legal Information Institute, n.d.a, Appendix to the Opinion of the Court, 8). Here, the Court’s reasoning was consistent with their ruling in *Roe* that the abortion decision is primarily a medical decision that should be governed by the physician’s discretion. As Manian (2009) writes, “although the Court upheld an abortion-specific informed consent law, the Court interpreted the law to require no more or less information than what physicians should be providing before any medical procedure in accordance with the general principles of informed consent" (p.9). In the Court's eyes, Missouri's "informed consent" law simply upheld shared standards of informed consent within the medical world.

Given the Court's historical reverence for physician authority, it is not surprising that the Court's majority defended an "informed consent" regulation they viewed as befitting standard medical practice. As has been well documented, Justice Blackmun, the author of *Roe*, had deep roots in the medical world.[38] According to the Court's logic, the "informed consent" law at issue in *Danforth* allowed physicians to exercise professional judgment and professional autonomy, and it provided women with medically relevant information. The Court's defense of the informed consent process in *Danforth*, therefore, reflected their ideal of reputable physicians alerting women to relevant medical information that the physician is equipped to recognize and deliver. When Missouri's "informed consent" law is read through the lens of medical protocol, there is no constitutional violation insofar as it aligned with a legal framework devoted to safeguarding physician's medical authority, even if the authors of the Missouri law were motivated by alternative, ideological reasons.

Importantly, however, the language of *Danforth* introduced a series of fault lines into the Court's logic on abortion rights, fault lines that will later be amplified to justify deeper regulative restrictions. For example, in his majority opinion, Justice Blackmun opined:

> The decision to abort, indeed, is an important, and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of

> the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent. (as cited in Shapiro, 2007, p.58)

The language Justice Blackmun used in this argument raises some alarm. There is, *prima facie*, something disturbingly reductive in the idea that one could obtain “full knowledge” of an issue as morally complex as abortion and that this knowledge could be captured and confirmed via the informed consent process.[39]

Likewise, Justice Stewart’s defense of informed consent provisions on the basis that the abortion decision should be made in a “knowing” manner replicated one of the major problems with the Court’s articulation of informed consent in general: it presumed that the only way for a decision to be made in a “knowing, intelligent, and voluntary fashion” (as cited in Legal Information Institute, n.d.a, Concurrence, para 7) is for the patient to receive specialized information from her provider. Although receiving specialized knowledge is a key part of the informed consent process, the Court’s treatment of informed consent failed to recognize how patients impart special insights during medical decision-making. If patient autonomy is the goal, then the Court’s articulation of informed consent also overlooked a critical component of the informed consent process: the recognition and engagement of patient values, goals, and desires. Once again, this oversight is particularly problematic in the abortion context where women’s decisions are highly unique and often driven by nonmedical issues.

In general, Justice Blackmun’s assumption that the abortion decision is an “often stressful one,” affirmed and perpetuated a general assumption lurking within dominant judicial articulations of informed consent: patients are inherently vulnerable and lack appropriate decision-making capacities (Katz, 1984). Problematically, this assumption finds particular traction in the abortion context where women's decisions have often been regarded with suspicion. However inadvertently, Justice Blackmun emboldened a stereotype common in antiabortion discourse: women who choose to terminate a pregnancy are irrational and uninformed. Under this view, informed consent becomes a tool for physicians to correct and recalibrate their patients, rather than a tool that compels the physician to reconsider medical options in light of the patient's needs, beliefs, and values.

Moreover, the Court's argument that abortion is inherently stressful may compound antiabortion narratives that abortion causes women stress because women should be, and should want to be, mothers. According to antiabortion ideology, abortion is stressful because it contradicts or undermines women's maternal "nature." Rarely do antiabortion narratives characterize pregnancy, childbirth, and parenthood as stressful even though such experiences arguably engender more lifetime stress than abortion. Instead, antiabortionists routinely suggest that abortion yields psychological disorder, a deceptive claim that will be tracked and unpacked in Chapter Three where I consider state-sponsored "informed consent" materials.

Ultimately, the Court's defense of "informed consent" statutes in *Danforth* should be read as a defense of medical professionalism and provider autonomy. Notably, however, the Court's view of informed consent in *Danforth* also provides fuel for antiabortion ideology. Although Justice Blackmun may not have had antiabortion ideology in mind when he argued that the abortion decision is "an important, and often stressful one," that should be made "with full knowledge of its nature and consequences," his language helped to crystallize the sentiment that women's reproductive decisions require regulative intervention and supervision.

Informed Consent and the Akron and Thornburgh Decisions

Emboldened by *Danforth*, other states soon passed "informed consent" laws. This time, however, states introduced scripted information into their "informed consent" provisions, forcing the Court to reexamine its position on informed consent in the abortion context.[40] In *Akron v. Akron Center for Reproductive Health* (1983) and *Thornburgh, Governor of Pennsylvania v. American College of Obstetricians* (1987) the Court continued its defense of physician authority by striking down "informed consent" laws that required physicians to parrot ideological information.

In *Akron v. Akron Center for Reproductive Health* (1983) the Court struck down regulations imposed by the Akron, Ohio city council regarding the abortion procedure (Akron, Ohio, Regulation of Abortions, 1978). These included a twenty-four hour waiting period and informed consent requirements that required the physician to inform the woman of the following information:

> That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members . . . . That abortion is a major surgical procedure which can result in serious complications . . . and that abortion may leave essentially unaffected or

> may worsen any existing psychological problems she may have, and can result in severe emotional disturbances. (as cited in Legal Information Institute, n.d.b, Opinion, 5, § 1870.06 Informed Consent, para 5, para 7)

As evidenced in the above citation, antiabortion rhetoric ("the unborn child is a human life from the moment of conception" and abortion can result "in serious complications," and "severe emotional disturbances") aligned the informed consent process with ideological concerns. The ideological specificity mandated by *Akron's* provisions marks a notable departure from the provisions that were at issue in *Danforth*.

In his majority opinion, Justice Powell argued *Akron's* "informed consent" provisions posed a constitutional violation because they exceeded the regulative limits established by the Court in *Roe*. Although *Roe* permitted states to impose regulations relating to maternal health after the second trimester, Justice Powell argued, "The State's discretion to regulate on this basis does not, however, permit it to adopt abortion regulations that depart from accepted medical practice" (as cited in Shapiro, 2007, p.126). Reinstating the Court's foundational belief that abortion is a medical decision, as well as the Court's subscription to paternalistic models of medical decision-making, Justice Powell insisted, "it remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances" (as cited in Shapiro, 2007, p.130). According to Justice Powell, Ohio's effort to infuse the informed consent process with antiabortion ideology marked a clear departure from "accepted medical practice," and it "extend[ed] the State's interest in ensuring 'informed consent' beyond permissible limits" (as cited in Shapiro, 2007, p.130).

Notably, Justice Powell argued the city of Akron used the informed consent process to illegitimately persuade a woman to carry her pregnancy to term. "First 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," Justice Powell explained, " . . . a State may require that a physician make certain that his patient understands the physical and emotional implications of having an abortion. But Akron has gone far beyond merely describing the general subject matter relevant to informed consent" (as cited in Shapiro, 2007, pp.130-131). As way of further example, Justice Powell noted:

> Much of the detailed description of 'the anatomical and physiological characteristics of the particular unborn child' required by subsection (3) would involve at best speculation by the physician . . . . And subsection (5), that begins with the dubious statement that 'abortion is a major surgical procedure' . . . and proceeds to describe numerous possible physical and psychological complications of abortion, . . . is a 'parade of horribles' intended to suggest that abortion is a particularly dangerous procedure. (as cited in Shapiro, 2007, p.130)

Importantly, Justice Powell's argument reflected the majority's recognition that antiabortion ideology was perverting standard practices of informed consent. It is important to note, however, that the Court's primary objection to Akron's law was that it infringed upon physician autonomy by dictating the content of physician speech.

This line of reasoning is continued in *Thornburgh, Governor of Pennsylvania v. American College of Obstetricians* (1987). Here, the Court struck down six provisions of the Pennsylvania Abortion Control Act (1982), a Pennsylvania law that included ideologically scripted "informed consent" provisions. Included in Pennsylvania's informed consent provisions was information alerting women to the “fact that there may be detrimental physical and psychological effects which are not accurately foreseeable,” (as cited in Shapiro, 2007, p.148), the medical risks of abortion and the medical risks of carrying a child to term, the gestational age of the fetus, a description of the availability of medical assistance benefits, and the father’s financial responsibility. An additional provision required the pregnant woman to be notified of the existence of written information describing the fetus and of agencies that provide alternatives to abortion. These written materials described the “probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including any relevant information on the possibility of the unborn child’s survival” (as cited in Shapiro, 2007, p.148).

Citing the Court’s prior ruling in *Akron*, Justice Blackmun argued, “the State may not require the delivery of information designed ‘to influence the woman’s informed choice between abortion or childbirth (Akron, 462 U.S., at 443-444)’” (as cited in Shapiro, 2007, p.147). In his majority ruling, Justice Blackmun explained that advising women of medical assistance benefits and paternal liability “are poorly disguised elements of discouragement for the abortion decision” (as cited in Shapiro, 2007, p.149). Justice Blackmun reasoned:

> . . . much of this would be nonmedical information beyond the physician’s area of expertise and, for many patients, would be irrelevant and inappropriate. For a patient with a life-threatening pregnancy, the ‘information’ in its very rendition may be cruel as well as destructive of the physician-patient relationship.
> (as cited in Shapiro, 2007, p.149)

In his concluding remarks, Justice Blackmun argued such provisions violate the principle of informed consent:

> This type of compelled information is the antithesis of informed consent. That the Commonwealth does not, and surely would not, compel similar disclosure of every possible peril of necessary surgery or of simple vaccination, reveals the anti-abortion character of the statute and its real purpose . . . . Section 3205's informational requirements therefore are facially unconstitutional.
>
> (as cited in Shapiro, 2007, p.149)

Justice Blackmun's reasoning reflected the majority's belief that information purveyed during the informed consent process cannot be used to facilitate an antiabortion perspective because such efforts usurp physician autonomy. Echoing a belief expressed in both *Danforth* and *Akron*, the Court objected to Pennsylvania's "informed consent" law because it assaulted medical autonomy.

From the standpoint of today's hostile regulative environment, the Court's rejection of ideological "informed consent" provisions in *Akron* and *Thornburgh* shines as a refreshing relic of a time when the Court's rulings benefitted and protected abortion rights. Problematically, however, the Court's rejection of "informed consent" provisions followed from its deference for physician authority rather than from explicit respect for women's reproductive autonomy. In general, the Court's arguments were predicated on the assumption that relevant information belongs to the physician alone, once again advancing the anemic vision of informed consent that was discussed in Chapter One. By routinely and almost exclusively stressing medical authority, the Court allowed women to conceptually drop out of the informed consent process.

Notably, the Court changed their view of informed consent in their next major decision regarding “informed consent” regulations, *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992). In *Casey*, the Court’s revision of informed consent replaced physician authority with state authority. Consequently, the Court continued to overlook women, but its revised framework turned informed consent into a tool of state scrutiny, rather than a protocol of medical practice.

Informed Consent and the Casey Decision

It is widely recognized that the Supreme Court decision *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) opened the legal doors to the wide range of “informed consent” requirements now recognized as constitutionally permissible. The constitutional backdrop and the accompanying arguments and amicus briefs that constitute *Casey* have been analyzed by a bevy of legal scholars.[41] For my purposes, however, it is useful to review the defining features of this case to help explain the creation of a legal environment that permits the antiabortion appropriation of the informed consent process. Additionally, a short review will expose how the Court pivoted its position on informed consent from a tool of medical practice to one of state power.

In 1988 and 1989 the Pennsylvania legislature amended the 1982 Pennsylvania Abortion Control Act to include a new series of abortion regulations (Friedman, L., 1993, p.29). Notably, these regulations closely mirrored the regulations the Court rejected in *Thornburgh*. Specifically, the Pennsylvania law mandated a 24-hour waiting-period, parental consent requirements, a spousal notification rule, informed consent requirements, and reporting requirements.

The Pennsylvania Abortion Control Act dictated that, "no abortion shall be performed or induced except with the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced." It also required the information to be purveyed by "the physician who is to perform the abortion or the referring physician" at least 24 hours prior to the abortion. Remarkably, the provision outlined in detail the informational content requisite to an "informed" decision. More specifically, this section required the woman to be informed of the probable gestational age of the "unborn child," and the medical risks of carrying "her child" to term (as cited in Legal Information Institute, n.d.c, Appendix to the Opinion, 18 PA. Cons. Sta. Ann., §3205. Informed Consent, para 4, para 5). In addition, the Pennsylvania law required the physician to inform the woman that:

> (i) The department publishes printed materials which describe the unborn child and list agencies which offer alternatives to abortion and that she has a right to review the printed materials and that a copy will be provided to her free of charge if she chooses to review it.
>
> (ii) Medical assistance benefits may be available for prenatal care, childbirth and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials published by the department.
>
> (iii) The father of the unborn child is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion. In the case of rape, this information may be omitted. (as cited in Legal Information Institute, n.d.c, Appendix to the Opinion, 18 PA. Cons. Sta. Ann., §3205. Informed Consent, para 10, para 11, para 12)

Section 3209 of the Pennsylvania Abortion Control Act, called the "husband notification" provision by challengers, and the "spousal notice" by its defenders, required a married woman to notify her husband before obtaining an abortion. Under penalty of perjury, the woman would be required to provide a signed statement indicating that her husband had been notified. Defenders of the provision argued it furthered state interest by "promoting the integrity of the marital relationship and to protect a spouse's interests in having children within marriage and in protecting the prenatal life of that child" (as cited in Friedman, L., 1993, p.195). Supporters of the law contended that the "spousal notice" would ensure

> . . . at least the possibility that the husband will participate in deciding the fate of his unborn child, a possibility that might otherwise have been denied him. The husband's participation, in turn, may lead his spouse to reconsider her options or rethink a hasty decision. (as cited in Friedman, L., 1993, p.230)

At the time, Pennsylvania did not require women or men to notify their spouses of any other medical or surgical procedure.

Although supporters of the Pennsylvania provisions argued that they "are rationally related to ensuring that the woman's choice is fully informed and not the product of coercion" (as cited in Friedman, L., 1993, p.191), the Pennsylvania amendments functioned as an experimental piece of antiabortion legislation designed to test the constitutional limits of abortion regulations. Recent Court rulings suggested that the Court had amended its views on abortion regulation since it had struck down "informed consent" laws in *Akron* (1983) and *Thornburgh* (1986). For example, in *Webster v. Reproductive Health Services* (1989) and *Hodgson v. Minnesota* (1990) the

Court countenanced laws regulating abortion provision. In *Webster*, the Court upheld a Missouri law prohibiting government facilities from providing abortions, and it argued that the law did not impede women's access to abortion because women could still obtain abortions from private healthcare providers. In *Hodgson*, the Court upheld a Minnesota law that mandated a minor to notify one parent prior to obtaining an abortion. Both of these rulings marked a significant departure from the privacy protections outlined by *Roe*, and they demonstrated the Court's willingness to defend state interference in the abortion decision.[42]

On June 29th, 1992, the Court issued its ruling. Although the Court reaffirmed a woman's constitutional right to abortion, it rejected *Roe's* trimester framework which had significantly limited regulations not related to maternal health prior to fetal viability. In its place, the Court adopted the "undue burden" standard to test the constitutionality of abortion regulations.[43] The Court defined "undue burden" as "a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus" (as cited in Shapiro, 2007, p.197).[44] Using the new "undue burden" standard, the Court ruled that Pennsylvania's informed consent provisions, parental consent provisions, and mandatory waiting periods were constitutionally permissible, but the spousal notification provision was not.[45]

Although the concept of an "undue burden" had been operative in judicial discourse on abortion for quite some time, the *Casey* decision formalized it as a lens of evaluation.[46] Essentially, the Court argued that the undue burden provided a form of evaluative compromise because it mitigated the "rigidity" (as cited in Shapiro, 2007, p.196) of the trimester framework which permitted "almost no regulation at all . . . during the first trimester of pregnancy" (as cited in Shapiro, 2007, p.195). In contradistinction to the trimester framework that relegated the abortion decision to physician purview, the undue burden standard permitted states to enter the informed consent process.

The Court's adoption of the undue burden standard in 1992 marked a notable change in the Court's articulation of the abortion decision, as well as its vision of the informed consent process. Whereas in pre-*Casey* rulings the Court repeatedly framed abortion as a medical decision that ultimately hinged on the discretion of the physician, the tropes of "physician authority" and "medical decision" are less active in the *Casey* ruling. Instead, the Court moved away from the medical rhetoric that dominated *Roe* and it moved toward the moral and psychological dimensions of the abortion decision (Manian, 2009, p.13; Daly, 1995). Remarkably, the Court's shifting rhetoric indicated the belief that physicians could no longer be trusted to manage the abortion decision correctly. Nan D. Hunter (2006) argues that following *Roe*, "[t]he tone of the Court's opinions continued to change, with increasing frequency, to skepticism about the professional reliability of physicians who performed abortions" (p.193). In *Casey*, an underlying moral distrust of the medical community, at least within the abortion context, took hold of the majority opinion and the Court's historical deference for the medical community migrated into the Court's minority opinions.

In effect, the Court's rhetorical transition from the medical to the moral dimensions of abortion allowed the Court to hold the woman, rather than the doctor, primarily responsible for the abortion decision (Manian, 2009). By positioning the woman as the primary decider, however, the Court did not present a renewed recognition of woman's reproductive autonomy. Instead, the Court used such positioning to justify enhanced regulations and to justify state intrusion upon the informed consent process.

Driven by the belief that neither women nor providers can properly negotiate the abortion decision, the Court articulated informed consent as a means to monitor women's decisions.

The Court's revised reading of informed consent as an appropriate channel for state intervention was predicated on a number of troubling and ultimately sexist beliefs regarding women and pregnancy. For example, the Court took as axiomatic that pregnancy and childbirth are the preferable options for women, and the Court assumed that women who seek an abortion have lost sight of this precept. The Court argued:

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage [a woman] to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy.
> (as cited in Shapiro, 2007, p.196)

Likewise, the Court argued:

> To promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion.
> (as cited in Shapiro, 2007, p.198)

Here, the Court's logic coupled a "thoughtful and informed" decision with the recognition that pregnancy is preferable, and it configured the state as a morally omniscient moderator of this knowledge. This configuration is evident when the Court claimed that the state has a right to use the informed consent process to argue, "in favor of continuing the pregnancy" without also recognizing that abortion is often in the woman's best interest, for either medical or nonmedical reasons. That is, the Court assumed that carrying a pregnancy to term is simply the right thing to do and that women who choose abortion are missing this insight. With this presumption in hand, the Court interpreted informed consent as an appropriate channel to deliver information designed to encourage women in the direction of childbirth.

Legal scholars have correctly observed that the Court's argument in *Casey* mobilized a series of stereotypes that depict women as irrational, ignorant, and essentially maternal, thereby justifying the need for enhanced regulation (Atkinson, 2011, Manian, 2009, Siegel 1992; Siegel & Blustain, 2006). The Court argued, for example,

> It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed. (as cited in Shapiro, 2007, p.201)

Here, the Court assumed that women have not factored the fetus into their decision and that women are somehow ignorant of the fact that an abortion terminates a developing embryo or fetus. Likewise, the Court assumed that if women really took the time to consider the fetus, the abortion decision would seem less attractive. Both assumptions are predicated on the stereotype that women are rationally undeveloped (women do not sufficiently understand what an abortion does to a fetus or embryo) and women are inherently maternal (women who have abortions suffer psychological fallout). In addition, the Court's argument that women who have abortions may experience "devastating psychological consequences" contributed to a growing trend in antiabortion rhetoric that abortion is psychologically damaging to the woman herself (Siegel & Blustain, 2006; Siegel, April, 2008), and the Court failed to recognize the wide-ranging multiplicity of emotional experiences generated by the abortion decision.[47]

The Court's adoption of nefarious stereotypes regarding women's agency is further evidenced by the Court's defense of Pennsylvania's mandatory waiting period. The Court argued,

> The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly when the statute directs that important information become part of the background of the decision. (as cited in Shapiro, 2007, p.202)

Once again, this assumption treats women as incapable of contemplating the abortion decision independently, thus justifying the need for state intrusion upon the informed consent process. Moreover, the Court's argument in favor of mandatory waiting periods demonstrates an unnerving ignorance of the economic and practical hardships waiting periods impose on some women.

It is also important to note that although the Court recognized the infinitely variable moral beliefs that accompany abortion and fetal ontology (Shapiro, 2007, p.191), the Court's logic was driven by an underlying presumption that the fetus or embryo is physiologically equivalent to a postnatal infant or child, and the Court's rhetoric suggests that the fetus or embryo deserves the same moral standing as a person. For example, to defend its argument that a state may require doctors to advise women of materials "relating to the consequences to the fetus" (as cited in Shapiro, 2007, p.201), the Court deployed the analogy of a kidney transplant operation. "We think it Constitutional," the Court argued, "for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself" (as cited in Shapiro, 2007, p.201). This analogy is strange insofar as a kidney transplant involves two people, whereas abortion involves a person and an embryo or fetus, and, on the Court's own admission in *Roe,* a developing embryo or fetus is not the same as a person.[48]

Indeed, throughout the *Casey* decision, the Court's rhetoric collapses the important physiological distinctions that mark gestation. The Court's unmodified use of the word "fetus," for example, is questionable given that the term "fetus" is not typically used until the eighth week of conception (Sandler, 2010), and 63.1 % of abortions occur before nine weeks of pregnancy (Guttmacher Institute, July, 2014). Following standard medical lexicon, many women are aborting an embryo, not a fetus. The Court's routine claim regarding the State's right to "express profound respect for the life of the unborn" (as cited in Shapiro, 2007, p.198) further suggests that the Court assumed that a developing embryo or fetus should be awarded and accorded the same moral status and moral respect as a child. In turn, this presumption bolstered the Court's stereotypical belief that maternity is the right choice for women.

In summation, the Court's ruling in *Casey* treated informed consent as a means to monitor women's reproductive decisions, rather than an ethical mechanism to enhance and safeguard women's autonomy. The Court justified its defense of the state's heightened involvement in the informed consent process on the basis that women are poor decision makers, especially in the abortion context. Once the Court adopted this position, it interpreted the informed consent process accordingly. That is, the informed consent process became a legitimate means to facilitate the Court's normative view that pregnancy is preferable. If neither women nor physicians can be counted upon to contemplate the abortion decision "correctly," then the state's involvement in the informed consent process is calculated as an asset rather than a "substantial obstacle."

Even though *Casey* upheld *Roe's* central ruling, the Court transformed the landscape of abortion provision, and the Court lent institutional credence to antiabortion ideology. In particular, *Casey* helped to legally enshrine the belief that women who wish to terminate a pregnancy require moral correction, and that the state knows what is best for women. Although *Casey* used this sexist narrative to institute a new era of abortion regulation, the belief that women's epistemic capacities are relatively inferior, whether in comparison to the doctor's or to the state's, has a long history in abortion jurisprudence. Consequently, the sexist stereotypes at work in *Casey* should be read as an iteration of a long cultural narrative that depicts women as incompetent decision-makers vis-a-vis the abortion decision.

Conclusion to Chapter Two

To conclude, the trajectory of the Court's treatment of abortion and "informed consent" can be summarized as follows. In *Roe*, the Court articulated abortion as a "medical decision," and the Court overturned regulations that exceeded medical concern prior to fetal viability. This articulation led the Court to reject "informed consent" statutes that invaded physician speech with ideologically driven information. In *Casey*, however, the Court turned informed consent into a tool of state surveillance, and the Court argued that the state's intrusion upon the informed consent process is warranted in order to make sure ". . . that a woman apprehend the full consequences of her decision" (as cited in Shapiro, 2007, p.201). This argument is shaped by the belief that the embryo or fetus is an unborn child, that childbirth is always preferable to abortion, and that women are often ignorant of these facts. Once the Court adopted the moral precept that pregnancy is preferable, their interpretation of informed consent was reconfigured in favor of heightened state intervention.

