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The purpose of this Article is to explore under what circumstances a woman who has sustained psychological damage from an abortion may maintain a cause of action against the abortion provider for failing to have properly informed her before the procedure of the risk of adverse psychological consequences which could be caused or aggravated by the abortion.

These consequences can be serious and destructive. Every year in the United States approximately one and one-half million legal abortions are performed.[1] According to some authorities, ten to fifteen percent of women who have had an abortion are subject to long-term depression or emotional distress caused by the procedure;[2] other studies have found that fewer than ten percent of women who have had a legal abortion during their first trimester develop long-term psychiatric or emotional reactions.[3] In addition to depression, reactions after abortion include repression,[4] a sense of loss,[5] guilt,[6] sleeping disorders,[7] anniversary reactions,[8] disturbed

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1 Paul K.B. Dagg, *The Psychological Sequelae of Therapeutic Abortion—Denied and Completed*, 148 AM. J. PSYCHIATRY 578 (1991); Jo Ann Rosenfeld, *Emotional Responses to Therapeutic Abortion*, 45 AM. FAM. PHYSICIAN 137 (1992).

2 HAROLD I. KAPLAN & BENJAMIN J. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1701 (6th ed. 1995). Dagg, *supra* note 1, at 579-83, contains a summary of studies on depression. He emphasizes that the great majority of women appear not to suffer long-term depression or adverse psychological impact from abortion. Short-term depression or stress, however, appears to be common. *See also* Nancy E. Adler et al., *Psychological Responses After Abortion*, 248 SCI. 41 (1990), which concludes from a study of medical literature that abortion most often does not lead to later psychological problems.

3 Rosenfeld, *supra* note 1, at 137.

4 Dagg, *supra* note 1, at 582; Linda L. Layne, *Motherhood Lost: Cultural Dimensions of Miscarriage and Still Birth in America*, 16 WOMEN & HEALTH 69 (1990), noting that in American culture, pregnancy loss is a subject not easily discussed.

5 Rosenfeld, *supra* note 1, at 138.

6 *Id.* at 139. Rosenfeld concludes that regret and guilt occur in women who have "poor ability to adapt to normal stress." *Id.*; *see also* sources cited *infra* notes 16-19.

7 Nancy B. Campbell et al., *Abortion in Adolescence*, 23 ADOLESCENCE 813 (1988), report significant nightmare and other problems in group members who had aborted during adolescence. Campbell et al.'s discussion of possible causes did not center on the act of abortion, but on adolescent development and relationships.

8 Nadja Burns Gould, *Post Abortion Depressive Reactions in College Women*, 28 J. AM. C. HEALTH ASS'N 316 (1980); Jesse O. Cavenar Jr. et al., *Aftermath of Abortion: Anniversary Depression and Abdominal Pain*, 42 BULL. MENNINGER CLINIC 433, 437 (1978), observing in two patients that the abortion was one of many factors leading to neurotic depression; Jean G. Spaulding & Jesse O. Cavenar, *Psychoses Following Therapeutic Abortion*, 135 AM. J. PSYCHIATRY 364 (1978). Spaulding and Cavenar report two serious anniversary cases in detail. In one case the patient required hospitalization for severe symptoms which occurred "at the time [she] would have had [her] baby." *Id.* at 365. The patient then experienced "insomnia, anorexia, agitation, and severe depression." *Id.*; *see also* Kathleen Franco et al., *Anniversary Reactions and Due Date Responses Following Abortion*, 52 PSYCHOTHERAPY & PSYCHOSOMICS 151 (1989), finding increased dependency and sleeping disorders in women who, responding to a survey, reported anniversary reactions.

relationships with men,[9] obsessive-compulsive behavior,[10] suicide attempts,[11] and psychotic and conversion reactions.[12] One factor which indicates whether a woman will sustain adverse psychiatric or emotional effects is her prior strength of character;[13] low self-efficacy also has been found to indicate that emotional or psychiatric harm may occur.[14] Other factors include conservative social values and religious beliefs,[15] high self-character blame,[16] unresolved conflicts about the pregnancy,[17] poor marital or home relationships,[18] present or previous psychiatric contacts,[19] lack of perceived

9 Rosenfeld, *supra* note 1, at 139.

10 Ronald K. McCraw, *Obsessive-Compulsive Disorder Apparently Related to Abortion*, 43 AM. J. PSYCHOTHERAPY 269 (1989).

11 C. L. Tishler, *Adolescent Suicide Attempts Following Elective Abortion: A Special Case of Anniversary Reaction*, 68 PEDIATRICS 670 (1981); *see also supra* note 8.