Of particular note for this work, however, is that *Casey* demonstrated a metamorphosis of the Court's informed consent doctrine. Whereas the Court defended physician authority in its early informed consent rulings, the Court later expanded states' rights to eclipse physician expertise during the informed consent process. Throughout these evolving articulations of informed consent and abortion, women are never once granted the status of primary decision-maker. In general, a thoughtful recognition of women's privileged perspective vis-à-vis abortion is missing throughout abortion jurisprudence. Although *Casey* marked a turning point in informed consent law, it perpetuated an abiding dismissal of women's reproductive authority that originated with *Roe*. Echoing a point I made in Chapter One, the Court's historical displacement of women's autonomy within informed consent jurisprudence demands a deeper rethinking of informed consent doctrine in general, and its relationship to abortion in particular.

CHAPTER THREE

“INFORMED CONSENT” IN THE CLINICAL CONTEXT

In Chapter Three I turn to state-sanctioned “informed consent” materials to demonstrate the troubling deployment of bioethics rhetoric within the clinical context of abortion. “Informed consent” practices vary across the states, and states rely upon different mediums to transfer abortion-specific information, ranging from printed materials to verbal recitations to websites. Here, I focus specifically on “informed consent” materials that are notable for their medical inaccuracies and aggressive antiabortion ideology. In general, this chapter will show in detail how antiabortion forces are using bioethics language to facilitate an antiabortion agenda.

As discussed in Chapter Two, the 1992 Supreme Court decision *Planned Parenthood v. Casey* opened the door for a tsunami of abortion regulations, including the “informed consent” laws at issue in this work. By 1996, eleven states—Idaho, Kansas, Louisiana, Mississippi, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, and Utah—had passed a biased “informed consent” law (Kolbert & Miller, 1998, pp. 100, 108). As of February 2015, twelve states include information regarding fetal pain, five states require that women be told that personhood begins at conception, five states incorrectly ascribe a link between abortion and breast cancer, and nine states emphasize negative emotional responses to abortion (Guttmacher Institute, February, 2015b).

Researchers at the Guttmacher Institute have compiled invaluable data on the existence of “informed consent” materials across the states. Yet, the rhetoric of “informed consent” materials has not been critically theorized. I ask, what strategies do antiabortionists use to incorporate scientifically misleading information into "informed consent" materials? An answer to this question will help to destabilize misleading "informed consent" laws and it will clarify why abortion-specific "informed consent" materials are violating standard practices of informed consent.

In this chapter, I expand upon preliminary research carried out by the Guttmacher Institute to discuss three rhetorical strategies trending within "informed consent" materials. More specifically, these strategies include: a) the deceptive use of methodologically flawed and discredited research studies; b) an embellished and empirically reductive discussion of post-abortion emotional response; and c) the careful construction of a fetal subject that sanctions antiabortion ideology. Collectively, these three tactics allow antiabortion politicians to appropriate terminology common to medical and research discourses to deliver information that is misleading, inaccurate, and ideologically driven.[49]

In general, Chapter Three explores the dramatic perversion of informed consent doctrine by antiabortionists, and it will explain why the antiabortion appropriation of informed consent bears little resemblance to informed consent doctrine as originally espoused and practiced by the courts, bioethicists, and clinicians. Although founding articulations of informed consent are plagued by a number of theoretical deficiencies, traditional articulations of informed consent are nonetheless motivated by ideals of equality, autonomy, and liberty, noble ideals even if they are not always substantiated in practice. Contrary to the liberatory aspirations that helped to beget informed consent practices, the "informed consent" materials considered in this chapter intend to erase, rather than empower, women's reproductive autonomy.

Strategy One: Flawed and Discredited Research Studies

In the current legal climate, abortion is an exceptionally safe medical procedure (Weitz, Taylor, Desai, Upadhyay, Waldman, Battistelli, & Drey, 2013; Gillman & Holmquist, 2008). Nevertheless, antiabortion ideology has managed to infect informed consent materials with deceptive information regarding the health "risks" of abortion. More specifically, the misleading and scientifically unsound claim that abortion causes breast cancer has been successfully incorporated into several states' "informed consent" materials.[50] Although the argument that abortion causes breast cancer has been a staple of antiabortion discourse for several decades, its mandated incorporation into medical practice marks a troubling new iteration. Currently, Alaska, Kansas, Mississippi, Oklahoma, and Texas provide information that inaccurately reports a causal link between abortion and breast cancer in their "informed consent" materials (Guttmacher Institute, February, 2015b). Each state includes information discussing the link between abortion and breast cancer in the written materials they administer to women seeking an abortion, and abortion providers in Kansas are required to discuss the abortion-breast cancer link in a verbal counseling session, as well (Guttmacher Institute, February, 2015b).

In general, "informed consent" materials manufacture a link between breast cancer and abortion by referencing fringe or discredited research studies and by falsely suggesting that the existence of such studies evidences an ongoing debate within the medical community over the relationship between breast cancer and abortion.[51] Although a few research studies claiming a causal relationship between abortion and breast cancer do exist, such studies have been widely discredited for their methodological weaknesses. Moreover, most major cancer organizations reject a causal relationship between abortion and breast cancer, and organizations that champion a connection between abortion and breast cancer are explicitly associated with antiabortion politics.[52]

In the following paragraphs, I review the history of abortion-breast cancer research, and I explain why studies purporting a correlation are methodologically flawed. Next, I turn to the “informed consent” materials themselves, and I critique the language and arguments used to perpetuate a fallacious relationship between breast cancer and abortion. Along the way, I explain why “informed consent” materials that purport a causal relationship between abortion and breast cancer violate standard practices of informed consent despite their use of rhetoric common to informed consent discourse.

Beginning in the 1980s, research into a possible link between abortion and breast cancer escalated as researchers explored the relationship between hormone levels, pregnancy, and breast cancer. According to Boonstra, Gold, Richards, & Finer (2006), abortion opponents “seized upon” (p.23) a 1996 study (Brind, Chinchilli, Severs, & Summy-Long) that suggested a relationship between abortion and breast cancer amongst women who had terminated past pregnancies. Then, at the beginning of George W. Bush’s presidency, the National Cancer Institute (NCI) succumbed to political pressure and included information on its website discussing a possible link between abortion and breast cancer (Joffe, 2009, pp.67-68).

However, the NCI’s decision to include this information on its website incited boisterous protest from many members of the scientific community. Consequently, in February 2003, the U.S. National Cancer Institute assembled a panel “of the world’s leading experts who study pregnancy and breast cancer risk” (American Cancer Society, n.d., What do experts say, para 1) to assess the relationship between abortion and breast cancer. After a three-day workshop whose outcomes were jointly reviewed by the NCI Board of Scientific Advisors and the Board of Scientific Counselors, the panel concluded that "induced abortion is not associated with an increase in breast cancer risk" (National Cancer Institute, n.d.b, Epidemiologic Findings, para 6); the panel claimed that the evidence for this conclusion is "well established," the highest rating possible (National Cancer Institute, n.d.b, Strength of Evidence Rating Key). The National Cancer Institute (n.d.b) has since removed information purporting a link between breast cancer and abortion from its website, and the NCI website now offers a detailed discussion discrediting the argument that abortion causes breast cancer.

For example, the NCI (n.d.c) explains that early studies were methodologically flawed and scientifically mishandled because they either used a small sample size or relied upon self-reporting rather than on medical records, and, thereby, were compromised by problems of recall bias (Background, para 1). According to the American Cancer Association, recall bias can occur in case-control studies or retrospective design studies where two groups of people, one group with a disease and one group without the disease, are asked to review their past exposures in hopes of identifying an exposure common only to those who are sick. There are a number of problems with this approach. For example:

> [P]eople with a disease like cancer often think very hard about what they may have done in the past that could have contributed to their getting cancer. They are more likely to remember things that the healthy people don't. They are also more likely to tell the researchers about things that they would otherwise feel was too

> personal or embarrassing to mention – like abortion. (American Cancer Society, n.d., How is this studied, para 3)

In other words, having a disease can influence a patient to remember certain events that a healthy person may not be motivated to recall or feel compelled to disclose. According to the American Cancer Society, studies suggesting a link between abortion and breast cancer are retrospective studies and, therefore, are weakened by the issue of recall bias (American Cancer Society, n.d., What do the studies show?, para 1).

Current studies that control for such problems as recall bias or small samples evince no correlation between abortion and breast cancer (Erlandsson, Montgomery, Cnattingius, & Ekbom, 2003; Mahue-Giangreco, Ursin, Sullivan-Halley, & Bernstein, 2003; Sanderson, Shu, Jin, Dai, Wen, Hua, & ... Zheng, 2001; Ye, Gao, Qin, Ray, & Thomas, 2002). The American Cancer Society argues that the largest "and probably the most reliable" study (n.d., Cohort and other prospective studies, para 1) was conducted in Denmark during the 1990s. This Danish study took advantage of Denmark's meticulous medical record system—Denmark maintains detailed medical records for all of its citizens—to look for evidence of a causal relationship between abortion and breast cancer. Researchers linked the medical records of all Danish women born between 1935 and 1978, a total of 1.5 million women, to the National Registry of Induced Abortions and the Danish Cancer Registry. After correcting for breast cancer risk factors, the study found no evidence to suggest that induced abortion increases breast cancer risk (Melbye, Wohlfahrt, Olsen, Frisch, Westergaard, Helweg-Larsen, & Andersen, 1997). By grounding their study in medical data drawn from a system of mandatory reporting, the Danish study avoids problems of recall bias and other concerns that can arise when research on a stigmatized issue, like abortion, is conducted through interviews and self-reports.

Other exhaustive studies carried out in both the United States and Europe that correct for problems of recall bias and small sample size have found no link (ACOG Committee Opinion No. 434, 2009; ACOG Committee Opinion Number 285, 2003; Collaborative Group on Hormonal Factors in Breast Cancer, 2004; Henderson et al., 2008; Lash & Fink, 2004; Michels, Xue, Colditz, & Willett, 2007; Reeves et al., 2006; Rosenblatt et al., 2006). Along with the National Cancer Institute (n.d.a), the American Cancer Society (n.d.) dismisses the correlation between abortion and breast cancer. From the perspective of breast cancer-abortion research as a whole, studies purporting a link between breast cancer and abortion are uncommon and are overshadowed by studies that demonstrate no causal relationship.

Nevertheless, some states continue to include information purporting a link between breast cancer and abortion in their informed consent materials. In Alaska, for example, a state-sponsored website discusses a host of issues relevant to abortion and pregnancy (Alaska Department of Health and Social Services Division of Public Health, 2013a; Alaska Informed Consent Requirements, 2013), including a subsection titled, “Possible Medical Risks or Complications of Abortion” (Alaska Department of Health and Social Services Division of Public Health, 2013b). Along with information discussing infection, incomplete abortion, cervical injury, blood clots, uterine perforation, hemorrhage, and allergic reaction, Alaska also includes a short discussion on the causal relationship between abortion and breast cancer.

Alarmingly, the Alaska website suggests that the breast cancer-abortion topic is still debated within scientific circles. The website fabricates this deception by juxtaposing the competing views of different professional medical associations while simultaneously failing to mention that organizations defending a causal link are in the minority and are affiliated with antiabortion organizations. For example, the website references a June, 2009 report issued by the American College of Obstetricians and Gynecologists (ACOG) which clearly states "… prospective studies conclude there is no association between induced abortion and breast cancer" (Alaska Department of Health and Social Services Division of Public Health, 2013b, para 8). Yet, in contradistinction to the ACOG's stance, the website also states: "The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) supports the view that there is a causal relationship between breast cancer and the termination of pregnancy" (Alaska Department of Health and Social Services Division of Public Health, 2013b, para 9). The website's visual presentation of this contradictory information falsely suggests that the competing arguments carry equal weight in scientific communities, when in fact the AAPLOG is an outlier on this issue. Although most professional cancer organizations eschew any causal correlation between abortion and breast cancer, the Alaskan website does not share this important information with its viewers. In explanation of the competing reports, the website simply instructs viewers to consult the website's reference list.

Oklahoma uses a similar tactic in their "informed consent" booklet, *A Woman's Right to Know* (Oklahoma State Board of Medical Licensure & Supervision, May 2013).

In the short section, "Is There A Link Between Abortion and Breast Cancer?" the Oklahoma booklet reads:

> Studies on this issue have reached differing conclusions. Some studies indicate that there is no increased risk of breast cancer after a woman has had an abortion. Other studies indicate that there might be an increased risk. If you have a family history of breast cancer or have clinical finding of breast disease, you should seek the advice of your physician in order to be informed. (The Oklahoma State Board of Medical Licensure and Supervision, May 2013, p.14)

Like Alaska, Oklahoma's informed consent material suggests that studies purporting a causal relationship between abortion and breast cancer carry equal weight in comparison to studies denying such a relationship, when in fact there is a significant imbalance between the competing arguments in terms of methodological rigor and scientific support.

In Kansas, abortion providers must present women with an informational pamphlet titled, *If You are Pregnant* (Kansas Department of Health and Environment, n.d.a).[53] In the section "Long Term Medical Risks" (p.29) the Kansas pamphlet warns women of a possible link between breast cancer and abortion. The Kansas booklet states:

> There are also studies that have found an increased risk of breast cancer after induced abortion, but other studies have found no risk. A 2003 National Cancer Institute panel reviewing studies at that time concluded there was no increased risk; however, study and review of the relationship continues.
> (Kansas Department of Health and Environment, n.d.a, p.29)

The Kansas booklet does not provide references or context for the various studies it cites. Despite the National Cancer Institute's (n.d.a) insistence that "women who have had an induced abortion have the same risk of breast cancer as other women," (Is abortion linked to breast cancer risk, para 2), Kansas' booklet obfuscates the details of breast cancer-abortion research to suggest that the issue is still deeply unsettled within the cancer research community. This suggestion is duplicitous as, in the words of the American Cancer Society (n.d.a), "At this time, the scientific evidence does not support the notion that abortion of any kind raises the risk of breast cancer or any other type of cancer" (Conclusion, para 1).

Of course, it is not technically a lie to claim that the abortion-breast cancer link has been debated by different professional medical organizations, and studies claiming a link between abortion and breast cancer do exist (Jiang, Gao, Ding, Li, Liu, Cao, & ... Tajima, 2012; Hajian-Tilaki, & Kaveh-Ahangar, 2011). However, in the realm of medical research and clinical practice, it is insufficient to simply say, "A study exists." Instead, healthcare providers should clarify that studies claiming a correlation between breast cancer and abortion are in the minority, they have methodological flaws, they are aligned with antiabortion ideology, and they have been dismissed as tenuous by leading scientific organizations. Informed consent practices are designed to deliver patients with the most reputable and reliable medical information available, a standard that is unabashedly ignored when "informed consent" materials suggest that abortion causes breast cancer. In the world of healthcare provision, medical and research information is not relative; some forms of information are indeed better than others and medical science is expected to privilege different forms of information. When "informed consent" materials discuss the abortion-breast cancer link, they recklessly bypass the standards, research guidelines, and rules of practice that guide the identification of sound medical information.

Finally, there is something particularly nefarious about the claim that abortion is medically dangerous and childbirth is preferable given that women are fourteen times more likely to die in childbirth than during an abortion (Raymond & Grimes, 2012). In addition to imposing the deep moral and material obligations that come with parenthood, carrying a pregnancy to term also introduces other medical complications like pregnancy-related hypertension and placental abnormalities that can be avoided with early-term abortion (Raymond & Grimes, 2012, p.217). In this sense, not only do fabricated claims of the health "risks" of abortion corrupt the informed consent process by distorting the best scientific evidence available, but they could also endanger women's lives by inciting unfounded fears. Unfortunately, the abortion-breast cancer link is not the only example of misleading information found in state-sponsored material on abortion.

Strategy Two: Embellishing the Reduction

A second tactic at work in "informed consent" materials involves a selective and empirically reductive discussion of post-abortion emotional response. As of February 2015, twenty-two states include information on the psychological consequences of abortion; nine of these states—Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, Utah, and West Virginia—only discuss negative emotional responses to abortion (Guttmacher Institute, February, 2015b). As I will demonstrate below, this second tactic mobilizes the language of "post-abortion syndrome" and it frames the stories of women who report traumatic emotional responses—most of whom are working with religiously conservative, antiabortion organizations—as representative of abortion experience in general. To help embellish this empirical reduction, antiabortion narratives of psychological disorder also conveniently downplay or omit the positive or neutral emotions some women report following an abortion. In general, "informed consent" materials that suggest abortion triggers emotional dysfunction defy institutionalized standards of medical information provision, and they contradict the viewpoints of major psychological organizations, such as The American Psychiatric Association and the American Psychological Association (American Psychiatric Association, 2013; American Psychological Association, 2008; Cohen, 2006, p.10). Moreover, antiabortion arguments espousing emotional disorder fail to situate abortion within a political climate that stigmatizes abortion, and they rely upon entrenched cultural stereotypes that depict women as poor decision-makers prone to irrational hysteria, a stereotype that also infected the *Casey* decision and other segments of abortion jurisprudence.

I begin this section with a brief history of the duplicitous concept of "post-abortion syndrome," a faux psychological disorder engineered through the personal testimonies of women who regret their abortion decisions, and I highlight the continued use of this concept within antiabortion discourse. Secondly, I turn to "informed consent" materials to show how the argument that abortion causes psychological disorder is being incorporated into the literature distributed to some women seeking an abortion. Thirdly, I draw upon peer-reviewed research to explain why antiabortion arguments purporting a causal link between abortion and emotional dysfunction are deceptive, inaccurate, and reductive.

To begin, the argument that abortion causes psychological disorder first found academic traction during the early 1980s when Dr. Vincent Rue, a professor of family relations and a vocal antiabortion advocate, articulated the concept of "post-abortion syndrome" during Senate hearings on the social effects of abortion (Siegel, April 2008, p.117). Later, Dr. Rue worked with a graduate student, Anne Speckard, to develop the concept of post-abortion syndrome in more detail. Speckard and Rue (1992) argued that women who suffer from post-abortion syndrome experience feelings of depression, grief, survivor guilt, substance abuse, and flashbacks, and they likened post-abortion syndrome to post-traumatic stress disorder experienced by some Vietnam War veterans. In the 1980s, women activists within the antiabortion movement seized upon Rue and Speckard's work, and aggressively distributed literature on post-abortion syndrome, while Crisis Pregnancy Centers incorporated threats of psychological disorder into their "counseling" procedures (Siegel, April 2008, p.118).

More recently, advocates of post-abortion syndrome, all of whom are committed to the antiabortion agenda, have turned to women's first-person narratives of post-abortion, emotional distress to help advance their argument. For example, the conservative law firm, The Justice Foundation, and their subsidiary project, Operation Outcry, claim to host the "largest collection of legally admissible, written sworn testimonies from women hurt by abortion" (Operation Outcry, 2015).[54] As way of example, Operation Outcry's webpage offers the video story of "Luna," who reports that her three abortions "started a life of devastation for me." Luna explains that after the abortions she "became very depressed," she "started drinking, started doing drugs," and "she became very promiscuous." Luna also "tried to kill herself three different times."

Using highly religious rhetoric, Luna preaches that, "guilt and shame prisons women who have abortions" and that it is necessary "to talk out about this from your pulpits" (Operation Outcry, 2015b). Luna's story is representative of many of the women showcased on Operation Outcry's website, all of whom describe in detail the ways they were traumatized by abortion.[55] In addition to supplying antiabortion groups with strong rhetorical weaponry, stories like Luna's lend support to "informed consent" materials that claim abortion causes psychological trauma. That is, "informed consent" materials can now claim that, "Some women have reported serious psychological effects after their abortion" (Texas Department of Health, 2003, p.16) because some women do, in fact, make this claim.

The migration of post-abortion trauma into clinical practices becomes evident when we turn to "informed consent" literature. It is important to note that the language used to discuss psychological trauma varies across states' "informed consent" materials. Whereas some states detail the emotional damage triggered by abortion, other states only allude to the emotional threats of abortion. In all cases, however, "informed consent" materials codify a biased and reductive narrative of women's emotional experiences with abortion, and the underlying message in each negative provision is the same: women who have abortions run the risk of debilitating emotional fallout.

For example, Kansas's informed consent booklet includes a section devoted to the "Psychological Risks of Abortion." The booklet claims:

> After having an abortion, some women suffer from a variety of psychological effects ranging from malaise, irritability, difficulty sleeping, to depression and even posttraumatic stress disorder. The risk of negative psychological

> experiences may increase if a woman has previously suffered from mental health problems.
>
> Talking with a counselor or physician may help a woman to consider her decision fully before she takes any action. Many pregnancy resource centers offer counseling services; a list of centers is available in the resource directory. (Kansas Department of Health and Environment, n.d.a, p.22)

Although the booklet does recognize a relationship between previous mental health problems and negative psychological responses to abortion—an important correlation not recognized by other states—the full range of emotional responses to abortion, such as feelings of relief or empowerment, are not mentioned. The Kansas booklet assumes women do not adequately consider the emotional hazards of having an abortion and that this failing that can be corrected by "talking with a counselor or physician" (p.22). Problematically, many of the centers listed in the resource directory operate on the premise that abortion harms women, and they aim to encourage women to carry their pregnancy to term regardless of their individual circumstances.

Likewise, Texas's informational booklet provides a biased view of emotional response. In the section "The Emotional Side of Abortion," the booklet reads:

> You should know that women experience different emotions after an abortion. Some women may feel guilty, sad, or empty, while others may feel relief that the procedure is over. Some women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks, and substance abuse. These emotions may appear

> immediately after an abortion, or gradually over a longer period of time. These feelings may recur or be felt stronger at the time of another abortion, or a normal birth, or on the anniversary of the abortion.
>
> (Texas Department of Health, 2003, p.16)

Once again, an "informed consent" booklet overemphasizes negative psychological experiences, and it suggests that all women are equally at risk for "suicidal thoughts" and "sexual dysfunction." Although the booklet admits that women "experience different emotions," its recognition of positive emotional responses is notably limited. More specifically, the booklet articulates relief as *relief that the abortion procedure is over* (p.16), rather than relief that one has avoided the undesired role of motherhood. Thus, even in its recognition of positive emotional experiences like relief, Texas still suggests that abortion itself is a terrifying event incapable of engendering positive outcomes.

In West Virginia, state law requires that the written material provided to women discuss the psychological effects of abortion (West Virginia Women's Right to Know Act, 2002, 16-21-3-(2)). In a section titled "Possible Detrimental Psychological Effects of Abortion" (West Virginia Department of Health and Human Services, n.d., p.15), the booklet lists "Post-Traumatic Stress Disorder Syndrome" as a possible outcome of abortion. The booklet warns, "Many women suffer from Post-Traumatic Stress Disorder Syndrome following abortion. PTSD is a psychological dysfunction resulting from a traumatic experience" (West Virginia Department of Health and Human Services, n.d., p.15). The booklet proceeds to enumerate the following panoply of possible symptoms associated with abortion-induced PTSD: guilt, depression, nightmares, fear and anxiety, alcohol and drug abuse, flashback, grief, suicidal thoughts or acts, sexual dysfunction, eating disorders, low self-esteem, and chronic relationship problems (West Virginia Department of Health and Human Services, n.d., p.15).

West Virginia's claim that "many" women suffer from abortion-related PTSD is scientifically unsubstantiated, and the language of "flashbacks" and "alcohol and drug abuse" demonstrates the appropriation of PTSD symptoms typically reserved for war veterans. Without stating so explicitly, the booklet suggests that post-abortion emotional response is on par with other psychological disorders catalogued by *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (American Psychiatric Association, 2013); this suggestion is predicated on the assumption that women, like soldiers, have survived something terrible. The list of symptoms included in the booklet is disquieting for both its simplicity and its volume. A large range of traumatic outcomes is listed without qualification or modification, thereby suggesting that women who have an abortion risk landing somewhere in a frightening spectrum of emotional trauma and social dysfunction.[56]

In general, the "informed consent" materials catalogued above demonstrates a biased and empirically reductive picture of post-abortion psychology, one that embellishes and amplifies antiabortion anecdotes in an attempt to ascribe a causal relationship between abortion and psychological trauma. Subsuming the manifold of emotional responses under a false psychological disorder disregards the multiplicity of contextual factors that influence the abortion decision, and it precludes important discussions regarding emotional response and moral decision-making in a social climate hostile to abortion. Moreover, the suggestion that abortion causes psychological disorder blatantly ignores the experiences of women who experience positive emotions subsequent to the abortion decision. Indeed, it is highly reductive to make blanket claims about the relationship between abortion and emotional response given the idiosyncratic experience of unwanted abortion, an insight recognized by The American Psychological Association Task Force on Mental Health and Abortion (2008) when it claims there "is unlikely to be a single definitive research study that will determine the mental health implications of abortion 'once and for all' given the diversity and complexity of women and their circumstances" (p.4). Put another way, any study claiming a causal relationship between abortion and mental disorder is deceptively reductive insofar as abortion is not a generic experience that precipitates uniform emotional response (Major, Appelbaum, Dutton, Russo, & West, 2009, p.866).

Leading psychological organizations have rejected the claim that abortion is psychologically damaging. For example, The American Psychiatric Association (2013) does not recognize Post-abortion Syndrome in its *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). In 2008, after a rigorous analysis of peer-reviewed literature, The American Psychological Association Task Force on Mental Health and Abortion (TFMHA) concluded, "the best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy" (p.4). In addition, the report explained, "TFMHA reviewed no evidence sufficient to support the claim that an observed association between abortion history and mental health was caused by the abortion per se, as opposed to other factors" (p.4). In general, peer-reviewed research suggests that the strongest indicator for gauging a women's mental health after an abortion is her emotional state prior to the abortion

(American Psychological Association Task Force on Mental Health and Abortion; 2008; Kimport, Foster, & Weitz, 2011; Major, Appelbaum, Dutton, Russo, & West, 2009; Major, Cozzarelli, Cooper, Zubek, Richards, Wichita, & Gamow, 2000). Collectively, this research demonstrates, contrary to the message underlying "informed consent" materials, that women who terminate an unwanted pregnancy do not risk psychological disorder.

In fact, a number of peer-reviewed research studies report that many women report positive feelings subsequent to abortion and "cope well" after the procedure, (Major, Appelbaum, Dutton, Russo, & West, 2009, p.882). And, in a meta-analysis of women's psychological responses to abortion, Adler et al. (1990) observe that women "most frequently report feeling relief and happiness" (p.41) after having a first trimester abortion and that "the time of greatest distress is likely to be before the abortion" (p.43). Thus, the notion of post-abortion syndrome obscures the very real fact that many women view their abortion as a psychologically empowering experience (Baumgardner, 2008; I'm not sorry.net, n.d.; Winter, 2013).

It is also important to note that antiabortion narratives of post-abortion syndrome rely upon a clumsy and unrefined understanding of emotional response. For example, arguments that claim abortion entails psychological disorder frequently conflate emotional response with psychological disorder. Of course, sadness, regret, and anxiety are all possible emotional reactions to an abortion, but, as Rubin and Russo (2004) wisely note, "having an emotion is not the same as having a mental disorder" (p.74). Regret, grief, and other "negative" emotions are complex experiences and cannot be taken *prima facie* as signs of abortion-induced pathology nor as evidence that abortion was a poor decision. It does not follow from experiences of grief, for example, that a woman has made an immoral or wrong choice. Like many ethical decisions, abortion can sometimes involve the coexistence of conflicting feelings and desires. It is possible for a woman to simultaneously experience relief and grief over her abortion decision, without rendering the abortion decision a poor or pathological one.

Moreover, in a society that routinely discredits women's decision-making capacities and stigmatizes abortion into constrictive practices of silences, it is not surprising that many women are left feeling vulnerable and insecure in their abortion decision. For these reasons, assessing and discussing emotional responses to abortion must be done with a critical eye to the social stigma and moral approbation that revolve around this issue. Yet, "informed consent" materials ignore such structural influences when they suggest that abortion itself causes psychological dysfunction.

Indeed, there is some research that demonstrates that negative emotional responses to abortion can be attributed to a lack of social support. For example, in one of the few research studies conducted to explore women's post-abortion negative emotions, where negative refers to "emotional difficulties" such as regret or depression (Kimport, Foster, & Weitz, 2011, p.103), analysts identified several social aspects that "produced, exacerbated, or mitigated" women's negative responses (Kimport, Foster, & Weitz, 2011). Negative responses arose when women experienced pressure from partners, parents, or others to have the abortion, and, consequently, felt that the abortion decision was not truly their own. Likewise, women who lacked emotional support or encountered hostile judgment after the abortion also reported negative emotional responses. Finally, women also experienced negative emotions due to the social stigma that shrouds abortion. Kimport, Foster, and Weitz (2011) write, “Although not telling anyone about their abortion may have saved some respondents from expected negative responses, it exacerbated feelings of secrecy and stigma. Women described insomnia, panic attacks and anxiety that stemmed from their effort to hide their abortion” (p.107). It is also possible that the additional burdens of accessing and paying for an abortion are adding to women’s negative emotional experiences with abortion. Considered alone, negative emotional responses do not provide sufficient grounds to infer psychological disorder.[57] Instead, post-abortion emotional distress demonstrates a need to address the larger social issues of unwanted pregnancy, social stigma, and economic instability.

Problematically, our culture’s longstanding tendency to pathologize women’s emotions likely lends support to antiabortion narratives of post-abortion trauma. Nineteenth-century diagnoses of hysteria, for example, are a good example of how women’s emotional experiences have long been interpreted and configured as medically deviant or neurotic. With this history in mind, “post-abortion trauma” both perpetuates and reflects a misogynistic intersection of patriarchal and medical paradigms that discredit women’s emotions. Tenacious cultural narratives of women’s emotional and moral ineptitude suggests that a successful revocation of “informed consent” laws will also require a deep rethinking of cultural attitudes toward women’s emotional experiences in general.

Finally, it is important to observe that “informed consent” discussions of psychological trauma not only violate medical standards of informational content, but they violate competency standards, as well. As discussed in Chapter One, the three pillars necessary to an informed consent include information, competency, and voluntariness. Within bioethics literature, patient competency is generally defined as a patients' ability to reason, understand, communicate and deliberate, and that an informed consent cannot occur absent such skills. Notably, information and competency are interrelated. Misinformation, when not recognized as such, interferes with decision-making capacity, and diminished capacity cannot properly assess medical information.

Of course, bioethicists debate the appropriate standards for evaluating patient competency, but one promising and widely-recognized framework is found in Buchanan and Brock's (1986) essay, "Deciding for Others." In this lauded article, Buchanan and Brock argue that patient competency is a decision-making capacity (p.22) that must be evaluated relative to the riskiness of a particular medical decision, where risk is a function of physical harm. Buchanan and Brock (1986) argue against deploying a single standard of patient competency across all medical cases, and instead propose that the "appropriate level of competence properly required for a particular decision must be adjusted to the consequences of acting on that decision" (p.34). That is, competency assessments should be made relative to the medical decision at hand; the greater the risk and the "more complex the array of possible benefits and burdens," (p.39) then the greater standard of competency required.

Buchanan and Brock's (1986) decision-relative concept of competency carries a number of interesting implications, but for the purposes of this work, I want to spotlight their argument that competency must be assessed patient by patient, case by case. On Buchanan and Brocks' (1986) model, the abortion-specific "informed consent" literature that I consider in this chapter perverts standard conceptions of competency. Insofar as "informed consent" materials are predicated on the assumption that *all* women seeking an abortion are mentally incompetent, they render the objective of informed consent incoherent in the abortion context. That is, if a woman seeking an abortion is already deemed incompetent, then an informed consent can be neither given nor sought. A deceit flawed with circularity, antiabortionists assume incompetency and then conclude that all women seeking an abortion are incompetent. Once incompetency is presumed, antiabortionists short-circuit the informed consent process and thwart women's autonomy. Of course, constricting women's reproductive autonomy has been the intent of the antiabortion movement from its inception. The novelty of "informed consent" materials, however, is that antiabortion forces use language that sounds supportive of women's rights to undermine women's rights.

Strategy Three: Fetal Constructions

A third strategy at work within "informed consent" materials involves the careful construction of a fetal subject that sanctions antiabortion restrictions. In general, the fetal subject of "informed consent" materials is constructed using two techniques: first, "informed consent" materials turn the fetal subject into an "unborn child" that is capable of experiencing pain, thus collapsing important physiological distinctions between the developing fetus and the postnatal infant; secondly, "informed consent" provisions use mandatory ultrasound readings to stress physiological continuities between a developing fetus and a postnatal infant. With this strategy, we once again see the assumption underlying the Supreme Court's view in *Casey* that the embryo or fetus deserves the same moral standing as a person. "Informed consent" materials that discuss the fetus or compel women to contemplate sonogram images do not provide genuine assistance for women interested in discussing the meaning and morality of fetal ontology and fetal imagery. Instead, they are designed to support antiabortion ideology and to usurp women's reproductive autonomy.

To begin, "informed consent" materials adopt the controversial and partisan position that personhood begins at conception in order to facilitate the claim that the fetus is tantamount to a postnatal being.[58] Currently, five states—Indiana, Kansas, Missouri, North Dakota, and South Dakota—"inform" women that personhood begins at conception (Guttmacher Institute, February, 2015b). The specific language used to make this claim varies across states. In South Dakota, for example, providers are required to tell women that an abortion will:

> [T]erminate the life of a whole, separate, unique, living human being; that the pregnant woman has an existing relationship with that unborn human being, and that the relationship enjoys protection under the U.S. Constitution and under the laws of South Dakota; and that by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated. (South Dakota Performance of Abortions, 200434-23A-10.1-1(a)-(d))

In addition to recklessly glossing over the philosophical questions regarding the meaning of a "living human being," South Dakota suggests that pregnant women hold the same responsibilities to a developing fetus as they do to other individuals by insisting that women already have "an existing relationship with that unborn human being."[59]

Kansas's "informed consent" material also advances the claim that personhood begins at conception, but they do so by giving a more detailed account of embryological development. In the opening lines of the section titled, "Human Development Before Birth" (p.4) the Kansas booklet reads, "Pregnancy begins at conception with the union of a man's sperm and a woman's egg to form a single-cell embryo. This brand new being contains the original copy of a new individual's complete genetic code" (Kansas Department of Health and Environment, n.d.a, p.4). Although medical terminology refers to the "brand new being" as a zygote or blastocyst, the booklet describes implantation as "the process whereby the unborn child embeds itself into the wall of the womb" (p.5). The Kansas booklet proceeds to explain, "At four weeks, the unborn child is less than 1/100th of an inch long" (p.6). Beside this claim, the booklet contains an enlarged picture of a fertilized egg, a glowing orb that resembles a translucent bubble or shiny sea stone. To the critical eye, the fact that the fertilized egg looks nothing like a "child" creates an incongruous disjunction between the book's written and pictorial depictions. Nevertheless, the language of "unborn child" is used throughout the booklet's description of fetal development, thereby collapsing important ontological, physiological and neurological differences between postnatal human beings, embryos, and fetuses.[60]

To further the construction of the fetal "person," twelve states currently provide information on the ability for the fetus to feel pain. In six states—Alaska, Georgia, Kansas, Louisiana, South Dakota, and Texas—women are given information on fetal pain regardless of their stage of pregnancy. In five states—Arkansas, Minnesota, Oklahoma, and Utah—providers are only required to deliver information on fetal pain to women who are in their 20th week of pregnancy or more, and in Missouri, women must be in their 22nd week of pregnancy or more. In Indiana, the law is currently unenforced as the courts adjudicate the measure (Guttmacher Institute, February, 2015b).

Of course, the claim that the early-term fetus can feel pain is not new to antiabortion discourse. What is new, however, is the inclusion of biased information on fetal pain within informed consent materials. This inclusion is cause for alarm because "informed consent" discussions of fetal pain contradict reputable scientific research on fetal pain and they disregard a number of important philosophical points regarding the concept of pain in general.

Professional medical organizations have long opposed the argument that early term fetuses experience pain. For example, in response to a 1980 antiabortion propaganda film, *The Silent Scream* (Dabner & Smith, 1984) which claimed that a twelve-week fetus experiences pain, Planned Parenthood organized a panel of medical doctors to co-author a report debunking many of the falsehoods fabricated by the film. The Planned Parenthood report (Dorfman et al., 1985/2002) referenced the American College of Obstetricians and Gynecologists to explain:

> We know of no legitimate scientific information that supports the statement that a fetus experiences pain early in pregnancy. We do know that the cerebellum attains its final configuration in the seventh month and that mylenization (or covering) of the spinal cord and the brain begins between the 20th and 40th weeks of pregnancy. These, as well as other neurological developments, would have to be in place for the fetus to receive pain. To feel pain, a fetus needs neurotransmitted hormones. In animals, these complex chemicals develop in the last third of gestation. We know of no evidence that humans are different. (Dorfman et al., 1985/2002, pp.2-3)

Since then, professional medical organizations continue to reject the argument that a fetus can experience pain prior to the third trimester (American Congress of Obstetricians and Gynecologists, June 20, 2013). After reviewing over 2,000 articles on fetal pain, a

2005 meta-analysis published in *The Journal of the American Medical Association* concluded:

> Pain perception requires conscious recognition or awareness of a noxious stimulus. Neither withdrawal reflexes nor hormonal stress responses to invasive procedures prove the existence of fetal pain, because they can be elicited by nonpainful stimuli and occur without conscious cortical processing. Fetal awareness of noxious stimuli requires functional thalamocortical connections. Thalamocortical fibers begin appearing between 23 to 30 weeks' gestational age, while electroencephalography suggests the capacity for functional pain perception in preterm neonates probably does not exist before 29 or 30 weeks.
>
> (Lee, Ralston, Drey, Partridge, & Rosen, 2005, p.947)

The Journal of the American Medical Association's meta-analysis challenges antiabortion arguments that conflate fetal movement with fetal pain. It is scientifically spurious to ascribe human senses such as "pain" to a being that lacks the enabling anatomical structures and neurological pathways necessary to experience pain (Royal College of Obstetricians and Gynecologists, March, 2010; The American Congress of Obstetricians and Gynecologists, June 20, 2013). Recent research also suggests that the fetus "never experiences a state of true wakefulness *in utero* and is kept, by the presence of its chemical environment, in a continuous sleep-like unconsciousness or sedation" (Royal College of Obstetricians and Gynecologists, March 2010, p.viii). Although the subject of pain is complex, and philosophers and neuroscientists commonly disagree over the very meaning of the terms "pain," "awareness," and "conscious recognition," the fact that "informed consent" materials fail to include the conclusions generated by major professional medical organizations marks a gross deviation from standard informed consent practice.

It is also worth noting that that a heightened focus on fetal pain may deflect attention from other pertinent issues that shape the abortion decision. Problematically, antiabortion arguments conflate a concept (fetuses experience pain) with a value (fetal pain must be avoided at all costs and, thus, abortion is always immoral). Common cultural practices demonstrate that pain itself is neither the ultimate nor lone factor in dictating the moral permissibility of actions. Although pain is something we generally seek to avoid, moral decisions are commonly predicated upon values and goals that exceed the issue of pain. Women considering an abortion, for example, are juggling a number of variables such as maternal health and personal circumstances, and sociological work on abortion demonstrates that the abortion decision is typically informed by a matrix of complex questions and concerns (Gilligan, 1982; Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). The reductive conclusion that fetal pain (a troubled concept, as discussed above) necessarily entails the impermissibility of abortion glosses over the phenomenology of moral decision-making vis-à-vis unwanted pregnancy.

The second technique used in the construction of the fetal subject of antiabortion ideology is the mandatory ultrasound.[61] In recent years, antiabortionists have turned to ultrasound technology as a potential ally and instrument in their co-option of the informed consent process. Unlike the provisions discussed above where women are provided with scientifically faulty or irrelevant information, ultrasound images do not inherently contradict sound scientific research on fetal ontology or fetal development.

Nevertheless, mandatory ultrasound images unjustly interfere with the informed consent process.[62]

Proponents of mandatory ultrasounds allege that women seeking to terminate a pregnancy are ignorant of the “reality” of fetal life, and that mandatory sonograms will correct this ignorance. For example, Republican Senator Tony Fulton of Nebraska, who in 2009 sponsored legislation that would require women to view an ultrasound image before having an abortion, explained, “If we can provide information to a mother who is in a desperate situation—information about what she’s about to choose; information about the reality inside her womb—then this is going to reduce the number of abortions” (as cited in Reeves, February 11, 2009, para 3). As a further example, Texas Governor Rick Perry has argued that mandatory ultrasounds would "[e]nsure that every Texas woman seeking an abortion has all the facts about the life she is carrying and understands the devastating impact of such a life-changing decision" (as cited in Basset, July 25, 2011). In 2011, Governor Perry made sonogram legislation an “emergency” item, and he signed into law a bill that requires women to undergo a sonogram and to hear a detailed description of the image before they can procure an abortion (Texas A Woman’s Right to Know Act, 2003 & Supp 2011). In a subsequent court ruling that upheld the Texas law, a panel of the 5th U.S Circuit Court of Appeals explained that this information is “the epitome of truthful, non-misleading consent” (Texas Medical Providers v. Lakey, 2012, p.12).[63]

Although ultrasounds are not considered medically necessary for a first-trimester abortion, twelve states—Georgia, Indiana, Kansas, Michigan, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, Utah, Virginia, and Wisconsin—now provide either written or verbal information on accessing ultrasounds to all women seeking an abortion. Ten states—Alabama, Arizona, Florida, Indiana, Kansas, Mississippi, North Carolina, Ohio, Oklahoma, and Virginia—currently require the abortion provider to offer the woman the opportunity to look at the ultrasound image. Three states—Louisiana, Texas and Wisconsin—require the abortion provider to show and describe an ultrasound image to the woman (Guttmacher Institute, January, 2015).

As way of example, Texas' mandatory ultrasound law institutes a notable interplay of both visual and verbal cues to construct an autonomous fetal subject that is the ontological equivalent of a post-natal infant.[64] For example, Texas law requires the sonographer to attest to "the presence of cardiac activity, and the presence of arms, legs, external members, and internal organs" (Texas A Woman's Right to Know Act, 2003 & Supp.2011,§ 171.012 (4) (A) (B)). Texas House Bill Fifteen also requires the sonographer to make "makes audible the heart auscultation for the pregnant woman to hear, if present, in a quality consistent with current medical practice" and to provide, "in a manner understandable to a layperson, a simultaneous verbal explanation of the live, real-time heart auscultation" (Texas A Woman's Right to Know Act, 2003 & Supp.2011, § 171.012 (4) (D)). The Texas law does not require the physician or provider to discuss inchoate or nonexistent organs or physiological features. In Texas, the physician is literally required to personify the fetus in ways that obscure the gradations of fetal development, or what doctors and scientists refer to as epigenesis. There is, of course, nothing medically false about identifying a "beating heart," but a more medically comprehensive reading of the sonogram should also call attention to the physiological aspects of the fetus that are absent, such as functioning lungs, or a fully developed or operational central nervous system. The omission of these important elements alongside the illumination of other elements works to bias the meaning of ultrasound images in the direction of antiabortion ideology.

In addition to obscuring important physiological differences that distinguish fetuses from postnatal infants, mandatory ultrasound laws, like those instituted in Texas, also overlook representational issues posed by ultrasound technology. New visualizing technologies that allow one to peer through a woman's body to see the fetus simultaneously document the fetus and erase the context within which the fetus develops, i.e., the woman's body. There is nothing in the ultrasound image itself that explicitly reflects the fact that the fetus develops inside the woman and the ultrasound laws at subject in this chapter do not require providers to emphasize nor explore this point. Indeed, mandatory ultrasound laws work very hard to construct a fetal subject that is unique and distinct from the woman within which it develops.

Requiring abortion providers to describe sonograms in ways that equate the fetus with a post-natal human subject distorts the rich interdependency of fetal ontology, and it glosses over the ethical import of this ontology.[65] Although the fetus' biological autonomy increases over the course of pregnancy, the fetus is tethered to, and dependent upon, the woman within which it gestates. This biological derivativeness institutes a particular form of ambiguous existence: fetuses are both of, and other to, the woman (Young, 2005, pp.46-61). Notably, the inextricable biological intertwinement of the fetus and the pregnant woman is not a symbiotic relationship; the woman supports and nourishes the fetus, a life-sustaining favor not returned by the fetus. To overlook this fact is to ignore the very significant fact that pregnancy occurs within women's bodies and exerts a biological toll upon women, though the specific health impact of pregnancy clearly varies across cases. Articulating the fetus as a "unique" human being, therefore, ignores the moral and medical implications that follow from the fact that fetuses develop inside, and are dependent upon, the woman's body, and it contributes to the mythology that pregnancy is easy and natural whereas abortion is dangerous and unnatural. One of the implicit dangers of ultrasound images is that they can inscribe a false autonomy to the fetal subject and draw attention away from the physiological context of pregnancy. Although antiabortionists routinely use sonograms to further the illusion that "one is looking directly at the fetus, rather than at an image of the fetus" (Mitchell, 2001, p.36), ultrasounds are ultimately only simulacra, a condition that should be recognized when discussing ultrasound images.

Finally, the very act of producing and reading an ultrasound image is itself a cultural event that is informed by the power structures endemic to any medical interaction. This point problematizes the use of ultrasounds as "objective" information. Women don't perceive an ultrasound image in a neutral social vacuum, and if providers are legally bound to interpret the image in specific ways then the image's meaning will be narrowly circumscribed from the start. The fact that ultrasounds are not always easy to read raises additional concerns regarding the use of ultrasound imagery in the informed consent process. Ultrasound images, particularly those produced during the first trimester of pregnancy—when the vast majority of abortions occur—are typically nebulous, blurry, and distorted and they require interpretation. As Janelle Taylor (1992) writes, "Ultrasound images themselves do not look exactly like photographs—they are grainier, fuzzier, less distinct. Their "reading" is in large measure a matter of specialist interpretation" (p. 76). In this sense, the ultrasound doesn't innocently speak to a woman to reveal the "truth" of the "unborn child." Rather, the scripted reading exploits the power endemic to medical vernacular, the informed consent process, and the clinical setting to legitimize the political message that a developing fetus is an unborn child. And although feminist work on fetal subjects demonstrates that ultrasound images signify different meanings to different women, the interplay of power, medical authority, and medical vernacular may significantly narrow the range of what gets recognized as a legitimate interpretation.

Conclusion to Chapter Three

In concluding this section on "informed consent" within the clinical context, I would like to reiterate two central claims of this chapter. First, abortion-specific "informed consent" laws pervert standard practices of informed consent. Secondly, the ideology that underwrites "informed consent" laws demonstrates a striking ignorance of women's phenomenological experiences with an unwanted pregnancy, as well as the issues and priorities that shape their decisions.

Informed consent practices were originally articulated on the premise that medical dialogue would help patients and providers to make better medical decisions. Although dominant articulations of informed consent are riddled with a number of theoretical deficiencies, patient autonomy is a constant, albeit at times underemphasized, value across informed consent literature. As this chapter argues, however, women's reproductive autonomy is repeatedly disrespected and undermined by "informed consent" laws. When antiabortion politicians pass "informed consent" laws on the basis that such laws will protect women from making bad decisions, their true aim is to negate women's autonomy altogether, despite dressing their agenda in language that sounds helpful to women. By smuggling false information into "informed consent" practices, antiabortion forces resort to scare tactics in an effort to restrict women's abortion choices. The irony here is clear: a medical practice originally designed to promote patient autonomy is being refitted to limit women's autonomy.

It also bears mention that the topics discussed within "informed consent" literature, such as fetal subjectivity and potential infertility, do not reflect the pivotal concerns of many women who are facing an unwanted pregnancy. A 2002 survey of the socioeconomic conditions of women who have abortions revealed that 27% of abortion patients identify as Catholic and 13% percent of abortion patients identify as evangelical or "born-again" (Jones, Darroch, & Henshaw, 2002). It is reasonable to conclude that many of these women view the moral status of the fetus as commensurate with postnatal human beings, yet they still chose to terminate their pregnancy. This would suggest that the logic driving mandated ultrasounds does not square with women's moral decision-making processes; in other words, the phenomenology of abortion decision-making cannot be reduced to a formulaic equation that hinges the permissibility of abortion on the (always constructed) status of the fetus.