Sizing up the patient by outward appearance to determine self-efficacy or the risk of post-abortion trauma may be inaccurate. Tischer, in the first of two case studies, notes a suicide attempt by a 17 year old who was seen by others as a "well adjusted, high achieving, beautiful adolescent," but who described herself as good on the outside but depressed inside. *Id.* at 670. We may infer that careful pre-abortion counseling may have uncovered indications of this condition (numerous accidents, drug experimentation, and previous suicide attempts).

12 Henry P. David et al., *Postpartum and Post Abortion Psychotic Reactions*, 13 FAM. PLAN. PERSP. 88 (1981); Gary D. Tollefson & Michael J. Garvey, *Conversion Disorder Following Termination of Pregnancy*, 16 J. FAM. PRAC. 73 (1983). The term "psychosis" was defined by David et al. not as a break from reality (a common meaning), but as a more general disorder requiring admission to a psychiatric treatment center. The conclusion emphasized, as do virtually all authors on abortion's psychological impact, that abortion cannot be viewed alone, but must be interpreted with other factors affecting the patient's health.

13 Joyce L. Dunlop, *Counselling of Patients Requesting an Abortion*, 220 PRAC. 847 (1978), observing that teenagers who are psychologically immature are at high risk to acquire post-abortion stress disorders, especially if the patient values the pregnancy.

14 Dagg, *supra* note 1, at 582 (describing self-esteem); Catherine Cozzarelli, *Personality and Self-Efficiency as Predictors of Coping with Abortion*, 65 J. PERSONALITY & SOC. PSYCHOL. 1224 (1993). Cozzarelli discusses the "overlap" of low self-efficacy with depression. Self-efficacy is an expectation of doing well in a specific situation and is fundamental to personality. Depression, while affecting personality, is not integral to it. Cozzarelli treats abortion as a stressful occurrence. *See also* Robert Athanasiou et al., *Psychiatric Sequelae to Term Birth and Induced Early and Late Abortion: A Longitudinal Study*, 5 FAM. PLAN. PERSP. 227 (1973). This early study noted very few serious psychological consequences from abortion in a study of 373 women, and concluded that "patients whose history shows such characteristics as low self-esteem, high alienation, potentially pathological [Minnesota Multiphasic Personality Inventory] patterns, contraceptive naivete, high levels of sexual activity and delay in seeking an abortion, may represent a special problem in rehabilitative medicine." *Id.* at 231. Delay, we may infer, indicates that ambiguity about the abortion is a predictor of post-abortion emotional trauma.

Gould's work, however, strongly suggests it would be wrong to conclude that only immature women, or those with low self-efficacy or weak prior character, are at risk. Gould, *supra* note 8, at 316. Thus, "[t]wo women, both graduate students, experienced depressions at the time of the expected delivery date. These depressions were characterized by nightmares specifically related to the baby, insomnia, inability to concentrate on studies, divisiveness in their relationships with partners, and some suicidal ideation." *Id.* at 319.

15 Rosenfeld, *supra* note 1, at 138; Marijo B. Tamburrino et al., *Postabortion Dysphoria and Religion*, 83 S. MED. J. 736 (1990).

16 Dagg, *supra* note 1, at 582; Pallas Mueller & Brenda Major, *Self-Blame, Self-Efficiency, and Adjustment to Abortion*, 57 J. PERSONALITY & SOC. PSYCHOL. 1059 (1989). The Mueller-Major study preceded Cozzarelli's study, *supra* note 14, and reported similar findings on self-efficacy.