The sociological research conducted by Carol Gilligan (1982) demonstrates that most women do not hinge their abortion decision on abstract questions of fetal ontology and instead assess the decision within the context of their socio-economic circumstances, their relationships with others, and their own goals and life projects.[66] According to

Gilligan, women's central concerns involve issues such as the ability to parent responsibly, their responsibilities toward others, and the meaning of motherhood (Gilligan, 1982, pp.64-105). Yet, "informed consent" materials ignore such concerns with an almost perverted focus on fetal subjectivity and emotional distress. The notion that a woman's abortion decision should be determined by an ultrasound image or by the specter of insanity insults the complex moral reasoning that accompanies an abortion decision. In this sense, "informed consent" laws have nothing to do with protecting or enabling women's autonomy and everything to do with short-circuiting women's ability to make autonomous medical decisions.

In short summation, state scripted "informed consent" materials impose a series of problematic hurdles for women seeking abortions, leading Dr. Gretchen Ely (2007), a professor of social work at the University of Kentucky, to argue that such laws

> . . . can be understood as part of a larger societal and political climate that seeks to punish women who get abortions and take away their confidence in their moral ability to know the best means by which to control the size of their families. (p.70)

In a similar vein, Rachel Benson Gold (2009) argues that antiabortion policies

> . . . at their heart, are premised on the notion that women who intend to have an abortion (and to some extent, the public at large) do not fully understand what an abortion really is—and that, if they did, they would behave differently. (p.1)

Of course, there is nothing new about sociopolitical campaigns that discredit women's ability to make sound reproductive decisions. What is new, however, is the use of informed consent rhetoric to service antiabortion ideology.

CHAPTER FOUR

“INFORMED CONSENT” AND WOMEN’S LIVES

The focus of Chapter Four is the material effects of “informed consent” laws upon women’s lives. Whereas the previous three chapters considered the bioethical, judicial, and clinical discourses that structure the meaning of abortion and informed consent, Chapter Four turns its eye to the voices of individual women who directly experience “informed consent” laws. A turn to anecdote is necessary because it is individual women who encounter, suffer, and resist abortion laws. That is, the intersection of abortion with informed consent is not simply a theoretical topic that requires further address; it is an experiential and morally lived problem as well. Consequently, insofar as this work is premised on the notion that “informed consent” laws are harmful to women’s reproductive autonomy it is important to provide concrete examples of how “informed consent” laws are impacting women specifically.

To date, women’s perceptions of, and responses to, “informed consent” laws are vastly understudied and undertheorized. Currently, there is limited empirical research on “informed consent” laws, and little is known about women’s idiosyncratic experiences with “informed consent” regulations. Despite this paucity of research data, I argue that it is still possible to illuminate the negative impacts of “informed consent” laws through a close analysis of the available data. To help theorize an undertheorized field of human experience, I break this chapter into three distinct sections.

In section one, I summarize limited research on women’s perceptions of “informed consent” laws in order to delineate the current research scene. Although empirical research indicates that “informed consent” laws are not influencing abortion demand, I argue this research nevertheless contains clues that suggest "informed consent" laws hurt women's autonomy. More specifically, I draw on structured interviews to propose that "informed consent" practices that *require* providers to offer women an opportunity to view an ultrasound image may interfere with some women's autonomy. In addition, I explore a common opinion surfaced by Cockrill and Weitz's (2010) research on women's perceptions of "informed consent" laws: "I do not require heightened regulation, but other women, do." I suggest that this opinion is both a cause and an effect of antiabortion ideology.

In section two, I turn to the story of Carolyn Jones whose first-person account of "informed consent" laws in Texas has received wide-ranging press. I recount Jones' distressing experience with abortion laws, and I expand upon her anecdotal observations to further demonstrate the insidious impact of "informed consent" laws. Jones' narrative is useful as it provides rich insight into both the psychological and administrative dimensions of abortion regulation in Texas, and her story demonstrates how the autonomy of abortion providers is being violated as well.

In section three, I couple Jones' story with feminist theories of intersectionality and relational autonomy to hypothesize other obstacles women may encounter during the "informed consent" process. More specifically, Jones' story provides a springboard from which to imagine the negative impact of "informed consent" laws upon women from other social locations. By integrating Jones' anecdote with theoretical insights, I argue that "informed consent" laws undermine, assault, and diminish women's reproductive autonomy, although not necessarily in any uniform way.

This chapter's focus on the impact of abortion-specific "informed consent" laws continues the argument established in Chapter Three that "informed consent" laws dramatically pervert the original doctrine of informed consent. More to the point, these laws not only fail to operationalize women's autonomy, but they aggressively limit and undermine women's reproductive autonomy as well. Thus, "informed consent" laws represent an appropriated discourse of the most troubling kind for reproductive rights advocates.

Current Research Exploring "Informed Consent" Laws

Inarguably, there is a shortage of scholarly research exploring women's experience with "informed consent" mandates, and the voices of women facing these regulations are notably absent from critical review (Ely, 2007; Cockrill & Weitz, 2010). In a 2010 journal article, Ely, Dulmus, and Akers write, "despite the large percentage of women affected by the mandatory counseling that accompanies an abortion procedure, a review of the literature indicates that little-to-no research has been conducted to explore patient perceptions of the pre-abortion counseling process" (pp.103-104). In the intervening time between Ely, Dulmus, and Akers' (2010) assessment and the completion of this work, additional research has occurred, although more is clearly needed.

The research that has been conducted suggests that "informed consent" regulations do not change women's minds about abortion (Cockrill & Weitz, 2010, p.16; Medoff, 2009, pp.639-649), and researchers do not report cases of women feeling dramatically undermined or assaulted by these laws.[67] In addition, some women report positive experiences with optional ultrasound-viewing laws. Nevertheless, I argue "informed consent" laws are undermining women's reproductive autonomy, and that it is possible to glean negative impacts from extant research.

To begin, the Bixby Center for Global Reproductive Health (2014) and their research group Advancing New Standards in Reproductive Health (ANSIRH) (June, 2014) have begun researching the use and perception of ultrasound viewing within the abortion context (Gatter, Kimport, Foster, Weitz, & Upadhyay, 2014; Kimport, Preskill, Cockrill, & Weitz, 2012; Kimport, Upadhyay, Foster, Gatter, & Weitz, 2013). Through the use of medical record data collection and in-depth interviews, these studies collectively argue that ultrasound viewing does not "have a uniform effect," upon women and "the vast majority of women proceed to termination whether they view the ultrasound or not."[68] The ANSIRH study (June, 2014) also demonstrates that many women "are interested in viewing their ultrasound image" (p.1), and that option-to-view law "increases the odds" that the woman will view the ultrasound image and, consequently, increase their feelings of control over the medical decision (p.1).

For example, Kimport et al. (2012) interviewed a woman named Joy, who requested to view her ultrasound image. In Joy's own words:

> I had an ultrasound so I could actually see it right there. And I actually have that imprinted in my mind. You know, I wanted to be completely aware as to what I was doing . . . I think it's also kind of traumatizing but it is what's occurring. I don't think there's any reason to pretend like it's not. (p.516)

Likewise, Jenifer, another interviewee, explained, "When she showed me the sonogram, it made me feel even better [about my abortion] . . . I really liked it. I really liked it because it made it feel more real" (p.516). In each of these cases, the women proceeded to termination, a decision that Kimport et al. (2012) argue challenges the antiabortion argument that women who view their ultrasound will choose to carry their pregnancy to term.[69]

Similarly, Wiebe and Adams (2009) found women who reported ultrasound-viewing as a positive experience, lending credence to anecdotal evidence from abortion providers that "most women who choose to see the [ultra sound] pictures are relieved to see that it is not what they had imagined, namely, something which looks like a small baby" (p.98). As Wiebe and Adams (2009) report:

> We have been aware that women tend to imagine something more like a miniature baby and this may be partly due to the images spread by antiabortion organizations. Since most abortions are carried out in the first trimester, often no more than a gestational sac is seen and many women find this reassuring. (p.101)

In such cases, viewing the ultrasound helped to bolster women's confidence in their abortion decision.

It would be rash, however, to conclude that option-to-view laws necessarily enhances the autonomy of all women. Notably, the ANSIRH data also demonstrates that ultrasound viewing "does have a small effect on the odds" that the woman will continue her pregnancy, if the woman expressed some uncertainty or ambivalence about her abortion decision prior to viewing the ultrasound (p.515). These data raise a series of questions that deserve further attention. Did the ultrasound image compel a woman to continue a pregnancy she would have otherwise terminated? If so, what did the woman see in the ultrasound that tipped her decision against the abortion? Did the woman's prior uncertainty allow her to see the ultrasound image differently than a woman resolved? Does the very act of offering an ultrasound image summon pronatalist norms? When do options carry normative subtexts? Scott Woodcock (2011) notes for example, that "the mere offering of certain kinds of information . . . can be disruptive [so] that in some cases it will significantly undermine the decision-making abilities of a patient facing an unplanned pregnancy" (p.497). The concern here is that within the context of a patriarchal society that circumscribes women's identity in terms of maternity, providers may inadvertently invoke feelings of guilt or doubt in some women by even mentioning the option of ultrasound viewing. With the rise of social networking websites like Facebook and Instagram, ultrasound images are increasingly becoming part of the public birth experience, making it difficult, if not impossible, to read ultrasounds as neutral medical information.

Moreover, there is the concern that even if some women find ultrasound images reassuring or empowering, other women may find them disturbing or upsetting. For example, Kimport et al. (2012) interviewed a woman named Cheryl for whom the ultrasound "exact[ed] an emotional toll" and caused "negative emotional consequences" (p.2012). In Cheryl's words:

> I said [to the doctor], 'You can tell me if I'm pregnant. I need to know because I'm going to terminate the pregnancy.' And he turned the screen around and said, 'Right there's the fetus.' And thump, thump, thump, you know, I could hear the heart beating and I put my hands on my ears and I said, 'That's enough . . . .' That gave me some psychological problems right there, because then I knew there was a human life there and all. But still, I knew I didn't want to give birth to it. I couldn't. (p.515)

Although Cheryl proceeded to have an abortion after viewing her ultrasound, it would be difficult to argue that ultrasound viewing enabled or empowered her decision. Instead, the ultrasound functioned as a form of state-sanctioned moral chastening. Notably, Cheryl was shown her ultrasound without request. However, it is possible to imagine a situation where a woman feels pressured to participate in an ultrasound viewing and subsequently experiences a similar set of "psychological problems" (p.515). In such cases, ultrasounds function more as disciplines of punishment, rather than as technologies to enhance autonomy.

The ANSIRH study concluded that "mandating that women view their ultrasound images may have negative psychological and physical effects even on women who wish to view . . ." and that mandating viewing may ". . . reduce women's perceptions of decisional control regarding abortion" (Advancing New Standards In Reproductive Health, June, 2014). What I am suggesting here, however, is that the coercion occasioned by mandatory ultrasound viewing can also occur with optional viewing laws. This is not to argue that women should never be offered the opportunity to view an ultrasound image. Rather, I am suggesting offered viewings could interfere with some women's reproductive autonomy if the offer is experienced as carrying a normative injunction to carry a pregnancy to term, or if the law channels women into an unnecessary or unsettling experience. When states institute a law that requires abortion providers to offer all women, in all cases, an opportunity to view an ultrasound, the state forecloses the providers' ability to respond to women's individual needs vis-à-vis ultrasound technology.

We can glean further insight into the possible negative ramifications of "informed consent" laws from the research by Cockrill and Weitz (2010) on women's perceptions of abortion regulations. In general, the 20 interviewed women were unaware of the existence of "informed consent" regulations prior to seeking an abortion (p.15), and most of the women were unable to distinguish state-mandated material from other materials provided by the clinic (p.15). Overall, the women surveyed by Cockrill and Weitz did not feel that state-mandated restrictions "impaired" (p.17) their experience.[70]

Nevertheless, the Cockrill and Weitz (2010) study does suggest that the antiabortion ideology underwriting "informed consent" laws may be infecting some women's perceptions of "informed consent" laws. More precisely, while some of the women interviewed by Cockrill and Weitz objected to state-mandated information and voiced concern that such information could mislead or coerce women, many women argued that this information might help "other women" make an informed decision. Cockrill and Weitz report, "In fact, responses to the question of whether a waiting period was a good law often included a caveat that while 'for me' it was unnecessary, 'other women' might benefit from the law" (p.16). According to Cockrill and Weitz:

> Most women in our study characterized their own abortion decisions as a good and thoughtful decision made in difficult circumstances. Yet their consideration for abortion regulation indicates that accepting their own reasons for abortion did not always translate into beliefs that other women had equally thought through their decisions. There was a consensus among our participants there are some circumstances or some women who need more regulation. (p.17)

Here, we witness a double standard at work in women's attitudes toward abortion regulation: few of the participants interviewed by Cockrill and Weitz self-identified as irresponsible, although they ascribed these qualities to "other" women.[71] This is to say, the subjects of this study opposed their need for regulation even as they defended the need to regulate "other" women.

It is important to clarify, however, that the opinions recorded by Cockrill and Weitz (2010) defend the regulation of abortion decision-making in general, not the appropriation of the informed consent process to deliver misleading information. Nevertheless, women's opinion that "other" women require heightened regulation is problematic if it lends support to "informed consent" laws. When women vocalize the belief that "other" women require abortion counseling, they may inadvertently reproduce and fortify sexist stereotypes of women's epistemic and moral incapacity.[72]

More specifically, the argument that "other" women require counseling may also interfere with efforts to challenge or dismantle "informed consent" laws. As Moore, Frohwirth, and Blades (2011) write:

> [T]he need to hold oneself apart, as we found in our data and as others have found (Cockrill & Weitz, 2010) hampers advocacy efforts to unite women's voices on behalf of the right to defend the right to an abortion, which is perhaps why in the first months of 2011, we have seen an assault on the right to access an abortion in the United States unparalleled in history. (p.438)

When we couple the observation made by Moore, Frohwirth, and Blades (2011) with the opinions captured by Cockrill and Weitz (2010), there is reason to argue that "informed consent" laws are both a cause and an effect of a belief system that discredits women's reproductive authority.

The Story of Carolyn Jones

Although peer-reviewed, published research on "informed consent" laws provides important, methodologically monitored insight into women's experiences with "informed consent" law, we can find other venues that also illuminate the disturbing ramifications of "informed consent" laws. For example, Texas journalist Carolyn Jones wrote a story for *The Texas Observer* detailing her distressing experience with the Texas sonogram law in March 2012. Upon publication, Jones' story received ample attention in both feminist forums (Baker, 2012; Dusenberry, 2012) and mainstream news sources (Egan, 2012; Rochman, 2012), and in January 2013, Jones was a guest speaker on Terry Gross' popular NPR program, *Fresh Air* (Gross, 2013).

It is possible that Jones' story received widespread attention because Jones is a sympathetic character, one whose abortion decision did not challenge social values of motherhood, as we will witness below. In this sense, there is an interesting continuum between her and Sherri Finkbine, the woman whose abortion decision in the pre-*Roe* era helped to bring the abortion debate into the public sphere and incite the abortion reform movement of the 1960s (Condit, 1990, pp.28-31; Solinger, 2005, pp.178-181).[73] What Michelle Condit (1990) writes about Finkbine could be applied to Jones: "her abortion clearly did not attack the key social symbols of 'family' and 'motherhood'" (p.29). Consequently, Jones, like Finkbine, becomes a sympathetic figure in terms of public discussions of abortion restrictions. I note the connection between Jones and Finkbine in order to highlight long-standing social attitudes about what constitutes a “justified” abortion.

In the following paragraphs I recount Carolyn Jones’ distressing experience with “informed consent” laws in Texas. This overview will provide a specific example of how “informed consent” laws negatively impact women’s reproductive autonomy. Jones’ narrative is useful as it provides rich insight into both the psychological and administrative dimensions of abortion regulation in Texas, insights that are not currently captured by academic studies.

To begin, Jones was pregnant with her second child when a routine sonogram revealed that the fetus had a malformed head. On the same day, a second sonogram at a specialists’ office confirmed that the fetus had a neurological problem that prevented the normal formation of the spine, legs, and arms. The physician warned Jones that her child would face a lifetime of physical suffering and medical care, if he even survived the pregnancy. Jones (March 15, 2012) writes:

> Our options were grim. We learned that we could bring our baby into the world, then work hard to palliate his pain, or we could alleviate that pain by choosing to ‘interrupt’ my pregnancy. The surgical procedure our counselor described was horrific, but then so seemed our son’s prospects in life. In those dark moments we *had* to make a choice, so we picked the one that seemed slightly less cruel. Before that moment, I’d never known how viscerally one might feel dread. (para 10)

That afternoon, Jones and her husband drove to a Planned Parenthood clinic to obtain an abortion. Once there, Jones learned that Texas' new sonogram law required Planned Parenthood to perform another sonogram, Jones' third one of the day. In conjunction with the sonogram, Jones was required to hear a detailed description of the fetus and then wait an additional twenty-four hours before the abortion could be performed. Notably, the scripted reading her provider was obligated to recite provided no medical benefit for Jones; the procedure was done under the onus of state law. Although Jones and her team of healthcare providers denounced the sonogram requirements, they all complied unwillingly. Jones' first-person account is telling, and so I quote her at length:

> 'I'm so sorry that I have to do this,' the doctor told us, 'but if I don't, I can lose my license.' Before he could even start to describe our baby, I began to sob until I could barely breathe. Somewhere, a nurse cranked up the volume on a radio, allowing the inane pronouncements of a DJ to dull the doctor's voice. Still, despite the noise, I heard him. His unwelcome words echoed off sterile walls while I, trapped on a bed, my feet in stirrups, twisted away from his voice. 'Here I see a well-developed diaphragm and here I see four healthy chambers of the heart . . .' I closed my eyes and waited for it to end, as one waits for the car to stop rolling at the end of a terrible accident. When the description was finally over, the doctor held up a script and said he was legally obliged to read me information provided by the state. It was about the health dangers of having an abortion, the risks of infection or hemorrhage, the potential for infertility and my increased chance of getting breast cancer. I was reminded that medical benefits

> may be available for my maternity care and that the baby's father was liable to provide support, whether he'd agreed to pay for the abortion or not.[74]
>
> (Jones, March 15, 2012, para 20)

To comply with Texas law, Jones returned home to endure the mandatory waiting period. She returned to Planned Parenthood the next day. During the procedure the nurses held her hand and let her "cry like a child in their arms."

Jones later learned that the Texas ultrasound law contains an exemption for cases of rape, incest, and fetal abnormality. Upon learning about such exemptions, she contacted the Planned Parenthood staff to ask why an exemption had not been recognized in her case. After reviewing Jones' case, Planned Parenthood apologized and explained that at the time of Jones' abortion, the sonogram law was too new to have allowed for appropriate review.

Upon further investigation, however, Jones discovered that Texas had not issued technical guidelines, such as exemptions, until four days after her abortion. In Jones' words: "So for three weeks, abortion providers in Texas had been required to follow the sonogram law but had not been given any official instructions on how to implement it" (Jones, March 15, 2012, para 29). This lack of legal clarity demonstrates the increasingly ambiguous intersection of law and medicine that abortion providers must navigate.

Notably, the exemptions that were later inserted into Texas' ultrasound law presume that women like Jones (read: women who want to become mothers, but are victims of nature-gone-wrong) should not be subjected to a mandatory ultrasound, but women who reject maternity should be. Proponents of mandatory sonogram laws might respond that Jones' experience was the result of an unfortunate bureaucratic oversight, and that the law now clearly provides guidelines for women in similar circumstances. Such a defense, however, does not negate the coercive affects this law has on women's reproductive autonomy, and it assumes that women who choose to terminate a pregnancy for reasons other than fetal abnormalities, or pregnancies that result from rape or incest, are misguided and morally impaired.

Clearly, Jones' story contains a number of elements that are unjust and unnerving. It is shocking to imagine an emotionally distressed woman in stirrups "closing her eyes" and "twisting away from [the doctor's] voice." This scenario reads like a chapter from Margaret Atwood's (1986) dystopian novel *The Handmaid's Tale* where the theocracy of Gilead reduces women to reproductive vessels. In addition, the trajectory of Jones' particular experience—beginning the day with a routine sonogram to learn the gender of her baby and terminating the same pregnancy 24 hours later—increased the sympathy of many of her readers. Texas' sonogram law compounded an already sad day.[75]

Jones' story strikes abortion rights supporters as an unequivocal and egregious affront to women's reproductive autonomy. Moreover, the physician's admission that he "was sorry he had to do this," and the nurses' attempt to drown out his voice by "cranking up the volume of the radio," indicates that their professional autonomy was also violated. After reading Jones' story, it is clear that the Texas "informed consent" law has nothing to do with patient autonomy and everything to do with antiabortion power.

Jones' narrative also demonstrates the harmful absurdity of a uniform distribution of information in the abortion context. As evidenced in Jones' story, she was alerted to the "health risks" of abortion, as well as options for maternity care and paternal liability during the "informed consent" process. Although this work aims to underscore the limitations of traditional articulations of informed consent, it is also important to recognize that many of the influential texts in American bioethics, including the President's Commission's (1982) report on informed consent and Beauchamp and Childress' (2009) *Principles of Biomedical Ethics*, rightly insist that the disclosure of information should be neither a monological process nor follow a unilateral model. This injunction is not reflected in "informed consent" laws that override any injunction for variation. Indeed, these laws compel abortion providers to share the same information regardless of the woman's particular circumstances and they usurp the healthcare providers' ability to determine and discuss relevant information. As demonstrated in Jones's case, the orchestrated reading of the health "risks" of abortion, and the declaration that "the baby's father is liable to provide support," can be irrelevant and emotionally cruel addendums.

Further troubles arise when we consider the ultrasound procedure itself. Notably, the procedure used on Jones differs from the procedure used on women who are in the early stages of pregnancy, the time period when most abortions are performed. During the early stages of pregnancy, a transvaginal ultrasound is the only way to produce a high-quality image and to make the fetal heartbeat audible. Contrary to a transabdominal ultrasound, sometimes termed "jelly on the belly ultrasound," a transvaginal ultrasound involves the insertion of a wand into the woman's vagina. The invasive nature of this procedure has led some commentators to liken mandatory ultrasounds to rape. "It's state-sanctioned abuse," said Dr. Curtis Boyd, a Texas physician who provides abortions. "It borders on a definition of rape. Many states describe rape as putting any object into an orifice against a person’s will. Well, that’s what this is. A woman is coerced to do this, just as I’m coerced” (as cited in Kristof, March 3, 2012). In the quest for high quality “information,” state-sanctioned rape is a justified means to an end. As Jones herself recounts,

> ‘I don’t *want* to have to do this [have a sonogram] at all,’ I told [the Planned Parenthood counselor]. ‘I’m doing this to prevent my baby’s suffering. I don’t *want* another sonogram when I’ve already had two today. I don’t *want* to hear a description of the life I’m about to end. Please,’ I said, ‘I can’t take any more pain.’ I confess that I don’t know why I said that. I knew it was fait accompli. The counselor could no more change the government requirement than I could. Yet here was a superfluous layer of torment piled upon an already horrific day, and I wanted this woman to know it. (Jones, March 15, 2012, para 17)

Here, it is difficult to view “informed consent” mandates as anything other than a tool to displace women’s reproductive authority. As Carol Sanger (2008) insightfully explains:

> Mandatory ultrasound disrupts a woman's control over her pregnancy, at least as far as the organization of her own attitudes. While an ultrasound screening is not quite like lining up with the kids at Kinder-Photo, once her fetus has had its little mug shot taken, the woman has embarked on the social experience of motherhood. Ultrasound operates as a technological quickening, though it works through visual rather than somatic sensation. (p.382)

Following Sanger’s argument, Jones’ case provides a clear example of how mandated ultrasounds “disrupt” women’s reproductive autonomy.

Relational Autonomy, Intersectionality, and “Informed Consent” Laws

Feminist theories of relational autonomy and intersectionality remind us that “informed consent” laws, like any social practice, will not affect women uniformly, and there is reason to argue that “informed consent” laws target the most vulnerable of women. In addition to providing important insights into the “counseling” experience, Jones’ story also affords the opportunity to imagine the impact of “informed consent” laws on women who are further disadvantaged along economic, sexual, or racial lines. By coupling theoretical insights with clues culled from Jones’ story, it is possible to illuminate how these laws may impact women from different social locations.

In recognizing the benefits that come from being a white, heterosexual women of certain economic standing, I do not mean to downplay Jones’ experience with Texas’ “informed consent” laws. The Texas sonogram laws violated Jones’ reproductive autonomy, and her maternal experience was shaped in objectionable ways. Rather, her story furnishes the material to imagine how women from other social locations may experience “informed consent” laws.

To begin, Carolyn Jones’ ability to discuss and defend her abortion decision is evidence of her strong autonomy skills, even if her autonomy was episodically violated during the “counseling” process. Jones is a professional woman who spoke elegantly on *Fresh Air*. She is clearly well educated and she holds professional status as a freelance writer. Jones is also white, heterosexual, and married.

Additionally, we learn that Jones’ husband accompanied her through the entirety of her ordeal. While narrating her story, Jones repeatedly uses the pronouns “our” and “we,” thereby indicating that she had an important network of support. She writes, “Our options were grim. We learned that we could bring our baby into the world . . . .” (Jones, March 15, 2012, para 10). This network extended beyond emotional support and includes pragmatic support, as well. For example, Jones recounts how “that afternoon, my husband and I drove through a spaghetti of highways,” (para 11) and “[w]hile my husband filled out the paperwork, I sat on a hard chair in the spartan reception area and observed my fellow patients. I was the oldest woman in the waiting room, as well as the only one who was visibly pregnant. The other patients either sat with their mothers or, enigmatically, alone” (para 12). These details are important because they tell us that Jones did not have to worry about transportation and that she had someone to help manage logistics like “paperwork.” Jones did not have to sit “enigmatically alone;” she had a partner who provided both emotional and administrative support.

There are clues in Jones’ story that alert us to her class status as well: she has a car, she has access to maternity care, and she later has the time and resources to publicize her story. Although the “informed consent” process was clearly traumatic for Jones, having specific resources—a car, maternity care, and the benefits that come from being married in a heterosexist society—may have contributed to Jones’ ability to think and respond autonomously to the “informed consent” process, even while “being trapped in bed,” feet in stirrups, listening to unwanted information.

Although “informed consent” laws require all women to go through the same process, the initial impact of this process may differ in relation to a woman’s social location. Feminist thinkers like Natalie Stoljar (2011) have shown that “the agent’s social situation has an impact not only on her identity and self-conception but also on the nature of important capacities like autonomy” (p.376). Insofar as women’s social situations vary widely, it follows that women's capacity for autonomy will vary as well. This reasoning, in turn, suggests that some women may respond less critically to the abortion "counseling" experience. Jones was capable of assessing the "informed consent" process as an unjust intrusion in her private life, but other women may lack that capability insofar as the ability to assess, judge, and respond to the process, i.e., to think autonomously, are themselves socially learned skills.

The reproductive autonomy of poor women, for example, may be more vulnerable to the "informed consent" process if they lack the financial resources or social standing that are useful to autonomous actions. Women who have to miss work, or women who have to struggle to find the money to pay for an abortion, may enter the clinic with increased anxiety or agitation, feelings that may be enhanced by the ritual of mandatory abortion "counseling." Diana Meyers (1987) views autonomy as a complex synthesis and coordination of different "skills" that collectively allow an individual to consider her choices vis-à-vis specific values and objectives. For Meyers, autonomy isn't reducible to one mode of behavior, like rational reflection. Instead, autonomous choices depend upon both the presence of other capabilities. Insofar as financial strain can cause heightened anxiety or doubt, then it follows that economically disadvantaged women may be at a greater risk for decreased autonomy skills during an "informed consent" session.

There are other hurdles to autonomy that can arise as a result of women's unique social locations. For example, women who don't speak English, or who speak English poorly, may not understand that providers disagree with ultrasound laws and they may not recognize their providers' efforts to mitigate the impact of "informed consent" laws (by way of apology or "turning up the radio"). Indeed such contradictory actions may lend additional ambiguity to an already confusing situation and thereby complicate a woman's ability to assess and respond to "informed consent" laws autonomously. If the physician or provider doesn't provide caveats, and if the woman doesn't have a critical consciousness about abortion politics in the United States (a consciousness that is often a function of social location), then the counseling ritual may have enhanced power because the provider occupies a position of authority. Insofar as "informed consent" laws are predicated on an antiabortion message, the upshot of this message may register more strongly with patients who do not understand that providers are acting under the pressure of state law.

This scenario is demonstrated in a brief scene in the popular television show, *Friday Night Lights* (Carpenter & Mann, 2010). In what may be the only television drama to recognize the reality of current "informed consent" laws, we witness a mother and daughter encountering Texas' "informed consent" law. Becky Sproles, a tenth grader living with a struggling single mom, becomes pregnant after a fling with a high school football star, Luke Cafferty. After discussing her options with Tami Taylor, the student guidance counselor, Becky makes a confident but emotionally wrought decision to terminate her pregnancy. Accompanied by her mother, Cheryl, Becky goes to an abortion clinic, where they are subjected to unwanted and clearly distressing information, although not without resistance. "We get it doctor, alright? This isn't necessary, you don't need to go through the whole procedural options, blah, blah, blah," Cheryl protests. "She's not having a baby; she's having an abortion." As they leave the clinic, Becky's agitated mother dissents, "Its unbelievable. I'm supposed to listen to some right-wing doctor . . . I'm supposed to take another day off from work so he can tell us we are trash."

This is Cheryl's assessment of the doctor's politics despite the doctor's confession that he is compelled to provide state-mandated information. Of course, it is unlikely that any abortion provider in Texas is "right-wing" and opposes abortion. Rather, abortion providers in Texas must be staunch and resilient supporters of abortion rights to be practicing in a state where they are heavily demonized. It is certainly possible, however, that some women, like Cheryl in the episode from *Friday Night Lights*, would perceive their providers as "right-wing" ideologues insofar as provider speech has been coercively conscripted for antiabortion ideology.

It is important to note that having a minority status or low economic standing does not necessarily mean that a woman will lack autonomy skills or be negatively impacted by "informed consent" laws. In fact, minority status may provide some women with critical distance vis-à-vis the message of "informed consent" practices. Rosemarie Tong (1989) speaks to this point when she writes:

> The condition of otherness enables women to stand back and criticize the norms, values, and practices that the dominate culture (patriarchy) seeks to impose on everyone, including those who live on its periphery—in this case, women. Thus, Otherness, for all of its associations with oppression and inferiority, is much more than an oppressed, inferior condition. Rather, it is a way of being, thinking, and speaking that allows for openness, plurality, diversity, and difference. (p.219)

Other feminist scholars have likewise argued that nonwhite women may operate with a critical consciousness that is necessary to the challenge of institutional power (Anzaldua, 2007; Collins, 2009). For example, Dorothy E. Roberts (1996) argues

> women of color may be more willing to resist medical domination. Because racism makes the oppressive use of medicine so obvious to many of them, women of color may be more suspicious of doctor's claims of beneficence. Denied the privileges of race and class, these women have the least to gain from the present institution of medicine and the most to gain from changing it. (p.117)

This is to say, different social locations will influence patients' perception of information, but minority status does not necessarily mean a woman is more vulnerable to the political ideology of "informed consent" laws. This insight is key to feminist efforts to overturn "informed consent" statutes, and it carries important implications for informed consent policies in general.

Moving on, Jones' story also awards us the opportunity to consider how women's "self-referring attitudes" (Stoljar, 2011, p.378) may impact their experience with "informed consent" laws. In general, self-referring attitudes include capacities like self-trust and self-esteem. As discussed in Chapter One, recent work by feminist theorists considers how autonomy skills can be diminished if a subject doubts or devalues her own epistemic capacities and moral worth (Benson, 1994; Dillon, 1997; Govier, 1993; McLeod, 2002).

It is likely that women will respond differently to "informed consent" practices depending on their various levels of self-trust. Carolyn Jones' narrative suggests that she had a strong degree of self-trust, an attitude that helped to fortify her abortion decision, and to defend her decision in subsequent discussions. This self-confidence is evident in her description of the decision-making process in her interview with Terry Gross (2013):

> And so to us, it was actually—it was a terrible choice; it was a heart-wrenching one. But it was also a simple one because as his parents, we chose what we believed was best for him, to prevent him from knowing a life of pain. And that was, in fact, quite a quick choice we were able to make as well, within minutes of my doctor giving us the terrible news. It was also almost an instinctive response about the choice that we would make. And this month, it's almost a year to the day that we made that decision. It was still the right decision for us because it was an instinctive one about protecting our child from pain.

Although Jones clearly experienced distress during the mandated ultrasound and the "informed consent" session, she retained confidence in her decision to terminate her pregnancy. In the *Fresh Air* interview, Gross (2013) asked Jones if the ultrasound had any impact on her decision to terminate her pregnancy. Jones responded:

> It had no impact on my decision to go ahead with the abortion; none whatsoever. It was a private choice I'd made, and I was going to stick with that private choice no matter the people who tried to interfere with me. In terms of my broader frame of mind, it did make me feel very angry, and I still do. (Gross, 2013)

Here, Jones' anger testifies to her self-trust as a decision-maker. Although Jones' self-trust did not preclude the emotional trauma precipitated by the Texas sonogram law, it did position her to critically evaluate her experience with "informed consent" laws.

Women who have a healthy degree of self-trust and who are confident in their decision to terminate their pregnancy may be more likely to view the delivery of unsolicited information as a nuisance or as state propaganda. For example, Cockrill and Weitz's (2010) study on patient perceptions of abortion regulations demonstrates that some women hold a critical stance towards the state's involvement in the delineation of informational content. One woman in their study, for example, expressed skepticism over the ideological intent that underwrites mandatory ultrasounds:

> This to me is one of those things where they want you to look and see what it is. And they want you to, they want you to look, and, and see exactly what it is that you're doing. And they, it's almost, it's almost like they want, they want you to understand that this is, that they are right, this is murder, you are killing a living, breathing thing, and we're gonna tell you, you know, what's going on exactly. (Cassie, age 25). (as cited in Cockrill & Weitz, 2010, p.15)

Of course, such critical skepticism does not necessarily mitigate the emotional dissonance and manipulation wrought by "informed consent" laws, but it does suggest that some women may be better equipped to respond autonomously to this information.

On the other hand, women who have diminished levels of self-trust may not be able to sustain the same level of critical reflection exhibited by Jones and Cassie. Given that women's decisions have faced historical hostility and disdain from a variety of fronts, some women's capacities for self-trust may be particularly vulnerable, especially in contexts of aggravated power-relations, like the medical or clinical setting. Insofar as cultural stereotypes of women as irrational or ignorant may infect practitioners' assessments of female patients' medical questions, responses, and informational needs (Sherwin, 1992, p.143), many women may enter the abortion context already uncomfortable with medical dialogue. If some women are accustomed to having their questions discredited or dismissed, then they may lack the confidence or self-trust to challenge, question, or debate the meaning of ultrasound images with their abortion-provider. Women who lack self-trust may already second-guess many of their life decisions. In a climate hostile to abortion rights it is reasonable to assume that many women will face heightened moral doubt when deciding how to respond to an unwanted pregnancy (Joffe, 2013), and they may be more sensitive to the normative import of "informed consent" laws.

Conclusion to Chapter Four

In short summation, the institutionalization of "informed consent" laws subjects women to a practice predicated upon inimical stereotypes of women's moral ineptitude. As demonstrated in the story of Carolyn Jones, "informed consent" laws are evolving into a form of state-sanctioned psychological abuse. Although empirical data is still limited, my goal has been to illuminate some of the social and psychological damages of "informed consent" laws by anchoring my theoretical discussion in the perspectives of individual women.

Catriona Mackenzie (2008) argues, "a just society has an obligation to promote autonomy by ensuring that its basic social, legal, political, and economic institutions provide the recognitive basis for its citizens to realize their autonomy" (p.524). "Informed consent" laws invade the provider-patient relationship and they attempt to short-circuit the "recognitive basis" that is crucial for reproductive autonomy. Although physicians and providers may themselves recognize women's autonomy, they are required to enact a ritual that suggests otherwise. In general, abortion-specific "informed consent" laws are a disciplinary practice that symbolically and systematically erodes women's reproductive autonomy. To this end, "informed consent" laws circumvent the obligations of a just society.

CHAPTER FIVE

CONCLUDING QUESTIONS AND SPECULATIONS

In the previous four chapters, I tracked “informed consent” across multiple discourses, looking at how it functions in judicial rulings, bioethics rhetoric, abortion discourse, and women’s lived experiences. In doing so, this dissertation likely raised more questions than answers, as is often the case with theoretical work. Although, I can neither anticipate nor answer all of the questions generated by my research on “informed consent” laws, in this concluding chapter I explore three questions that especially warrant further address.

First, how are “informed consent” laws being challenged? In this section, I identify resistance to antiabortion hegemony. Although “informed consent” laws are an abusive instance of power, it is important to remember that women and abortion caregivers are not simply victims; they are also agents capable of critical response and counter-action. This section illuminates some of the ways resistance to “informed consent” laws occurs.

Secondly, how are professional medical associations responding to “informed consent” laws? In earlier chapters, I argued that traditional formulations of informed consent focus disproportionately on physician authority. Insofar as “informed consent” laws override medical authority and assault physician autonomy, they veer dramatically from both theoretical formulations and medical practices of informed consent. In light of this departure, I consider how professional medical associations are responding to “informed consent” laws. In particular, I illustrate the American Medical Association’s

(AMA) silence on this issue, and I challenge the AMA's current policy on abortion provision.

Finally, how should informed consent practices proceed in the abortion context? Although my work is clearly critical of the doctrine and practice of informed consent, I also believe it would be calamitous if informed consent practices disappeared. Policies that protect and enable patient autonomy are still necessary, particularly in the context of reproductive healthcare where women's autonomy is assaulted on a number of fronts. In this section, I draw upon feminist clinical practice to espouse a renewed vision of informed consent practices within the abortion context.

Resistance and Insurgence

Feminist scholarship is freighted with the difficult task of revealing the injustices women suffer without simultaneously typecasting women as agentless victims. As important as it is for contemporary feminist scholarship to dwell on social inequities, adverse consequences can follow if we tarry exclusively with the negative. For example, an exclusive focus on social injustice can be disheartening and overwhelming, feelings that can discourage and frustrate activism. Moreover, shining a lone spotlight on the obstacles that obstruct women's autonomy paints a partial picture of reproductive healthcare practices and it further victimizes women, politicians, and healthcare providers by erasing their resistance. For these reasons, and to add balance to my previous focus on the darker corners of reproductive politics, I use this section to foreground resistance to "informed consent" laws.

This is a difficult task. As we know by now, sociological research on any dimension of "informed consent" law is lacking. Nevertheless, it is possible to glean acts of resistance from available research and reports. In this section I identify and discuss four modes of resistance: legal challenges, provider strategizing, first-person narratives, and academic and research publications.

To begin, it is important to call attention to the legal challenges issued by abortion-rights groups, politicians, and lawyers. Although abortion-rights groups face a formidable network of antiabortion legislation, legislative success has not been entirely elusive. For example, the Center for Reproductive Rights, a legal advocacy group that uses “the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill” (Center for Reproductive Rights, 2013a), has challenged many restrictive abortion laws (Center for Reproductive Rights, 2013b, p.2). As way of specific example, The Center for Reproductive Rights, in conjunction with American Civil Liberties Union, ACLU of North Carolina Legal Foundation, Planned Parenthood, and the law firm of O’Melveny and Myers, challenged a North Carolina law that required abortion providers to perform scripted readings of ultrasound images. The legal team succeeded in winning a preliminary injunction preventing the ultrasound requirements from taking effect, and in January 2014, the United States District Court for the Middle District of North Carolina permanently blocked the ultrasound law, later arguing that “the state cannot commandeer the doctor-patient relationship to compel a physician to express its preference to the patient” (as cited in Center for Reproductive Rights, December 22, 2014, para 1). The North Carolina court’s ruling is an inspiring testimony to the possibility of overthrowing unjust “informed consent” legislation via the courts.

Of course, state lines circumscribe the impact of legal rulings, a limiting demarcation that underscores the need for a formal federal rejection of "informed consent" laws. Auspiciously, in November of 2013, Senator Richard Blumenthal**,** Senator Tammy Baldwin**,** Representative Judy Chu, Representative Lois Frankel and Representative Marcia Fudge introduced the Women's Health Protection Act (2013). If passed, "states could no longer impose oppressive restrictions on reproductive health care providers that apply to no similar medical professionals" and "Dangerous regulations passed under pretext that stifle access to abortion care and endanger women's lives would be prohibited" (Center for Reproductive Rights, 2013c, para 9). The Women's Health Protection Act would invalidate laws that impose excessive or unwarranted regulations on abortion providers, laws that require women to make multiple trips to their abortion provider for nonmedical reasons, and restrictions on medication abortions and previability abortions (Boonstra & Nash, Winter 2014, p.14). In the words of Boonstra and Nash (Winter 2014), this Act represents "the first major proactive abortion rights legislation to be introduced in Congress in many years" (p.14). Though the law was referred to committee, and GovTrack.us (n.d.) predicts the bill only has a 2% chance of being enacted, it is encouraging to see congressional opposition, albeit marginal, to "informed consent" laws.

While legal experts are pursuing legal avenues of resistance, abortion providers are also working to neutralize the impact of "informed consent" laws. Carolyn Jones' (March 15, 2012) story, for example, provides an important window into provider efforts to counteract the impact of intrusive abortion regulations. Jones reported that the nurse turned up the music while the doctor "interpreted" the sonogram, and she also relayed that the doctor apologized for having to implement the law. Both acts helped to discredit the content of the law, even if they made for a more disjointed abortion experience.

Dr. Carol Joffe's (2009) book *Dispatches From the Abortion Wars* documents one strategy shared by a provider on a closed listserv. After fulfilling the "breast cancer requirement," the provider offered this addendum:

> By law I am required to tell you that there is a 'possibility' of an increased risk of breast cancer later in life for women who have an abortion. However, there is no medical evidence to support this idea. In fact, this has been taken very seriously and proven by medical research not to be so . . . . To put the risk of abortion in perspective, let me say this: Be sure to buckle your seatbelt and drive carefully on the way to the clinic and back home. Your trip to and from the clinic in your car will probably be the most dangerous part of your abortion.
>
> (as cited in Joffe, 2009, p.71)

By couching misleading "informed consent" provisions in this manner, providers may be able to mitigate the impact of deceptive abortion mandates. Likewise, in an early study of patient perceptions of abortion regulations, Cockrill and Weitz (2010) report a pragmatic strategy for negotiating mandatory waiting periods: "Our recruitment site in State B was able to maintain a one-day appointment schedule for out-of-town patients by having a doctor available for phone consultations on certain days" (p.15). Such phone consultations save patients' time, money, and effort without strictly violating the law. Unfortunately, a number of states have proposed recent legislation that would ban phone consultations and other forms of telemedicine (Boonstra, 2013).

Notably, some states permit providers to distance themselves from the content of "informed consent" materials. Nebraska's law, for example, contains such a provision: "The physician and his or her agent may disassociate themselves from the materials and may comment or refrain from commenting on them as they choose" (Nebraska's Informed Consent for Abortion, 2010). In Kansas, providers have incorporated their objections directly into the informed consent form. In response to state-mandated information regarding fetal pain, Kansas' Certification of Voluntary and Informed Consent form includes the following disclaimer: "The State of Kansas requires us to make the following statements, which we believe to be medically inappropriate, misleading, and ideologically motivated. We are currently challenging the validity of this requirement in court" (Kansas Department of Health & Environment, n.d.b, p.6). And later, in a rider on the final page of the informed consent form, abortion patients are advised:

> The State of Kansas requires us to inform you of the risks of breast cancer and preterm birth related to abortion . . . . Although a lot of junk science has been published by opponents of safe and legal abortion, there is no credible scientific evidence that abortion causes breast cancer or preterm birth in subsequent pregnancies. (Kansas Department of Health & Environment, n.d.b, p.11)

Both interpolations challenge antiabortion hegemony, and they are powerful counter-measures to misinformation otherwise legitimated by the authority of government-sanctioned documents.

Of course, the coexistence of competing claims may be confusing for many women, and the fact that counselors are now required to devise resistance tactics in order to do their jobs without punitive consequence is cause for alarm. Moreover, examples of providers explicitly distancing themselves from "informed consent" literature is further testimony to how far "informed consent" laws have drifted from standard practices of informed consent. In the high-paced world of healthcare provision, providers should not be required to devote their limited time to inventing creative solutions to minimize the adverse health impacts of scientifically unsound information.

Moving on, resistance to "informed consent" laws occurs through the words of women themselves, despite longstanding social taboos that have blocked women from publically discussing their abortion experiences. Historically, the topic of abortion has been inflicted by the silence of stigma. Rhetorician Celeste Michelle Condit (1990) notes that prior to 1960 abortion was "a whisper-word, not to be spoken in polite company or in public" (p.1). Although public discussions of abortion have proliferated substantially since the 1960s, social conventions continue to limit the scope and domain of socially acceptable abortion discourse. Most Americans are wise to the inflammatory and polarizing nature of abortion, and abortion is an issue many people avoid raising as a topic of casual conversation. The deeply personal nature of abortion and the manifold moral issues that orbit abortion, along with abortion's intimate link to sexual intercourse, further contribute to the common belief that abortion is a private issue that should not be discussed openly. One of the unfortunate consequences of such discursive constraints, however, is the reinforcement of antiabortion ideology. When women's silence is the rule, then the meaning and morality of abortion belongs to those who are authorized to speak, or to those who speak the loudest. Arguably, the voices of antiabortion protestors and politicians have dominated the airwaves in past decades, effectively overshadowing the experiences of women who seek an abortion.

Unfortunately, antiabortion discourse received further institutional support with a 2014 unanimous United States Supreme Court ruling that overturned a Massachusetts law that created a 35-foot buffer zone around abortion clinics (McCullen et al. v. Coakley, Attorney General of Massachusetts et al., 2014). Abortion-rights activists argue buffer zones are necessary in light of clinic violence and antiabortion infringements upon patient privacy; in essence, buffer zones allow women to enter abortion clinics free from close-contact street harassment. The Supreme Court ruled, however, that buffer zone laws violate protestors' First Amendment rights, a decision that effectively increases the acoustics of antiabortion voices within the clinical context.

In recent years, however, abortion rights groups have adopted a number of strategic policies to help pivot women's voices to the center of abortion discourse. For example, abortion rights activists have developed important online forums for women to discuss their abortion experiences openly (I'm not sorry.net, n.d.; Exhale, n.d.), and the work of groups such as the 1 In 3 Campaign (n.d.) and film productions like *I Had an Abortion* (Aldrich & Baumgardner, 2005) are making notable strides in challenging the stigmatic silences that still riddle abortion discourse by encouraging women to publically personalize abortion. As way of further example, a recent *New York Magazine's* cover story, "My Abortion" (Winter, 2013) featured twenty-seven women recounting their abortion experiences,[76] and Emily Letts broke new cyber ground when she posted a nongraphic video of her surgical abortion to her Facebook page (Rudolph, 2014). Collectively, such stories help to expand the ethical boundaries of the abortion debate beyond the confines of the deceptively simplistic pro-choice/pro-life binary that has dominated abortion discourse for decades, and they help to challenge antiabortion discursive monopolies.

More specifically, women who positively affirm their abortion experiences help to support and reassure other women who have had an abortion, or are considering having an abortion, by demonstrating that the abortion decision is not psychologically devastating and is often empowering. In addition, anecdotal stories can help other women to feel less alone, and they serve as a powerful countermeasure to "informed consent" literature that suggests abortion is traumatizing or dangerous. Women who discuss their abortions take control of how their abortion experience is framed and consequentially challenge the narratives favored by antiabortion protestors and politicians. One of Emily Letts' motivating factors for posting her surgical abortion to Facebook, for example, was to show that a surgical abortion in the early stages of pregnancy is quick and safe, and not necessarily scary. Letts (Rudolph, 2014) reports that most of the comments responding to her Facebook abortion were "breathtakingly supportive" (para 19), a testimony to the networks of camaraderie and resistance women can create when they share their abortion experience.