17 Rosenfeld, *supra* note 1, at 139; *see also* Campbell et al., *supra* note 7.

18 McCraw, *supra* note 10, at 269-70. Dagg similarly reported that "[s]ingle women who maintained a strong relationship with their partners after the abortion were more likely to experience regrets at 1 year and had more negative scores on the [Minnesota Multiphasic Personality Inventory] at 6 months." Dagg, *supra* note 1, at 581 (citing James M. Robbins, *Out-of-Wedlock Abortion and Delivery: The Importance of the Male Partner*, 31 SOC. PROBS. 334 (1984)).

support on abortion decisions from others,[20] history of multiple abortions,[21] the fact of adolescence itself,[22] and pressure from others in deciding to have an abortion.[23] The risk of depression is also higher in women who undergo abortions because of medical or genetic reasons than in those having abortions for psycho-social reasons.[24] On the other hand, an abortion after the first trimester is more likely, unless performed for genetic reasons, to cause adverse mental and emotional consequence than one performed earlier.[25]

It would be reasonable to expect, therefore, that there would be a number of reported court cases in which women have asserted claims for psychological injuries on grounds that they were at predictable high risk to sustain these injuries from an abortion and were not properly warned of relevant risks beforehand by the provider. Surprisingly, the little case law there is does not focus on informed consent or on core questions of constitutional rights but on whether damages are recoverable for the asserted injury.[26] Each area, however, is relevant to this Article's basic question and we should begin with informed consent.[27]

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19 Dagg summarized studies showing feelings of post-abortion guilt in seven to twenty-four percent of women who had therapeutic abortions with "some degree of psychiatric or other medical consultation." Dagg, *supra* note 1, at 581 note a.

20 *Id.* at 581. Rosenfeld noted that "[t]eenagers who do not tell their parents about their abortion have an increased incidence of emotional problems and feelings of guilt." Rosenfeld, *supra* note 1, at 138; *see also* Judith S. Wallerstein et al., *Psychosocial Sequelae of Therapeutic Abortion in Young Unmarried Women*, 27 ARCHIVES GEN. PSYCHIATRY 828 (1972).

21 Ellen W. Freeman et al., *Emotional Distress Patterns Among Women Having First or Repeat Abortions*, OBSTETRICS & GYNECOLOGY 630 (1980). Under another view, women with first pregnancies may be at higher risk. *See* R. C. Hall & S. Zisook, *Psychological Distress Following Therapeutic Abortion*, 8 FEMALE PATIENT 47 (1983).

22 Wanda Franz & David Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 ADOLESCENCE 161 (1992) (suggesting that adolescence itself may be a predictability factor for post-abortion psychological stress and other negative factors).

23 Dagg noted two studies in which teenagers who made the abortion decision without parental pressure had fewer adverse emotional effects after abortion than those who experienced pressure. Dagg, *supra* note 1, at 581-82; *see also* Campbell et al., *supra* note 7. Dunlop noted that, besides the patient, others such as the "husband, boyfriend, mother, previous children" should be seen "to help clarify hidden stresses which may strongly affect the issue. They may in fact be the last people to understand the situation correctly, influenced as they are by their own difficulties, family bias and so on." Dunlop, *supra* note 13, at 848-49. Thus, what might appear as support for the abortion could in fact be harmful pressure. *See* Wallerstein et al., *supra* note 20, at 832, observing that "where the women did not centrally participate in the decision making process, the experience tended to be regressive overall."

24 ANNE SPECKHARD, THE PSYCHO-SOCIAL ASPECTS OF STRESS FOLLOWING ABORTION (1987), *cited in* Dagg, *supra* note 1, at 582. Dagg found consistently that, in women reporting a high degree of post-abortion mental distress, attachment to the aborted fetus was high. Attachment to the fetus is, of course, generally equivalent to wanting the pregnancy. *See* HAROLD I. KAPLAN & BENJAMIN J. SADOCK, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY/IV 1054 (4th ed. 1985), discussing the loss of the wanted pregnancy.

Speckhard reported her sociological study of 30 post-abortion patients who had substantial stress after abortion. Very common among the women studied were feelings of grief, anger, victimization, bitterness, disappointment, and hurt, often accompanied by frequent crying. SPECKHARD, *supra*, at 40. The women's reaction suggests the existence of a separate post-abortion syndrome.

25 Rosenfeld, *supra* note 1, at 138.

26 Perhaps not surprisingly. *See* Layne, *supra* note 4. Another reason, perhaps, is that post-abortion trauma cases can arise in persons whom courts may not find to be credible witnesses. *See* Tollefson & Garvey, *supra* note 12, and sources cited *supra* note 14.

27 Many professional articles focus on informed consent. Bruce C. Recher, Note, *Informed Consent Liability*, 26 DRAKE L. REV. 696 (1977), contains a useful summary of policy and rule

I. A PATIENT'S RIGHTS

The right of the patient to be informed of the consequences of a medical procedure was articulated by Justice Cardozo in 1914 in *Schloendorff v. Society of New York Hospital*,[28] who wrote:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.[29]

In determining whether the patient's right to receive information about relevant risks before consenting to a procedure was protected, courts first focused on whether the physician had given the patient advice which a reasonable physician of the community customarily would have given under similar circumstances.[30] Proof of a violation of this standard was therefore dependent in most situations upon expert opinion.[31] In 1960, the Kansas Supreme Court in *Natanson v. Kline*[32] summarized the physician's duty:

> This rule in effect compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.[33]

The plaintiff sought recovery in an informed consent action under a battery theory, but this approach was rejected in a more famous part of *Natanson*. The court held that since a review of professional practice was in issue,

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development. Other continuingly relevant articles include Andrea Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51 (1983) (writing forthrightly from a feminist perspective); Susan Oliver Renfer et al., *The Woman's Right to Know: A Model Approach to the Informed Consent of Abortion*, 22 LOY. U. CHI. L.J. 409 (1991) (setting out the Model Woman's Informed Choices Act); David E. Seidelson, *Lack of Informed Consent in Medical Malpractice and Product Liability Cases: The Burden of Presenting Evidence*, 14 HOFSTRA L. REV. 621 (1986); Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749 (1986); Mary Anne Wood & W. Cole Durham, *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U. L. REV. 783 (1978).

28 105 N.E. 92 (N.Y. 1914).

29 *Id.* at 93 (citations omitted).

30 *E.g.*, Grosjean v. Spencer, 140 N.W.2d 139 (Iowa 1966); *see also* Recher, *supra* note 27, at 702.

31 Recher, *supra* note 27, at 702.

32 350 P.2d 1093 (Kan. 1960).

33 *Id.* at 1106.

disputes in informed consent actions should be determined under negligence and not battery principles if the patient had given consent to the medical procedure.[34]

By the late 1960s, informed consent law was criticized by commentators for not focusing on the need of the patient to make an informed choice on the course of treatment.[35] In 1972, the Court of Appeals for the District of Columbia in *Canterbury v. Spence*[36] set out new standards to determine whether information given by a physician to a patient was sufficient to allow the patient to be properly informed in making the decision to have or refuse a specific treatment. Its holdings eventually were described in shorthand fashion as either the patient's rule or the patient autonomy rule; the previous approach was characterized as the professional rule.[37] *Canterbury*, which adopted the negligence approach,[38] stated that the patient was entitled to learn from the physician "all risks potentially affecting the decision."[39] Whether the physician complied with the duty to inform the patient was approached on the basis of reasonableness and foresight rather than hindsight.[40] Nonetheless, the inherent and potential hazards of a proposed treatment,[41] the alternatives to this treatment, and the results if a patient were not treated,[42] had to be disclosed to the patient.[43] Full disclosure was rejected as impossible.[44] The physician, accordingly, was not obligated to communicate information immaterial to the patient's decision,[45] and the duty did not exist if the patient was unconscious[46] or if the patient's health would be harmed by a discussion of the risks.[47]

The court was careful to limit exceptions to disclosure, stating:

> The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for

34 *Id.* at 1100-03. Certain jurisdictions have retained a battery instead of a negligence approach. *E.g.*, Doe v. Dyer-Goode, 566 A.2d 889 (Pa. Super. Ct. 1989); Cary v. Arrowsmith, 777 S.W.2d 8 (Tenn. Ct. App. 1989).

35 Among the many articles cited in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), is Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628 (1969).

36 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064(1972). Waltz and Scheuneman heavily influenced the analysis in this case. *See* Wiesbard, *supra* note 27, at 759 n.19.

37 *Natanson*, 350 P.2d 1093, applied the professional rule.

38 *Canterbury*, 464 F.2d at 793. The court cited both *Schloendorff* and *Natanson* for the general proposition that informed consent is a fundamental right of all adults. *Id.* at 780.

39 *Id.* at 787. In similar language the court stated, "It is the duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care." *Id.* at 782.

40 *Id.* at 787.

41 *Id.* at 781-82.

42 *Id.*

43 *Id.*

44 *Id.* at 786.