Although there is a paucity of women discussing their experiences with "informed consent" laws, an unsurprising lacuna given the discursive gaps that structure abortion discourse in general, some examples do exist. In the *New York Magazine's* cover story, for example, Abby notes, "They gave me all this paperwork that said, "This is serious. You could die . . . ." (as cited in Winter, 2013, sec. 6). Another woman, Madeline, writes, "I was at twenty weeks, just a few days away from being too late. During the ultrasound, the technician told me how big the head was—it was the most scarring thing. The next day, the procedure took fifteen minutes" (as cited in Winter, 2013, sec. 8). Although these passing references do not stand out as brazen acts of resistance to antiabortion legislation, I argue they can be understood as micro acts of antiabortion insurgency given social prohibitions on abortion as an acceptable topic of conversation. This is to say, the fact that women are discussing their experiences is politically important, whether or not they explicitly couple an abortion-rights prescription with their story. In simply mentioning the existence of abortion regulations, women like Amy and Madeline increase public awareness of the issue and complicate the reductive simplicity typical of antiabortion arguments.

Finally, opposition to antiabortion legislation has kindled important academic and research publications. Recently, a number of articles across a variety of disciplines have found their way to publication (Atkinson, 2011; Cockrill & Weitz, 2010; Graham, Ankrett, & Killick, 2010; Manian, 2009; Medoff, 2009; Woodcock, 2011). Although this work can really only be considered preliminary, the fact that research and analysis has begun indicates a growing awareness within academic and research circles of the problems precipitated by "informed consent" practices. I consider this dissertation, informed as it is by feminist methodology, to contribute to this growing body of literature.

In terms of quantitative research, the Guttmacher Institute continues to track and publish data on emerging configurations of state laws regulating abortion. In addition to analyzing social policy pertaining to sexual and reproductive health issues such as pregnancy, contraception, and biotechnologies, the Guttmacher Institute has considered the co-option of "informed consent" by antiabortionists. For example, Richardson and Nash's 2006 policy review, "Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials," and Joyce et al.'s (2009, April) "The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Lit Review" are notable examples of early work that calls attention to the misuse of "informed consent" in the abortion context. Likewise, the Bixby Center for Global Reproductive Health and their research group Advancing New Standards in Reproductive Health (ANSIRH) (2014) have begun investigating women's perceptions of "informed consent" laws, and their project, Evaluation of Abortion Restrictions Project, promises to unearth additional insight into the impact of abortion restrictions.

In the field of sociology, Ely (2007) and Ely, Dulmus, and Akers (2010) make a plea for additional studies considering patient satisfaction with abortion counseling in the era of heightened regulations, and Ely and Dulmus (2010) call attention to the impact of heightened regulations upon vulnerable women. In legal journals, the work of Atkinson (2011), Daly (1995), Gans (1995), Manian (2009), Siegel (1992; April, 2008; June, 2008), Siegel and Blustain (2006), and Suk (2010) stand out as alert and perceptive legal analyses of "informed consent" laws, and this community of legal scholars have provided powerful analyses of how abortion regulations deviate from informed consent law and practice. Concurrently, philosophers and political theorists, like Scott Woodcock (2011), James Rocha (2012), and Joanne Boucher (2004), bring a theoretical eye to "informed consent" regulations, unpacking the philosophical implications of autonomy and the rhetoric of ultrasound regulations. Although such articles are individually limited in scope and content, a limitation this work attempts to remedy through a sustained analysis of informed consent across multiple discursive practices, each academic publication provides a unique angle of theoretical critique, and collectively they work to expand the discursive territory of abortion rights resistance. Of course, academic work is not sufficient to challenge or end "informed consent" laws, but it is a necessary component as theoretical accounts can help to inform, incite, and drive legislative action, just as legislative actions help to drive theoretical discourse.

Finally, it is important to notice and enhance the connections between each of the discrete strategies discussed above. Although legal challenges, provider strategizing, first-person narratives, and academic publications each pursue unique routes of resistance, they are not isolated discourses and they certainly interconnect and influence one another. For example, abortion providers must remain fluent in the legal discourses that govern abortion provision in order to comply with the law and to develop legal modes of resistance. Likewise, the testimony of abortion providers often informs *amicus curiae* briefs submitted during court hearings on abortion regulations. Moreover, academic publications like those produced by Cockrill and Weitz (2010) engage and document the multiple resistance methodologies deployed by healthcare providers, thereby providing a forum for providers to learn from one another. In addition, it is indubitable that women's first-person narratives inform other resistance practices, even if their names are not always directly cited due to privacy reasons. For example, doctors and clinicians who are committed to providing abortions often anonymously reference their patients' personal stories as reason why they continue to work in such a socially divisive, and oftentimes dangerous, field (Physicians for Reproductive Choice and

Health, June 2005). Patient narratives clearly serve as a grounding inspiration for provider strategizing.

The previous examples offer a brief sampling of the myriad ways the discrete discourses of abortion interact. As reproductive rights advocates continue to challenge "informed consent" laws, they would do well to interweave the various strategies deployed by different groups working at different fronts of the "abortion wars" (Joffe, 2009; Solinger, 1998). Insofar as abortion is a multifaceted experience that is configured by a host of distinct discourses, then a robust and informed response to "informed consent" laws should deploy an interdisciplinary strategy that incorporates the unique perspectives and insights of lawyers, politicians, clinicians, academics, and patients.

Professional Medical Associations Respond

In this section, I consider the policy statements issued by professional medical associations in response to "informed consent" legislation.[77] It is important to consider policy statements because in the words of the American Medical Association, policies "provide the conceptual foundation and organizational framework for the activities that the Association undertakes to achieve its Core Purpose of promoting the science and art of medicine and the betterment of public health" (American Medical Association, 2014a). In other words, a policy statement serves as both an indicator and an instigator of action; if an organization lacks a policy statement on "informed consent" legislation, then it is unlikely that the organization will issue challenges to "informed consent" laws.

Here, I suggest that the "informed consent" policy statements of the American College Of Gynecologists (ACOG), the American Woman's Medical Association (AWMA), and the American College of Physicians (ACP) are important initial volleys against “informed consent” laws. However, I critique the American Medical Association’s (AMA) official policy on abortion for its tepidity and rhetorical imprecision. Given that the AMA wields the most social power of any medical organization, the AMA’s silence on “informed consent” laws is particularly troubling.

Mainstream judicial and medical discourses have long emphasized and underscored the supremacy of physician knowledge, and the courts have traditionally recognized and protected the privacy of doctor-patient communication. As argued in previous chapters, even the doctrine of informed consent, originally proposed as a means to mitigate physician power and to strengthen patient autonomy in a context of medical power relations, characterizes physician knowledge as authoritative and primary. Given the dominance of this view, one would expect professional medical organizations to boisterously object to legislation that overrides their professional expertise.

The powerful role historically played by the American Medical Association vis-à-vis abortion policy supports this expectation. Whether in the era of legalization or in the era of criminalization, physicians have long held deep control over women’s abortion decisions, and this control has received legal sustenance from the courts. As scholars of abortion know well, the AMA fronted the nineteenth-century campaign to criminalize abortion. Historians Kirstin Luker (1984) and James Mohr (1978) have both illustrated that the AMA’s antiabortion campaign reflects physician efforts to consolidate their power and legitimize medical authority in an era prior to the professionalization of medicine. By advocating for the criminalization of abortion, and then arguing that some abortions were medically necessary and that physicians alone had this knowledge, the AMA configured abortion as a strictly “medical” decision. Later, when the AMA reversed its position on abortion in the direction of legalization, physicians continued to articulate abortion as a medical decision, one that criminal abortion statutes unfairly interfered with. Historian Rickie Solinger (2005) confirms that physician challenges to criminal abortion statutes were primarily driven by the desire to safeguard physician authority, rather than feminist concerns regarding women's reproductive autonomy. All of this is to say, professionalized medicine has long monitored and controlled abortion regulation.

Given this history, and given the fact that abortion-specific "informed consent" laws displace physician autonomy, it is unsurprising that professional medical associations object to invasive legislation. However, individual medical associations have responded very differently to abortion legislation. The range of responses varies from explicit rejection of abortion-specific requirements to generalized disapproval of government interference with patient-provider relationships. In terms of policy positions on "informed consent" legislation, the most explicit and robust opposition has come from the American Congress of Obstetricians and Gynecologists (ACOG) and the American Medical Women's Association (AMWA).

In May 2013, the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists issued a policy statement addressing legislative interference with the patient-physician relationship, and they mentioned abortion legislation specifically. The ACOG states:

> The College and ACOG strongly oppose any governmental interference that threatens communication between patients and their physicians or causes a

> physician to compromise his or her medical judgment about what information or treatment is in the best interest of the patient.
>
> (American Congress of Obstetricians and Gynecologists, May 2013)

The ACOG clarifies that "examples of such problematic legislation include . . . laws that require medically unnecessary ultrasounds before abortion and force a patient to view the ultrasound image; laws that mandate an outdated treatment protocol for medical abortion" (American Congress of Obstetricians and Gynecologists, May 2013). The ACOG urges physicians to "oppose" and "advocate against" any legislation that interferes with professional medical care, and they argue that such legislation affects all physicians, not only OBGYNs. In addition, the ACOG has targeted specific abortion laws, such as those passed by the North Dakota and Texas legislatures. In response to Texas abortion legislation, ACOG Executive Vice President Hal C. Lawrence argues,

> The Texas bills set a dangerous precedent of a legislature telling doctors how to practice medicine and how to care for individual patients. ACOG opposes legislative interference and strongly believes that decisions about medical care must be based on scientific evidence and made by licensed medical professionals, not the state or federal government.
>
> (American Congress of Obstetricians and Gynecologists, July 2, 2013)

The American Medical Women's Association (AMWA) has also issued a policy statement on legislative interference with abortion decisions. In a position paper on abortion access, they carve out their clear opposition to "informed consent" laws. The AMWA writes,

> The American Medical Women's Association will oppose efforts to overturn or weaken Roe v. Wade. We will oppose laws and court rulings that interfere with the doctor-patient relationship, either in requiring or proscribing specific medical advice to pregnant women. We will oppose measures that limit access to medical care for pregnant women, particularly for poor or underserved groups.
>
> (American Medical Women's Association, n.d.)

The AMWA views abortion care as a necessary ingredient to social equality, and their policy position is notable for its emphasis on the medical, individual, and social benefits of abortion. The AMWA contends:

> Abortions will be chosen whether they are legal or illegal. When abortion was illegal in this country, it was brought about by dangerous, self-induced methods or by clandestine, often untrained, practitioners under unsterile conditions with no follow-up care. Many women suffered reproductive tract damage, infection, bleeding, permanent sterility, or death. Since the advent of legal abortion in the United States, there has been a dramatic decrease in all pregnancy-related deaths and in pregnancy and abortion-related complications.
>
> (American Medical Women's Association, n.d.)

Although the policy statements of both the ACOG and the AMWA may be partly driven by a guild mentality that resents outside influences upon medical authority, I argue their policy statements are also deeply informed by a genuine concern for women's reproductive autonomy and general compassion for women's well-being. The opening lines of the AMWA's (n.d.) policy position on abortion evidences this concern: "The American Medical Women's Association, an organization of women physicians and medical students, values equality for women and equal opportunity for women to achieve their full professional and personal potential." By recognizing the enabling relationship between abortion and social equality, the AMWA expands the meaning and importance of abortion beyond strictly medical concerns. Likewise, the ACOG's (July 2, 2013) language indicates their belief that Texas abortion legislation affronts women's medical autonomy:

> Both bills are plainly intended to restrict the reproductive rights of women in Texas . . . . All women, including the women of Texas, must have the legal right to abortion, unconstrained by harassment, unavailability of care, procedure bans, or other legislative or regulatory barriers, including those posed by these Texas bills. (para 1, para 5)

Both the ACOG and the AMWA recognize that a meaningful defense of women's reproductive autonomy requires a vocally specific opposition to "informed consent" laws.

Like the ACOG and the AMWA, The American College of Physicians (ACP) explicitly challenges "informed consent" laws, although they do not defend abortion rights as boldly as the ACOG and the AMWA. In July of 2012, The American College of Physicians published a paper explicitly addressing legislative mandates that infringe upon the physician-patient relationship and jeopardize patient safety and autonomy. Among examples of inappropriate regulations, the ACP mentions abortion laws such as mandatory ultrasounds and multiple unnecessary visits to the clinician's office (p.3). In this paper, the ACP offers a series of principles to guide the assessment of laws governing clinical practice. For example, the ACP (July, 2012) argues,

> Laws and regulations should not mandate the content of what physicians may or may not say to patients or mandate the provision or withholding of information or care . . . . Patients should not be required to undergo tests or interventions, especially invasive and potentially harmful interventions, that violate the patient's values, are not medically necessary . . . . Physicians should be guided by evidence-based clinical guidelines that allow flexibility to adapt to individual patient circumstances. (pp.6-7)

Notably, however, the ACP states the purpose of their paper is to provide "a framework for broadly addressing" issues relating to government infringement without "expressly taking positions on the controversial and related issues of abortion, reproductive rights, and gun control" (p.1). In other words, the ACP's paper argues that "informed consent" laws are misguided not because abortion care is an ethical good or a constitutional right, but because such laws "inappropriately infringe on clinical medical practice and patient-physician relationships" (p.2). Apparently, the ACP seeks to defend the legal sanctity of medical relationships while simultaneously avoiding the quagmire of abortion politics. In seeking to adopt a politically neutral position, however, the ACP produces an arguably anemic policy position vis-à-vis reproductive healthcare. The fact that a professional medical organization hesitates to take a more aggressive position on abortion is troubling, for reasons which will be explored in richer detail below.

Of the major professional medical organizations, The American Medical Association's policy statement on abortion-specific "informed consent" laws is the most anemic when it comes to abortion rights. In general, the AMA paints its position with broad strokes, and the AMA does not mention "informed consent" for abortion laws specifically. To clarify, the AMA unequivocally objects to legislative acts that straightjacket healthcare providers and the AMA supports legalized abortion (American Medical Association, 2014b). However, unlike the ACP, the AMWA, and the ACOG, the AMA does not specifically mention abortion in their policy discussions of problematic legislation.

Instead, the AMA frames its opposition to undue government intrusion upon the medical process with terminology that is troubling for its generality. For example, the AMA's policy on "procedure-specific" informed consent reads, "Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure" (American Medical Association, 2014c). Likewise, AMA policy on Government Interference in Patient Counseling dictates, "Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients" (2014d, para 1). Absent from the AMA's position are specific examples of the type of legislation that is at issue, such as mandatory ultrasounds. Indeed, the AMA is remarkably reticent when it comes to restrictive abortion legislation specifically. While researching the AMA's policy database, I was unable to find any direct mention of abortion-specific "informed consent" laws.

I argue that the AMA's failure to aggressively challenge "informed consent" laws can be understood in terms of the AMA's overall policy on abortion, which has been arguably impacted by antiabortion politics. Although the AMA defends the right of practitioners to provide abortion services, the AMA distances itself from the issue of abortion by articulating abortion as a matter of "personal value." AMA policy states:

> The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.
>
> (American Medical Association, 2014e)

Although the AMA supports legalized abortion, the AMA fails to proffer a robust defense of abortion rights.

The AMA's effort to maintain political neutrality in the face of abortion and their defense of provider opposition to abortion is likely informed by an escalation of provider conscience laws in recent decades, a legislative tactic fronted by abortion opponents. Provider conscience clauses allow healthcare providers and medical institutions to refuse to provide abortion services with legal impunity (Guttmacher Institute, 2014, December). Although conscience clauses are justified using the language of physician rights, such laws can interfere with women's ability to obtain abortion care (Sonfield, 2005). In effect, the AMA's defense of provider-conscience clauses can carry negative consequences for some women seeking an abortion, a consequence that antiabortionists surely applaud. As it stands, AMA rhetoric on abortion provision does more to protect physicians who oppose abortion services than physicians who struggle to provide them.

In this vein, the AMA's stance on abortion training is also watered-down. AMA policy explains,

> The AMA encourages education on termination of pregnancy issues so that medical students receive a satisfactory knowledge of the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. (American Medical Association, 2014f)

Insofar as abortion can be a life-saving procedure, it is disturbing that the AMA does not take a position stronger than simple "encouragement."[78] This is especially true in light of the alarming decrease in abortion training that has occurred in the United States over recent years.[79] It matters little if abortion is technically legal if there is no one who can provide the service, an enabling condition not lost on abortion opponents.

Ultimately, contemporary AMA policy on abortion proffers what I take to be a negative-rights view of abortion provision. That is, AMA policy supports the position that abortion providers should be free from laws criminalizing abortion, but it does not place an ethical imperative upon physicians and state governments to provide abortions. AMA policy on abortion states, "The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law" (American Medical Association, 2014b). This language is problematic as an ethical injunction to "not prohibit" differs from an ethical responsibility to provide. The former obliges inaction while the latter obliges action, and in the world of abortion provision this distinction is not trivial. When it comes to abortion, a suspension of laws outlawing abortions is insufficient to secure reproductive autonomy; in order for women to obtain abortions, the medical infrastructure necessary to abortion services must also exist, as must institutional support of physicians willing to provide abortion services. When antiabortion efforts are enjoying wide-ranging success and abortion services are dwindling (Jones & Jerman, 2014), then the failure to actively encourage abortion provision lends support to the antiabortion crusade.

Although the AMA offers no official explanation for their weak defense of abortion provision, I argue their effort to retain political neutrality is an unfortunate consequence of antiabortion pressures. The advent of "informed consent" laws marks a novel moment within informed consent rhetoric where the authority of physicians is diluted by nonmedical agendas. One would expect the AMA to lead the charge against "informed consent" laws given its historical defense of physician authority over the abortion decision and its stated opposition to excessive government infringement upon the medical process. Instead, the AMA is conspicuously absent from professional challenges to intrusive abortion regulations.[80] Carole Joffe (2009) draws upon thirty years of reproductive-health research to observe, "what I have come to see, over and over, is that in a peculiarly medical version of 'not in my backyard,' American physicians often don't support abortion provision in their own medical institutions" (p.17). Joffe (2009) attributes this failure of support to the stigma of abortion, persistent stereotypes of medical practitioners as the "back-alley butcher," a history of clinic violence and harassment, and American medicine's aversion to controversy (p.19). Joffe (2009) also argues that the "political mobilization by antiabortion activists has reached into medicine" (p.17), and she notes the existence of antiabortion caucuses within the ACOG and other medical organizations, such as the American Academy of Family Physicians (p.17). Given social hostility to abortion, it is surely probable that the AMA's tepid support of abortion rights in the current era is traceable to the zealotry of abortion opponents, coupled with the reluctance and reticence of abortion supporters within the medical community.

In a culture that continues to curtail abortion-rights, the AMA has a moral obligation to vociferously defend access to a routine and safe medical procedure. I argue that the AMA must issue a more aggressive policy position opposing abortion-specific "informed consent" laws. After all, it is possible to advocate for abortion rights without violating the legal rights of providers who refuse to provide abortions.

Revisions of Informed Consent

Thus far, this work has taken a critical approach to the concept and practice of informed consent. In Chapter One, I argued that traditional articulations of informed consent fail to address the power dynamics that structure society and medical relationships, and in subsequent chapters I considered how the rhetoric of informed consent has been turned against women who wish to terminate a pregnancy. In turn, my critique raises the question, if we agree that current informed consent practices are unacceptable and inadequate, how should informed consent practices proceed for women seeking an abortion?

This is not an easy question to answer. When it comes to informed consent, abortion problematizes the criteria of information and patient competency. Given the host of seemingly irreconcilable philosophical questions abortion poses, what information should providers tell their patients, and to what depth should this information be discussed? In theory, an informed consent requires that patients understand their medical condition and their treatment options. However, when philosophers, religious leaders, and ethicists continue to disagree over *how* abortion should be understood, what criteria should be used to identify and assess patient understanding? Given the deep moral particularity of abortion, is it reasonable to expect healthcare providers to serve as the primary conduits of information and the official gatekeepers of understanding?

Although coupling abortion with informed consent yields a profusion of potential philosophical and practical pitfalls, I do not mean to suggest that informed consent practices should be expunged from the abortion process. Indeed, a dialogical process of informational interchange still remains the most likely vehicle for respecting and encouraging patient autonomy during the medical decision-making process. In this concluding section, I articulate an alternative vision of informed consent for abortion, one to replace the current network of problematic restrictions that endanger women's reproductive autonomy.

More specifically, I argue it is imperative that legislators eliminate the "informed consent" laws critiqued in this work. In their place, we should adopt a renewed practice of informed consent that recognizes the value of the subjective standard of informational disclosure (Beauchamp & Childress, 2009, p.122) and includes *an option* for discussing emotional response and fetal ontology, subjects that have often been avoided by feminists in the past. Notably, many members of the abortion care community advocate for and implement many of the techniques I champion in this section. Despite antiabortion characterizations of abortion clinics as capitalist "mills" or abortion-factories, abortion providers have long recognized the moral complexities of abortion and the necessity of dialogue in the context of abortion.[81]

To begin, any discussion of informed consent must tangle with questions of information disclosure. What, and how much, information should a healthcare provider supply? What criteria should be used to assess and determine informational content? When has a healthcare provider supplied enough information to permit an informed consent, and when have they provided too much information? Insofar as patients' needs vary, it is difficult to formulate general criteria to answer such questions. It is thus unsurprising that there is a lack of precision regarding the issue of informational content within legal discourse and clinical practice. As Berg et al. (2001) report,

> Despite the large number of court decisions and varying formulae, there is a lack of clear definition of the scope of required disclosure. The legal requirements for informed consent remain unclear, and probably inherently so, given the development of judicially created rules from particular cases with idiosyncratic factual settings. (p.64)

Currently, informed consent literature recognizes three standards of disclosure and content: the professional standard, the patient-oriented or "reasonable person" standard, and the subjective standard. The professional standard identifies sufficient medical disclosure in terms of "what is customary and usual in the profession" (Berg et al., 2001, p.46). That is, medical professionals dictate the standard of informational content from their professional standpoint; medical custom governs medical disclosure (Beauchamp & Childress, 2009, p.122).

The second most widely used standard is the patient-oriented standard. This standard dictates the scope of disclosure on the basis of what "a reasonable person in the patient's circumstances would find material to a decision either to undergo or forgo treatment" (Berg et al., 2001, p.48). Advocates of the patient-oriented standard applaud the dialogical requirements it places upon the provider insofar as patient needs dictate the standard of measure, rather than medical authority. In general, the courts recognize one of these two standards and Berg at al. (2001) report, "roughly half the states use a professional standard of disclosure, and half use a patient standard" (p.58).[82]

As mentioned in Chapter Two, a third standard, the subjective standard, also exists within informed consent literature, although according to Beauchamp and Childress (2009), the "courts have generally avoided it" (p.122). This is unfortunate as the subjective standard of disclosure is perhaps the most promising in terms of abortion care. Insofar as the abortion decision is highly unique and relative to each woman's concrete circumstances, it is imperative that healthcare providers assess informational needs relative to individual patients. Whereas the professional standard overlooks the insights and epistemic contributions of the patient, and the patient-oriented standard is limited by the imprecise and abstract concept of a "reasonable person," the subjective standard dictates informational content in terms of the individual patient. That is, the subjective standard mandates providers to familiarize themselves with the patient's value systems, unique health problems, and family histories (Beauchamp & Childress, 2009, p.123), a requirement that compels deeper degrees of patient-provider dialogue. In addition, the subjective standard resonates most closely with the ideal of shared decision making as articulated by Jay Katz (1984) and the President's Commission (1982), a model that, despite certain weaknesses, offers perhaps the most auspicious guidelines for medical decision-making within the abortion context.