45 *Id.* at 787.

46 *Id.* at 788-89.

47 *Id.* at 789.

> even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.[48]

The physician's advice, the court observed, could not be imposed upon the patient and, for the consent to be valid, it had to be an expression of the patient's true choice.[49] The duty to inform the patient of the risks and options available in a particular procedure thus did not depend on the patient's actions or the absence of the patient's request.[50] To simply answer the patient's questions was not enough to meet the informed consent requirement. The physician was held to have the duty to "volunteer, if necessary, the information the patient needs for intelligent decision."[51] Because of the physician's duty to disclose risks and choices to the patient, *Canterbury* therefore abolished the professional rule requirement that the plaintiff by the use of expert evidence prove a violation of the physician's duty to inform the patient. In defense, the physician could use expert evidence showing customary disclosure practices, but this evidence could not normally establish the standard or scope of required disclosure.[52]

Questions of the causal relationship between the lack of informed consent and the patient's damages were to be decided on an "objective" basis. Thus, the patient's decision was considered an informed decision if it was "what a prudent person in the patient's position would have decided if

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48 *Id.*

49 *Id.* at 783.

50 *Id.* n.36.

51 *Id.*

52 *Id.* at 785. The court noted that when medical judgment was involved, as applied to disclosure, "prevailing medical practice must be given its just due." *Id.* A full discussion on defenses is beyond the scope of this Article. Nonetheless, observations can be made. Certainly ERISA and the Federal Tort Claims Act, if applicable, should be carefully reviewed. Defenses generally have focused on limiting the scope of materiality (what is significant enough to trigger peril and alternative warnings) and on whether expert evidence is required to establish elements of the plaintiff's case. Diverse results have occurred. Regarding expert testimony, for instance, it has been held that this testimony is required to establish materiality unless the risk is obvious. *E.g.*, Revord v. Russell, 401 N.E.2d 763 (Ind. Ct. App. 1980); Woolley v. Henderson, 418 A.2d 1123 (Me. 1980). Expert testimony on materiality, however, has been held not to be a requirement. *E.g.*, Mallett v. Pirkey, 466 P.2d 466 (Colo. 1970); *see also* Griffith v. Jones, 577 N.E.2d 258 (Ind. Ct. App. 1991), holding that a medical review panel could not give expert evidence on what a reasonable prudent patient would determine to be material; lay testimony alone would suffice. In Hill v. Ohio Univ., 610 N.E.2d 634 (Ohio Ct. Cl. 1988), it was held on materiality that a physician must determine whether, under the risks, the patient would elect the recommended course of treatment. This arguably established a professional rule application to the reasonable patient standard. *Hill*'s analysis was based on a mixture of patient's and physician's rule concepts and will therefore probably not be followed elsewhere. On abortion materiality, see the New York cases discussed *infra* text accompanying notes 79-81 and 83-84.

It is important to analyze informed consent cases not only in terms of their immediate holdings, which often center on the need for reliable proof, but also in view of the institutional purposes of the physician-patient relationship. The need for reliable proof (which can be based on credentials) will tend to re-establish professional rule requirements unless the court specifically allows for the patient's right to reasonably direct the course of treatment when determining the standards for reliable proof. It would be easy to cynically dismiss *Canterbury* as creating a right that has become an illusion in view of demanding requirements of proof. This would, however, be incorrect, because once those standards are met, the patient's right to make a reasonable decision becomes the substantive focus of the litigation.

suitably informed of all perils bearing significance."[53] By requiring that recoveries be grounded on this standard and not on a particular patient's subjective values, the rule thus sought to require patients to make decisions reasonably.[54]

Canterbury, it has been stated, made the informed consent action a "mainstream" tort,[55] and its holdings were adopted shortly thereafter in California in *Cobbs v. Grant*.[56] *Cobbs* held that there is "no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence."[57] This language, of course, required disclosure of remote risks if the consequences were not minor. *Cobbs* further held that a patient could refuse to be informed by the physician of particular risks and alternatives.[58]

Other states, but certainly not all, quickly followed in adopting the patient's rule.[59] The action which came into being, as stated later in *Pauscher v. Iowa Methodist Medical Center*,[60] required the plaintiff to prove four elements:

1. The existence of a material risk unknown to the patient;
2. A failure to disclose that risk on the part of the physician;
3. Disclosure of the risk would have led a reasonable patient in the plaintiff's position to reject the medical procedure or choose a different course of treatment; [and]
4. Injury.[61]

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53 *Canterbury*, 464 F.2d at 791. We should not confuse requirements of expert evidence on the standard of care required in informing the patient with the requirement that there be proof (often by competent expert evidence) showing damages were caused by the procedure. *Id.* at 791-92; *see infra* text accompanying notes 61-67.