Beauchamp and Childress (2009) recognize the subjective standard as the "preferable moral standard of disclosure," but they maintain this standard is impractical because, "we cannot reasonably expect a doctor to do an exhaustive background and character analysis of each patient" (p.124). It is lamentable that Beauchamp and Childress fail to provide a more energetic endorsement of the subjective standard given its focus on individual patient needs. Although the subjective standard certainly places more demanding obligations upon providers, this standard's dedication to patient specificity makes it indispensable in the context of abortion care.

Insofar as the abortion decision is often informed by factors that fall outside the jurisdiction of medical expertise, such as patient values, it is especially important that providers operate with a model of disclosure that works to bring patient concerns to voice. As has been reiterated throughout this work, women may seek an abortion for economic reasons, for circumstantial reasons such as work or family life, or because they are not interested in birthing or raising a child. Although abortions are sometimes necessary for medical reasons—Carol Joffe (2009), for example, relates the story of a seventeen-year-old with a recurrent pulmonary embolism who accidentally becomes pregnant and requires an abortion because pregnancy "could exacerbate her condition, possibly leading to death" (p.84)—many abortions are sought for nonmedical reasons. Although abortion is a medical procedure, the meaning of abortion always exceeds medical issues. In the words of Kristin Luker (1984), an individual's thoughts about abortion are but the "tip of the iceberg" of that individual's entire "world-view" (p.158). Insofar as abortion is interwoven with a host of other ethical beliefs, including the moral significance of parenthood, female sexuality, and fetal personhood, and insofar as the abortion decision is intimately tied to a woman's other life projects and goals, then a woman's relationship to abortion will always be informed by her unique set of values and beliefs.

Here, my point is that the abortion decision must always be evaluated in light of the individual's social context and ethical perspectives. Given the highly personalized and irreducible specificity of pregnancy and abortion, and because women exist within different social configurations of abortion and motherhood, dialogical options and opportunity are key to a robust and meaningful practice of informed consent that recognizes and engages patients' unique value systems. The subjective standard demands dialogical exchange, and thus it stands as the most appropriate standard to be used within the abortion-care context where recognizing and engaging patient values is imperative.

Along with deploying the subjective standard, I argue it is also necessary for abortion caregivers to recognize the topics of emotional response and fetal ontology. Insofar as reproductive discourse is saturated in antiabortion ideology, a deeper discussion of these topics may help to bolster some women's reproductive autonomy. Given the highly politicized nature of abortion, and given the stigmas that continue to restrict abortion discourse, the informed consent process may be the only time that some women are afforded an opportunity to discuss topics of emotional response and fetal ontology. In the following paragraphs, I explain why it is necessary for abortion providers to be cognizant of the topics of emotional response and fetal ontology, an explanation that consequently provides further support for the value of the subjective standard as the preferred measure of information disclosure.

For one, current “informed consent” materials that warn women of psychosis following abortion, or only stress negative psychological consequences of abortion, must be removed from state-sponsored “informed consent” materials. However, this does not entail that abortion providers should sidestep the subject of abortion-related psychological response. Historically, abortion rights activists have avoided the ambivalent psychological responses wrought by abortion. In an article for *The American Prospect*, Dana Goldstein (2008) argues,

> The feminist movement is built upon the cornerstone of women controlling their reproductive destinies—on the imperative of valuing women’s lives over the potential for life represented by a pregnancy. In the past, that often meant not talking at all about post-abortive women’s feelings about the fetus. (para. 3)

Feminists, Goldstein notes, “worried that discussing abortion's after effects would play into Christian right talking points” (para. 7).

Although there is good reason to trouble over reductive discussions regarding the psychological consequences of abortion, a failure to attend to the psychological dimensions of abortion may let the pendulum swing too far in the other direction. After all, overlooking women’s emotional responses to abortion only perpetuates the historical omission of women’s perspectives and experiences. Some women may find the abortion decision psychologically disruptive and they may have a real need for further discussion of their affective experiences. As mentioned earlier, the taboo nature of abortion means that many women lack the opportunity to tangle with the moral ambivalences of unwanted pregnancy free from the pressures of antiabortion ideology. In a society that routinely stigmatizes and castigates abortion, many women experience conflicting and complex emotions about their abortion, the moral status of the fetus, and the meaning of motherhood. In such cases, the informed consent process may be the only opportunity they have to candidly discuss their thoughts and feelings.

Phenomenologically speaking, pregnancy is inimitable; there is no other somatic experience in which a human being harbors, co-exists, and grows another potential human being. Although the fetus or embryo is not interchangeable with a human subject, it is undeniable that the developing fetus or embryo exists along a trajectory that uninterrupted culminates in another human subject. Of course, the moral significance of embryonic development is contested, variable, and ever-shifting. Yet, the biological potentiality inherent to a fetus as an organism, the not-yet-but-soon-to-be quality that so many ascribe to the developing fetus, distinguishes pregnancy from any other human experience. The mistake made by antiabortionists is to assume that fetal potentiality necessarily entails the strict moral imperative to carry all pregnancies to term, but the mistake made by many reproductive rights advocates is to avoid the cultural ascriptions and phenomenological insights that accompany pregnant biology, a point well-made by Morgan and Michaels (1999). Rather than avoiding the ethical implications of pregnancy, these implications should be recognized in a way that does not disempower women or concedes to antiabortion dogma.

In fact, engaging women’s unique feelings about abortion during the informed consent process could carry added benefits in terms of abortion rights. That is, a failure to address the emotional aspects of abortion may inadvertently lend credence to antiabortion narratives and leave women vulnerable to antiabortion opportunists. Lisa Rubin and Nancy Felipe Russo (2004) note:

> For some women, the effects of unwanted pregnancy and abortion are more profound and serious. If they do not receive help from unbiased therapists they will be ripe for manipulation by antiabortion organizations seeking to exploit their vulnerabilities to advance an antiabortion political agenda.[83] (p.72)

Affording women a nondirective opportunity to discuss their emotional experiences with unwanted pregnancy would help to legitimate their perspectives and to advance their autonomy, powerful defenses against antiabortion crusaders who would use women's emotional responses as reason to mitigate women's autonomy.[84]

Of course, other women may neither desire nor require further discussion of the psychological or ethical dimensions of abortion. Such emotional versatility, therefore, requires that providers bring flexibility to the informed consent process. Rather than following a predetermined script, healthcare providers should tailor the informed consent process to women's individual emotional needs. Terry Nicole Steinberg (1989) notes, for example, "some women, but not all, may benefit from a waiting period and extensive information. Other women may actually be harmed by extensive information" (p.501). This is to say, the particularity of women's experiences with unwanted pregnancy should inform the type of conversations that occur during the informed consent process. Some women may not want to discuss their abortion decision any further with a stranger; other women may have questions or concerns.

Although it is unrealistic to expect abortion providers to be omniscient counselors who thoroughly understand each woman's unique psyche and character, it is reasonable to expect providers to clear the space for discussion of issues relating to the psychological dimensions of abortion. Terry Nicole Steinberg (1989) argues abortion counseling should be unbiased, nondirective, and responsive to the variable needs of women. She defines the term "unbiased" to mean "a counselor who recognizes differences among women, providing information and emotional support on an individual basis, without advocating a particular moral view of abortion" (p.484, footnote 8). Following Steinberg's blueprint, abortion providers should cultivate a responsive and humbled sensitivity to each woman's unique condition, recognizing when women are emotionally conflicted and desire further discussion of their decision, yet also cognizant of cases when further dialogue is unnecessary. Women's emotional diversity further underscores the benefits of the subjective standard of disclosure.

Secondly, informed consent practices should include optional discussions pertaining to fetal ontology and sonogram imagery. The ontology and moral meaning of the fetus is, after all, a real concern to many women, and the irreducible and contested nature of fetal semantics makes this issue particularly volatile. As the Supreme Court noted in *Roe*, when "those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus [as to when life begins]" (as cited in Shapiro, 2007, p.40), it is unlikely that the ethical issues relevant to fetal ontology will ever be fully resolved. Therefore, abortion providers and abortion-rights activists alike should recognize the potential need to discuss the fetus during the informed consent process.

Like issues of psychological response, however, feminists have historically avoided discussing the fetus, though scholars rightly point out that this lacuna is not without merit. "To talk about fetuses," writes Lynn M. Morgan and Meredith W. Michaels (1999), "has been thought to cede to the pro-life movement its major premises, and so to foreclose the feminist insistence on reproductive freedom for women" (p.2). More recently, however, the proliferation of sonogram imaging and the rise of the "public fetus" (Taylor, 1992) has led some scholars to suggest that eschewing the fetus is a political misstep (Petchesky, 1987; Casper, 1998; Morgan & Michaels, 1999). "To the extent that feminists avoid 'fetal subjects,'" caution Morgan and Michaels (1999), "we risk leaving the field entirely in antagonistic hands and unwittingly contribute to the persistent and insidious backlash against women's procreative integrity" (p. 2). Instead, abortion-care providers should critically engage the meaning of fetal subjects during the informed consent process, *when such discussion is beneficial to the woman.* Once again, the subjective standard of disclosure is the most promising insofar as it recognizes the specificity and variability of women's informational needs.

Of course, it is often difficult to know when enhanced discussion is beneficial and when it is potentially patronizing or unwarranted. In some cases, even raising the topic of sonogram images can be problematic. The fact that women live in a patriarchal society that systematically promotes norms of maternity (even as it fails to provide proper social support for mothers) complicates the mere mention of ultrasound in the abortion context. As feminist bioethicist Janet Farell Smith (1996) observes, "Because of the authority physicians have in our society, a patient may hear as an imperative or command what the physician-speaker intends only as an factual assertion or one among many options" (p.189). Indeed, the antiabortion legislators who introduce "informed consent" laws are counting on the innate power structures of the clinical setting to reinforce their normative message; medical descriptions are meant to operate as medical prescriptions.

The solution to this predicament lies not in avoiding the subject of fetal ontology, however, but in recognizing the impact of social power upon medical discourse, and incorporating this recognition into medical discussion. Although there can be no way to fully exorcise politically prescriptive messages from discussions of fetal subjectivity, it is possible to introduce other readings and interpretations into medical dialogue and, thereby, reclaim some discursive territory from antiabortion rhetoric. Lisa Rubin and Nancy Felipe Russo (2004) suggest:

> Therapists must equip women to recognize how images of the fetus are manipulated to create feelings of distress and guilt in women . . . . In addition to exposing women to alternative viewpoints, therapists need to be prepared to explain how the nervous system develops and what this means for the idea that the fetus can feel pain . . . . Practitioners can reassure women by giving them accurate information, including the fact that the neocortex, where human consciousness, thinking, problem-solving, and language are located, does not develop until late in pregnancy, in the third trimester. (p.83)

Rubin and Russo's suggestions are useful strategies that help to produce a more informed and multidimensional discussion on fetal ontology. In general, we should be less concerned with identifying and articulating an overarching methodology to guide discussions of fetal ontology and instead we should be mindful that fetal ontology is a contested subject that generates different emotional responses and informational needs.

In conclusion, Kim Atkins (2000) writes,

> Respect for autonomy is an acknowledgment of the limitations of our knowledge of other people and a willingness to incorporate that understanding into our world

> views. When we respect autonomy we don't simply observe another's freedom from a distance, as it were; we accede to our fundamental fallibility and epistemological humility. (p.75)

In the case of informed consent for abortion, such epistemic humility in the face of fetal subjectivity and emotional response is key to respecting women's autonomy and preventing informed consent practices from deteriorating into inflexible acts of empty protocol. Informed consent practices must recognize women's irreducible specificity, and informed consent practices should be crafted in response to unique patient needs.

ENDNOTES

[1] The statistics reported in this paragraph are cited from Jones and Jerman's (2014) report, which documents abortion rates for the 2010-2011 year. Although Jones and Jerman's (2104) study offers an updated glimpse on abortion and service availability, it is important to note that certain factors limit the collection of abortion data. Despite surveying "the known universe of abortion providers" (p.2), Jones and Jerman also recognize the likelihood that "some abortion providers were not counted because we were unable to identify them" (p.9). There are several reasons why some providers may not have been counted. For one, Jones and Jerman (2014) speculate that some providers who offer early medication abortions went uncounted (p.9). Secondly, some women may be obtaining the drug misoprostol (available only with a prescription and generally prescribed in conjunction with mifepristone, in the United States) from the Internet, or from other countries to terminate their pregnancies without medical supervision (Grossman, D., Holt, K., Pena, M., Lara, D., Veatch, M., Cordova, D., . . .Blanchard, K., 2010; Jones, R., 2011). Additionally, Jones and Jerman (2014) were unable to obtain data from some hospitals and physicians' offices, though these facilities generally perform a low number of abortions. Collectively, these factors lead Jones and Jerman (2014) to concede the possibility that their "estimate of the number of abortions [may be] artificially low, and the actual drop in the abortion rate was not as large as it appears" (p.10). Alternatively, the Center for Disease Control and Prevention (CDCP) also records abortion rates. The last year for which the CDCP has data is 2011. According to the CDCP, 730,322 abortions were performed in 2011 (Centers for Disease Control and Prevention, November 18, 2014). The discrepancy between the CDCP's data and the

Guttmacher Institute's data is easily explained. In order to collect data on abortions, the Guttmacher Institute periodically conducts an independent collection survey, as states are not required by federal law to submit data to the CDCP. The CDCP's data for 2011 does not include abortions that were performed in California, Maryland, or New Hampshire (Pazol, Creanga, Burley, Hayes, & Jamieson, 2014) and thus the CDCP reports a lower number of abortions.

[2] This work assumes that autonomy is a valuable ideal. Although I recognize the difficulty that accompanies any formal definition of "autonomy," and I doubt that sufficient criteria can be identified to anchor autonomy into perennial definitional place, I do not think either of these difficulties prevents one from identifying "autonomy" as a working ideal in women's reproductive lives. In a nutshell, I understand autonomy as an agent's socially constituted capacity for self-determination and self-rule. There is, I maintain, very good reason to keep autonomy at the forefront of medical ethics, though a revised conception of autonomy that is aware of autonomy's socially constructed nature is necessary. In this sense, I distinguish my work from other feminist analyses of autonomy in bioethics, many of which raise concern about the decision to privilege autonomy as the guiding ethical ideal in the doctor-patient relationship. For an example of such a feminist critique see Tronto (2009, p.184). For further example of bioethicists who challenge autonomy's privileged position see O'Neill (Feb 2003), O'Neill (2003), and Schneider (1998).

[3] Throughout the course of this work, I will place the phrase informed consent in quotation marks when I am referring to antiabortion appropriations of the informed consent process, or I will follow the Guttmacher Institute and use the phrase: abortion-specific "informed consent" laws (Richardson & Nash, 2006, p.11). Therefore, if I use the term informed consent without quotation marks or without the qualifier "abortion-specific," then I am referring to traditional deployments of informed consent or to informed consent discourses other than antiabortion ones.

[4] To the degree that I ground my analysis in linguistic practices, the spirit of my methodology is informed by Ludwig Wittgenstein's philosophy of language as espoused in his Philosophical Investigations. Wittgenstein (1953/2001) argues, "For a large class of cases—though not for all—in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language" (43). Accordingly, if we want to know the significance of a word, we must look and describe how the word functions in and across discourses. Thus, Wittgenstein's imperative, "don't think, but look!" (66).

[5] See also Gold and Nash (2007).

[6] For a fresh critique of informed consent see Manson and O'Neil (2007).

[7] Beauchamp and Childress (2009) define competence as the "capacity to understand the material information, to make a judgment about this information in light of their values, to intend a certain outcome, and to communicate freely their wishes to caregivers or investigators" (p.113).

[8] Beauchamp and Childress (2009) argue a voluntary action occurs if the patient "wills the action without being under the control of another's influence" (p.132).

[9] For a useful overview of the different models of medical decision-making see Emanuel and Emanuel (2003).

[10] See *Pratt v. Davis* (1905), *Schloendorff v. The Society of the New York Hospital* (1914), *Haskins v. Howard* (1929), and *Hunt v. Bradshaw* (1955). For an analysis of these cases, see Faden and Beauchamp (1986, pp.116-125) and Katz (1984, pp.48-84). For a much earlier ruling on consent in the medical context see *Slater v. Baker and Stapleton (*1767).

[11] Faden and Beauchamp (1986) claim that prior to the 1950s, "we have not been able to locate a single substantial discussion in the medical literature of consent and patient authorization" (p.86).

[12] Although Justice Bray is typically identified as the progenitor of the term "informed consent," the term actually originated in an amicus brief submitted by the American College of Surgeons to the California Court of Appeals (Katz, 1984, p.64).

[13] This is not to suggest, however, that disclosure requirements immediately became the law of the land. Shortly after *Salgo*, a physician was ruled as liable for "mental anguish" for the troubling information he disclosed to a patient in the New York case *Ferrara v. Galluchio* (1958). See Berg et al. (2001, p.44).

[14] Such questions include: How much information are physicians liable to share? Who determines this information? How exhaustive must physicians be in their enumeration of possible risks and benefits? How do physicians determine if the patient has adequately processed the necessary information?

[15] Along with the Natanson case, the cases of *Canterbury v. Spence* (1972) and *Scott v. Bradford* (1979) contributed to the judicial and legal development of informed

consent. For a useful discussion of the importance of these cases, see the work of Katz (1984, pp.71-84).

[16] It is important to note that many physicians resisted these new legal requirements. Physicians voiced concern that informed consent set impossible standards and that the ideal of informed consent did not translate well into the reality of medical practice. Moreover, some physicians worried that bombarding patients with detailed information might discourage them from surgery and treatment (Faden & Beauchamp, 1986, pp.90-91). After all, informing patients of their medical condition, procedural risks, and possible alternatives expands the range of choices available to the patient and increases the possibility of patient-physician dispute. For an early example of physician critiques of informed consent see Fellner and Marshall (1970).

[17] For a lively account of problematic western medical constructions of female patient competency see Ehrenreich and English (2005).

[18] Smith's (1996) article originally pointed me to this citation (p.195).

[19] For an excellent discussion of the import and impact of implicit stereotypes upon women's self-perceptions see Fine (2010).

[20] First published in 1977, *Principles of Biomedical Ethics* is described by Dr. Albert Jonsen, former member of The National Commission and The President's Commission, as "the thesaurus of bioethical discourse" (as cited in the Oxford University Press, 2015, para 7). Likewise, Daniel Callahan, co-founder and president emeritus of The Hastings Center, asserts it is "the most used, most praised, and most distinguished book in the field [of bioethics]" (as cited in the Oxford University Press, 2015, para 1). In this book, Beauchamp and Childress

(2009) propose four moral principles that are “basic for biomedical ethics” (p.2): 1) respect for patient autonomy, 2) nonmaleficence, 3) beneficence, 4) justice. Beauchamp and Childress defend their principled approach on the basis that it provides “a framework of norms with which we can start in biomedical ethics” (p.16). Referred to as “principlism,” this strategy attempts to provide moral anchorage without assuming the truth or supremacy of any particular moral theory (Iltis, 2000, p.273). Although this strategy is debated in bioethics literature (Clouser & Gert, 1990; Evans, 2000), Beauchamp and Childress’ four principles remain a guiding framework of the field.

[21] Diana Meyers (1987) distinction between episodic and programmatic autonomy insightfully reminds us that agents who are oppressed or subjugated are still capable of autonomous actions.

[22] The concept of relational autonomy was initially proposed in an effort to preserve the emancipatory promise of autonomy while simultaneously recognizing and integrating the concerns voiced by feminist scholars regarding the patriarchal origins of autonomy. Feminist theorists have treated autonomy with critical suspicion for a number of reasons. For one, some have argued that autonomy presupposes a self-sufficient, pre-social, atomistic and independent self, a paradigm that overlooks the contribution of social forces to the production of selfhood (Baier, 1985). Some feminists have argued that autonomy is a particularly “masculine” ideal that privileges activities and traits historically associated with, or limited to, the lives of upper class, heterosexual, white men (Code, 1991; Code, 2000). Other feminists have insightfully argued that identifying autonomy as the ethical ideal par excellence, overlooks other equally important ethical

ideals, such as care, interconnection, trust, and compassion (Chodorow, 1978; Held, 1993; Nedelsky, 1989).

[23] Mackenzie and Stoljar (2000, p.26) credit Jennifer Nedelsky with being the first scholar to explicitly articulate a feminist conception of relational autonomy (Nedelsky, 1989; Nedelsky, 1990; Nedelsky, 1993; Nedelsky, 1995). Subsequent to Nedelsky's articulation, other scholars have explored and developed the idea of relational autonomy. For some good examples see Donchin (2001), Freeman (2011), Mackenzie and Stoljar (2000), and Sherwin (1998).

[24] Theorists, for example, disagree whether autonomy is a pre-social capacity that is nurtured in social contexts, or one that is activated by social relations. Likewise, there is a tension between procedural and substantial accounts of autonomy. Procedural accounts argue autonomy occurs so long as the agent has subjected her ideas to certain procedures of reflection and evaluation, no matter the content or conclusion of her thoughts. Substantive accounts worry that procedural accounts fail to recognize the import of oppressive socialization, and they add additional requirements in terms of content and process. For a concise discussion of this distinction see Mackenzie and Stoljar (2000, pp.12-15).

[25] McLeod (2002) recognizes that the relationship between autonomy and self-trust is reciprocal: one must have self-trust to act autonomously, and one must have some autonomy to have self-trust.

[26] McLeod (2002) has insightfully suggested that if patient autonomy is truly the goal, then the provider will need to encourage the patient's general capacity for self-trust, as lack of self-trust may foreclose autonomy completely (p.147).

[27] In the blog My Ecdysis (2008, April 26), kyriarchy is defined as a “neologism coined by Elisabeth Schussler Fiorenza and derived from the Greek words for ‘lord’ or ‘master (kyrios) and ‘to rule or dominate’ (archein) . . . . Kyriarchy is best theorized as a complex pyramidal system of intersecting multiplicative social structures of superordination and subordination, of ruling and oppression.”

[28] It is important to note, however, that shared decision making is valued for its emphasis on provider participation, as well. In many ways, shared decision making marks a middle ground between paternalistic models which overlook patient input and “independent choice” models which deemphasize physician input and potentially place too much responsibility on patients, thus leading to concerns of patient abandonment. For a discussion of concerns raised by these competing paradigms see Quill and Brody (1996).

[29] Smith (1996) defines the information transfer model as:

> On what I call an information-transfer model, a source of information transfers it to a receiver. As the model applies to medicine, one source, usually the physician, obtains relevant information on patient symptoms, status, and history, by medical interviews and tests. Subsequently, after objective analysis, the physician transfers diagnostic and treatment information back to the patient-receiver or his or her family. (p.187)

For another critique of the treatment of “information” by bioethicists see Manson and O’Neill (2007).

[30] Alternatively, abortion was permitted for any reason in Alaska, the District of Columbia, Hawaii, New York, and Washington (Craig & O’Brien, 1993, p.75).

[31] The Due Process Clause reads, "No state shall . . . deprive any person of life, liberty, or property, without due process of law" (U.S. Const. amend. XIV, § 3). In prior decisions, the Court ruled that the notion of liberty encompasses an individual's right to privacy. The Court recognizes a right of personal privacy as far back as the 1891 decision *Union Pacific River Company v. Botsford*, but the Court's articulation of privacy in the reproductive context originates in the 1965 decision *Griswold v. Connecticut* and in the 1972 decision *Eisenstadt v. Baird*. For a discussion of privacy within judicial discourse see Shapiro (2007, p.xxix) and Garrow (1998). Although the Court turned to these past cases to defend abortion on the basis of privacy, it is important to note that the Court recognized that the privacy defended in *Roe* differed from the privacy articulated in *Griswold* and *Eisenstadt*. For example, Justice Blackmun argued, "The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus." The Court reasoned, "The situation therefore is inherently different from marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education . . . ." (as cited in Shapiro, 2007, p.40).

[32] In *Roe*, the Court explained,

> Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility, and the like.
> (as cited in Shapiro, 2007, p.42)

In other words, states were permitted to place prohibitions on the abortion decision to protect the woman's health and medical safety.

[33] For insightful legal criticisms of *Roe's* excessive focus on physician rights, see Tribe (1985) and Asaro (1983).

[34] I do not mean to imply that the respective members of the Court are insensitive to the varied conditions that inform the abortion decisions of individual women, and the Court does recognize the existence of nonmedical factors that influence the abortion decision, like stigma or family size. However, *Roe* ultimately insists on the medical nature of abortion. This insistence reflects Justice Blackmun's unswerving belief that abortion ultimately requires medical oversight and that "the physician's guidance was essential" (Hunter, 2006, p.185). Years after *Roe*, Blackmun argued, "I think to this day there ought to be the physician's advice in there. I don't believe in abortion on demand" (Blackmun, July 6, 1994-December 13, 1995).

[35] As an example of this type of strategic thinking see Wood and Durham (1978).

[36] Laws that prohibited abortion in public hospitals were, in many cases, simply maintaining the status quo, as many public hospitals had never provided abortions (Henshaw, 1986, p.253).

[37] The Missouri law defined viability as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems" (as cited in Shapiro, 2007, p.58). Opponents argued this definition conflicted with the definition provided by *Roe* because it failed to reference gestational time periods and the trimester framework as established in *Roe*.

[38] Before choosing a career in law, Justice Blackmun considered going to medical school, and he later served as general counsel for the Mayo Clinic, a medical and research center in Rochester, Minnesota. It is likely that this experience deepened his reverence for the medical world. See, for example, Hunter (2006), Koh (1987), and Greenhouse (2004).

[39] It should also be noted, however, that Justice Blackmun had demonstrated a profound awareness of the moral complexity of abortion in the past, and there is reason to argue that his phrase "full knowledge" did not reflect his belief that the informed consent process could comprehensively cover all of the moral dimensions of abortion. Nevertheless, Justice Blackmun's ruling enshrines the idea of "full knowledge" within judicial articulations of informed consent vis-à-vis the abortion decision.

[40] For a full list and discussion of these laws see Wood and Durham (1978, pp.817-818).

[41] For legal discussions of the *Casey* decision see Borgmann (2004), Blumenthal (2008), Dresser (2008), Goldstein (1996), Manian (2009), Tholen & Baird (1995), Wharton, Frietsche, & Kolbert (2006), and Whitman (2002). For a concise discussion of the political context that impacted the *Casey* decision see Craig and O'Brien (1993, pp.325-359) and Friedman, L. (1993, pp.3-18).

[42] There was further reason to believe the judicial winds had shifted to favor antiabortionists. The personnel of the Court had changed significantly since *Roe*, when the Court defended abortion rights by a majority of seven to two. By the time of *Casey*, only Justice Blackmun and Justice Stevens openly defended abortion rights, giving

abortion opponents reasons to believe the new coalition of conservative judges would support enhanced abortion regulations (Friedman, L., 1993, pp.10-12).

[43] Like all laws that potentially interfere with a fundamental constitutional right, the Court had to assess the provisions instituted by the Pennsylvania Control Act using a standard of judicial review. Traditionally, this standard is chosen from a three-tiered system of review that includes rational basis, intermediate scrutiny, and strict scrutiny. In effect, these standards prohibit the federal government or state governments from passing laws that could have discriminatory effects. Each tier dictates a different set of necessary requirements to measure the constitutionality of a law. Strict scrutiny is the most demanding standard. If a right is protected by strict scrutiny, it receives the highest level of protection and little can be done to regulate or restrict that right. For a cogent summary of the requirements necessary for a law to pass strict scrutiny see Oshana (2011, pp.51-52).

[44] The undue burden standard is vague and imprecise, a problem recognized by dissenting members of the Court. The potential arbitrariness of the undue burden standard is evident if we contrast the provisions overturned by the Court with those it upheld. For example, the Court determined that the spousal notification provision of the Pennsylvania Abortion Control Act was unconstitutional because of the prevalence of physical and psychological abuse inflicted by husbands against their wives (as cited in Shapiro, 2007, p.207). At the same time, however, the Court ruled that Pennsylvania's mandatory waiting period did not pose an undue burden on a woman's decision to terminate her pregnancy, despite recognizing that waiting periods may pose "increased costs and potential delays" (as cited in Shapiro, 2007, p.202). In a brief filed by twenty-

four organizations supporting the right to an abortion, petitioners enumerated problematic consequences of mandated waiting periods, including "duplicate journeys," missing work, and lost pay (as cited in Friedman, L., 1993, p.121). Surely, increased costs, lost work, and time delays constitute a legitimate obstacle. Must there be an extant threat of physical abuse to qualify regulations as unduly burdensome, as the Court's ruling seems to suggest?

[45] Justices Blackmun, Kennedy, O'Connor, Stevens and Souter upheld *Roe's* central ruling that a woman has a constitutional right to terminate her pregnancy. Justice Blackmun disagreed with the Court in upholding Pennsylvania's regulations; Justice Rehnquist, Justice White, Justice Scalia, and Justice Thomas maintained that *Roe* was wrongly decided and that the spousal notification provision "rationally furthers legitimate state interests" (as cited in Shapiro, 2007, p.223).

[46] In her dissenting opinion in Akron, Justice O'Connor argued in favor of adopting the "unduly burdensome standard" (as cited in Shapiro, 2007, p.134) to assess abortion regulations. In deploying the undue burden standard, Justice O'Connor explains that the concept of undue burden has a history in Supreme Court Rulings. For example, in *Maher v. Roe* (1977), the Court argued that a woman's constitutional right to abortion protected her only from "unduly burdensome interference with her freedom to decide whether to terminate her pregnancy" (as cited in Shapiro, 2007, p.81). When the Court ruled in *Bellotti v. Baird* (1979) that a Massachusetts law requiring minors to obtain parental consent before procuring an abortion without exception was unconstitutional, it argued that "the constitutional right to seek an abortion may not be unduly burdened by state-imposed conditions . . ." (as cited in Shapiro, 2007, p.103). In *Casey*, the majority

opinion includes a list of past uses of "undue burden" by the Court (as cited in Shapiro, 2007, p.197).

[47] Notably, the Court's contention that abortion is psychologically damaging sets a dangerous precedent that influences later Court decisions regarding abortion regulation. In *Gonzales v. Carhart* (2007), for example, the Court upheld a ban on a specific type of abortion procedure on the unfounded basis that abortion is psychologically traumatic for women. In his majority opinion, Justice Kennedy argued that it is "self-evident that a mother who comes to regret her choice to abort must suffer grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know" (as cited in Legal Information Institute, n.d.d, Justice Kennedy delivered the opinion of the court, IV, A, para 9). Notably, the only evidence supporting Justice Kennedy's argument that abortion is psychologically damaging came from an amicus brief submitted by the antiabortion organization The Justice Foundation (Siegel, April 2008, p.102).

[48] In *Roe* the Court argued, ". . . the word "person," as used in the Fourteenth Amendment, does not include the unborn" (as cited in Shapiro, 2007, p.39).

[49] The strategies I discuss in this chapter are not exhaustive; there are other equally problematic topics couched within "informed consent" materials that I do not attend to. As way of example, six states—Arizona, Kansas, North Carolina, South Dakota, Texas, and West Virginia—suggest a correlation between abortion and future infertility within their "informed consent" materials (Guttmacher Institute, February, 2015b), despite widespread consensus within the medical community that other than in very rare cases of infection, abortions performed during the first trimester using vacuum

aspiration present no long-term risk of infertility or ectopic pregnancy (Atrash & Hogue, 1990; Boonstra, Gold, Richards & Finer, 2006; Frank, McNamee, Hannaford, Kay & Hirsch, 1991; Hogue, 1986; Hogue, Boardman, Stotland, & Peipert, 1999, p.217; Hogue, Cates, & Tietze, 1982; Kalish, Chasen, Rosenzweig, Rashbaum, & Chervenak, 2002).

[50] To be clear, the National Cancer Institute does claim that some pregnancy-related factors may lower a woman's risk of breast cancer later in life. For example, studies suggest that women who carry full-term pregnancies before the age of 30 face a decreased risk of breast cancer when they are older (NCI, n.d.a, Are there any pregnancy-related factors associated with a lower risk of breast cancer?, para 2), and the likelihood of breast cancer decreases in relation to the number of births (NCI, n.d.a, Are there any pregnancy-related factors associated with a lower risk of breast cancer?, para 3; Lambe et al., 1996). However, some evidence shows that multiple births only protect women from hormone receptor-positive breast cancer (NCI, n.d.a, Are there any pregnancy-related factors associated with a lower risk of breast cancer?, para 2, para 3). Additionally, the National Cancer Institute (n.d.a) claims that "women who are older than 30 when they give birth to their first child have a higher risk of breast cancer than women who have never given birth" (Are any pregnancy-related factors associated with an increase in breast cancer risk?, para 2), and that women face a short-term increased risk of breast cancer immediately following birth (Are any pregnancy-related factors associated with an increase in breast cancer risk?, para 3; Dickson, Pestell, & Lippman, 2004). Moreover, many women who have abortions early in life will later carry a pregnancy to term and may thus still benefit from the protective benefits of pregnancy. In summation, there is an incredibly important difference between the claim that some pregnancies appear to

protect some women from some types of breast cancer and the claim that abortion causes breast cancer.

[51] Antiabortion arguments purporting the psychological "dangers" of abortion also make use of discredited research studies. For example, antiabortion politicians in South Dakota have referenced a disputed study published in *The Journal of Psychiatric Research* titled, "Induced abortion and anxiety, mood, and substance use disorders: Isolating the effects of abortion in the national co-morbidity survey" (Coleman, Coyle, Shuping, & Rue, 2009). For arguments disputing or refuting the Coleman, Coyle, Shuping and Rue study, see Steinberg and Finer (2011) and Kessler and Schatzberg (2012, p.410).

[52] For examples of medical organizations driven by antiabortion ideology see The Coalition on Abortion/Breast Cancer (n.d.) and The American Association of Pro-Life Obstetricians and Gynecologists (2013).

[53] The booklet can be downloaded from a state-sponsored website (Kansas Department of Health and Environment, n.d.a) where one can also watch size-enhanced videos of developing embryos. The Kansas booklet includes information on the psychological "risks" of abortion (Kansas Department of Health and Environment, n.d.a, p.30), paternal responsibility, alternatives to abortion, medical risks of abortion and pregnancy, and illustrated accounts of fetal development.

[54] Operation Outcry's strategy exemplifies what Reva Siegel terms the "woman-protective antiabortion argument" (Siegel, April 2008, p.1648; Siegel, June, 2008; Siegel & Blustain, October 2006). According to Siegel, the woman-protective antiabortion argument is a rhetorical strategy that expands antiabortion discourse beyond the fetal-

centric arguments favored by antiabortion groups in the past, and argues that abortion psychologically damages women as well.

[55] Here, I do not mean to suggest that the women who share their stories on the forums provided by Operation Outcry are disingenuous or fabricating their abortion experiences. Many of these women appear genuinely regretful. However, it does not follow from their stories that post-abortion regret is an authentic psychological disorder that will afflict all women.

[56] Similar tactics are found within the "informed consent" materials of Michigan, Nebraska, North Carolina, and Utah. In North Carolina, false claims regarding the psychological consequences of abortion are not extensively developed, yet they exist. For example, under a section detailing medical risks, North Carolina's abortion booklet simply states "possible increased risk of mental health problems" (North Carolina Department of Health and Human Services, December, 2011, p.23). In other state "informed consent" materials, however, the psychological "risks" of abortion are discussed in more detail. In Michigan, women are only given information detailing the negative emotional consequences of abortion (Michigan Department of Community Health, 2001-2014, Medication-Induced Abortion, Risks and Complications, para. 5). Nebraska's "informed consent" booklet warns women that, "[s]ome reports suggest that some women experience reactions such as sadness, grief, regret, anxiety and guilt" (Nebraska Department of Health and Human Services, 2012, p.28). Likewise, the Utah Department of Health Division of Family Health and Preparedness (2012) publishes a booklet that claims:

> Right after the abortion, some women report a sense of relief. This relief may be the short-term result of ending what was viewed as a problem. Possible negative emotional responses to having an abortion include: depression, grief, anxiety, lowered self-esteem, hostility toward self and others, regret, difficulty sleeping, suicidal thoughts and behavior, sexual dysfunction, relationship disruption, flashbacks, and a sense of loss and emptiness.
>
> (Utah Department of Health, 2012, p.28)

[57] Any assessment of women's negative emotional responses to abortion must also recognize the hostile environment that circumscribes many abortion facilities. Antiabortion harassment is common, and it can take multiple forms including picketing, vandalism, bomb threats, and Internet harassment. Eighty-eight percent of abortion clinics report at least one type of harassment, with increased levels of harassment reported by clinics in the Midwest and the South (Jones & Kooistra, 2011, p.48). More specifically, 85% of clinics in the Midwest, 75% of clinics in the South, 48% of clinics in the Northeast, and 44% of clinics in the West report harassment (Jones & Kooistra, 2011, p.48). In a research study carried out between 2008 and 2010 at thirty abortion facilities, researchers determined that most facilities experience "regular" protestor presence, and one third of these facilities described the protestors as "aggressive" toward women. Of the 956 women interviewed, 46% reported seeing protestors, 25% reported feeling "a little upset" and 16% reported being "quite a lot or extremely upset." Researchers determined that, "women who had difficulty deciding to abort had higher odds of reporting being upset by protesters" (Foster, Barar, Gould, & Weitz, 2011, p.303). See also Foster, Kimport, Gould, Roberts and Weitz (2013).

[58] It also bears mention that women are provided information detailing fetal development throughout the full course of pregnancy in twenty-seven states, notwithstanding the fact that third-trimester abortions have always been prohibited, unless the woman's life is in danger (Guttmacher Institute, February, 2015b). Many "informed consent" booklets carry detailed photos or depictions of fetal development through all stages of pregnancy, including the third trimester. For women considering abortion, extensive information on third-term fetal growth is superfluous and unnecessary. Although it is possible that some women may find such information helpful or interesting, there is no medically sound reason that justifies subjecting all women to this information.

[59] North Dakota also requires physicians to tell women that, "the abortion will terminate the life of a whole, separate, unique, living human being" (North Dakota Abortion Control Act, 2009, 14-02.1-11(a)(2)).

[60] Although the informed consent materials of Indiana and Missouri do not extensively discuss the claim that human life begins at conception, this claim still occupies an aggressively rhetorical spot within each state's informed consent booklet. Indiana's *Abortion Informed Consent Brochure* (Indiana State Department of Health, July 1, 2013) opens its section on fetal development with the following claim, "Human physical life begins when a human ovum is fertilized by a human sperm" (p.3). In Missouri, the first page of the "informed consent" booklet declares in bold print, "The life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being" (Missouri Department of Health and Senior Services, n.d.,

p.1). Though laconic, the underlying moral message of each statement is reductively clear: abortion kills a person.

[61] My analysis of ultrasounds owes a debt to feminist work that precedes me. See Boucher (2004), Casper (1998), Dubow (2010), Duden (1993), Franklin (1991), Hartouni (1992), Hartouni (1999), Mitchell (2001), Morgan (2009), Morgan and Michaels (1999), Oaks (2000), Petchesky (1987), Taylor (2004), and Taylor (2008).

[62] Recently, antiabortion politicians have proposed legislation that articulates how a woman may comport herself during a mandatory ultrasound. For example, Republican Michelle Bachmann introduced a bill to the 112th U.S. Congress titled The Heartbeat Informed Consent Act (Heartbeat Informed Consent, 2011, §3402). Regarding mandatory ultrasounds, the bill states:

> Nothing in this section shall be construed to prevent a pregnant woman from closing or averting her eyes from the ultrasound images required to be displayed, or not listening to the description of the images required to be given, by the provider or the provider's agent pursuant to paragraph.
>
> (Heartbeat Informed Consent, 2011)

Regarding the fetal heartbeat, the bill also grants the woman the "Ability to not listen—Nothing in this section shall be construed to prevent the pregnant woman from not listening to the sounds detected by the hand-held Doppler fetal monitor, . . . " (Heartbeat Informed Consent, 2011, §3402). The very fact that politicians are trying to legislate where a woman can and cannot look and what a woman can and cannot listen to is alarming. By arguing that women are permitted to "not listen," the legislation implies that such permission can be withdrawn. Moreover, this proposed law raises pragmatic issues about how women might exercise their decision not to look or listen. Referencing the Heartbeat Informed Consent Act, James Rocha (2012) notes, “while a woman could avert her eyes to avoid seeing the image, it is hard to believe that she could avoid hearing a heartbeat merely by ‘not listening to the sounds’ (p.46). The bill did not pass.

[63] For additional examples of this type of thinking see Focus on the Family (2011) and National Institute of Family and Life Advocates (2014). I am grateful to the work of Wiebe and Adams (2009) for directing me to these websites.

[64] In Texas, a woman is required to hear an explanation of the sonogram unless her pregnancy is a result of sexual assault or incest, she is a minor with a judicial bypass, or the fetus has an irreversible medical condition or abnormality (Texas A Woman’s Right to Know Act, § 171.012 (5)). In addition, Texas’ ultrasound law carries punitive consequences for abortion providers who resist or ignore its requirements. According to section 171.008 of the Texas law, physicians and abortion providers who do not comply with such requirements commit a misdemeanor and are punishable with fines not exceeding $10,000.

[65] Historically, the physiological differences between a fetus and a postnatal human being have long held moral significance in abortion practice, and the legality of abortion has always varied in relation to stages of pregnancy. Prior to criminalization, abortion was legal until “quickening,” or the point where the woman can feel fetal movements. Prior to 1869, Catholic doctrine did not view early abortions as murder because the embryo had not yet been ensouled or “animated” (Luker, 1984, p.13). It was not until Pope Pius IX’s 1869 declaration that all abortions entailed excommunication, that Catholic doctrine categorically prohibited abortions. Likewise, *Roe’s* trimester

framework, which forbids states from proscribing abortion prior to viability, links the legal permissibility of abortion to fetal development. A 2012 Gallup poll demonstrates that American support for abortion changes in response to the stages of pregnancy, with 61% supporting legal abortion in the first trimester, 27% supporting legal abortion in the second trimester, and 14% supporting legal abortion in the third trimester (Saad, January 22, 2013).

[66] For additional discussions of the rich and diverse moral reasoning that informs women's abortion decisions see Baumgardner (2008) and Jacob (2004).

[67] Notably, available data on abortion rates is not current enough to adequately reflect the recent surge of "informed consent" regulations. The most recent and comprehensive study of abortion incidence and service availability was published in 2014 (Jones & Jerman). However, the Jones and Jerman study only reflects abortion rates during 2010 and 2011. Consequently, the data do not reflect abortion incidence in the wake of heightened regulations passed during the last three years.

[68] It is important to note that the data generated by ANSIRH (June, 2014) only reflect situations where women were offered the choice to view an ultrasound image, not situations where women are required to view the image.

[69] Other limited studies also report that many women find viewing the image helpful, although not for the reasons advanced by antiabortionists. See Graham, Ankrett, and Killick (2010), Bamigboye, Nikodem, Santana, and Hofmeyr (2000), and Wiebe and Adams (2009).

[70] There are a number of limitations that shape Cockrill and Weitz's (2010) study. They caution that, "one of the main limitations to our research is that we only interviewed

women who successfully negotiated access issues like cost and distance" (p.18). Likewise, their study is limited by small sample size: only 20 participants were interviewed (p.12). In addition, the mandated information provided by the state in which Cockrill and Weitz (2010) conducted their research did not contain overtly misleading information. Instead, the information provided to the women at the clinic they surveyed was designed to encourage "motherhood or adoption by fostering a bond between the pregnant woman and her fetus . . . or to encourage her to consider alternatives like adoption or motherhood . . . ." (p.14). Consequently, their study does not reflect women's ability to recognize gross misinformation, like the false claim that abortion causes breast cancer or psychological disorder.

[71] The exception is one participant named Lyndsay who discussed an abortion she had when she was 17. She writes, "I was being careless, you know just like 'oh well, there's abortion out there'" (as cited in Cockrill & Weitz, 2010, p.17). Lyndsay's comments occurred in the context of a discussion addressing parental notification and minors seeking an abortion.

[72] It is also important to note that the belief that "other women" need information could be coming from a place of genuine concern for other women. Many women lack the proper venues, opportunities, and discursive arenas for fruitful, insightful, and beneficial conversations about unwanted pregnancy. In a society that stigmatizes abortion and routinely collapses the complex moral elements of the abortion decision into reductive clichés and hackneyed rhetoric, many women may require additional conversations and information about abortion, a need that other women facing the abortion decision may be sensitive to.

[73] In 1962, Sheri Finkbine, a married mother of four, attempted to terminate a wanted pregnancy after learning she had taken an anti-nausea drug that contained thalidomide, a compound that causes severe fetal defects. Although her doctor advised her to have an abortion, the hospital later rescinded the doctor's recommendation, forcing Finkbine to travel overseas for an abortion.

[74] It is important to note that Jones was halfway through her pregnancy at the time of her sonogram. According to the Guttmacher Instituted, 88.8 % of U.S. abortions occur in the first twelve weeks of pregnancy, and 63.1% occur in the first nine weeks of pregnancy (Guttmacher Institute, July, 2014). Given that first-trimester fetuses are less developed than Jones' fetus, it follows that Jones' ultrasound description may have included morphological details that would not be included in other readings.

[75] For a sympathetic response to Jones' story see Turits (March 26, 2012), although many of the article's online commenters do not share Turits' sympathy.

[76] Importantly, Meaghan Winter, the author of the story, later explained that whereas it was easy to find white urban women in their 20s and 30s who were willing to discuss their abortion experiences, it was difficult to find women of color, or women who were living in rural or conservative pockets of the country to share their abortion stories (Herold, 2013, para 5).

[77] I do not mean to suggest that the American Medical Association represents the opinion of all physicians. Notably, the majority of physicians and medical students do not belong to the AMA, and membership in the AMA has been declining over time. As of 2011, approximately 15% of practicing United States doctors belong to the AMA, as opposed to a 75% membership rate in the early 1950s (Collier, 2011).

[78] To be fair, AMA publications have provided important forums for discussing onerous abortion laws. In April of 2014, for example, the AMA's online ethics journal *Virtual Mentor* focused on the impact of third parties and outside influences upon medical decision-making, and it featured a short report on mandated ultrasound viewing. In one essay, Jen Russo (April, 2014) concludes that mandated ultrasound legislation violates the core principles of medical ethics, and Steinauer and Sufrin (April, 2014) argue that "micromanagement" of abortion-care "exists to no comparable degree anywhere else in medicine" (p.267). Importantly, such articles testify to a growing awareness amongst AMA community members of the injustice occasioned by invasive abortion legislation. It is important to note, however, that the AMA includes a disclaimer at the bottom of each article that states, "The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA." Thus, although the AMA provides a platform for critical discussion of abortion laws, one cannot extrapolate the AMA's official position from individual critiques.

[79] In one study, 17% of medical educators surveyed reported no training in abortion in clinical or preclinical years; almost a quarter of educators surveyed reported no training during third year OBGYN rotation; and only 32% of educators surveyed offered a third year OBGYN lecture on abortion specifically. Roughly half of all medical schools surveyed offered a fourth year reproductive health elective, but participation rate amongst students was low (Espey et al., 2005). For further discussion regarding the diminution of abortion provision see Joffe, Anderson, and Steinauer (1998).

[80] For an example, see American Academy of Family Physicians (2012).

[81] For an interesting discussion of the history of abortion counseling practices in the clinic settings see Carol Joffe (January, 2013).

[82] In general, both standards dictate that patients be given information regarding the following elements: "The nature and purpose of the proposed treatment, its risks and benefits, and any available alternatives" (Berg et al., 2001, p.53). The standards differ in the criteria they use for identifying the content and scope of each element.

[83] It is important to note that although leading psychological organizations have rejected the notion of Post-abortion Syndrome and feminists have correctly identified abortion stigma as the source of much abortion-related emotional distress, some women may experienced genuine emotional distress. In such cases, it may be necessary to meet women's psychological distress with professional mental health services.

[84] Of course, the model of patient-provider interaction that I advocate here would also require fundamental institutional changes to our healthcare system. The healthcare financing system, for example, would have to recognize and value the added time necessitated by robust medical dialogue. The difficulty of any overhaul to the healthcare system should not be underestimated, as demonstrated by the prolonged and acrimonious debates surrounding the Patient Protection and Affordable Care Act (2010).

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