54 *Canterbury*, 464 F.2d at 787, 790-91.

55 Renfer et al., *supra* note 27, at 411.

56 502 P.2d 1 (Cal. 1972).

57 *Id.* at 11.

58 *Id.* at 12.

59 Adopting the patient's rule early: Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294 (Conn. 1983); Crain v. Allison, 443 A.2d 558 (D.C. 1982); Cowman v. Hornaday, 329 N.W.2d 422 (Iowa 1983); Goodwin v. Aetna Casualty & Sur. Co., 294 So. 2d 618 (La. Ct. App. 1974); Sard v. Hardy, 379 A.2d 1014 (Md. 1977); Harnish v. Children's Hosp. Medical Ctr., 439 N.E.2d 240 (Mass. 1982); Pultshack v. University of Minn. Hosps., 316 N.W.2d 1 (Minn. 1982); Reikes v. Martin, 471 So. 2d 385 (Miss. 1985); Gerety v. Demers, 589 P.2d 180 (N.M. 1978); Nickell v. Gonzalez, 477 N.E.2d 1145 (Ohio 1985); Scott v. Bradford, 606 P.2d 554 (Okla. 1979); Beauvais v. Notre Dame Hosp., 387 A.2d 689 (R.I. 1978); Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972); Peterson v. Shields, 652 S.W.2d 929 (Tex. 1983); Small v. Gifford Memorial Hosp., 349 A.2d 703 (Vt. 1975); Smith v. Shannon, 666 P.2d 351 (Wash. 1983); Miller v. Kennedy, 522 P.2d 852, (Wash. Ct. App. 1974), *aff'd*, 530 P.2d 334 (Wash. 1975); Scaria v. St. Paul Fire & Marine Ins. Co., 227 N.W.2d 647 (Wis. 1975).

A careful defense of the physician's rule is found in Hook v. Rothstein, 316 S.E.2d 690 (S.C. Ct. App.), *cert. denied*, 320 S.E.2d 35 (S.C. 1984).

State statutes also have implemented informed consent requirements. Renfer et al. cited informed consent statutes on specific risks which had been adopted by 1991. Renfer et al., *supra* note 27, at 427-28 nn.107-15. Current statutes are collected by Leonard J. Nelson III in *Informed Consent*, 2 MEDICAL MALPRACTICE ¶ 22.11 (David W. Louisell & Harold Williams eds., 1987). Nonetheless, informed consent is seen as a court-made area of the law and not as an area dominated by legislatures. In this respect, it parallels abortion law.

60 408 N.W.2d 355 (Iowa 1987).

61 *Id.* at 360. The causal relationship has continued to be determined by the prudent person objective standard. Oklahoma, however, in 1990 adopted a subjective standard based on what the

To this, we should add a fifth requirement that the patient normally also had to testify that if the patient had known the risks, the patient would not have consented to the procedure.[62] The exceptions to the physician's duty to inform set out in *Canterbury* and *Cobbs*, of course, could be asserted affirmatively as defenses or could be used to negate the plaintiff's proof in the determination of liability.[63] The new tort thus had become a strict liability action, because a plaintiff was not required to prove negligence in the failure to give the requisite information.[64]

The anticipated impact on medical practice of the emergent tort was to improve medicine itself by bringing the patient into the decision-making process. The Rhode Island court, in adopting the patient rule, quoted a medical-legal authority:

> Accordingly, prudent advice to the doctor would seem to be as follows: All medical procedures have risks (the patient not allergic to penicillin yesterday may be violently so today); the greater the risk, the greater the duty to inform. *Rule of thumb*: unless therapeutic reasons contraindicate, make a simple, quiet, but honest disclosure commensurate with the risk in all cases and let the patient choose what risks he wishes to run with his body. * * *
>
> Besides being good medicine, good humanity, good public relations, and good medicolegal defense, the preceding advice has a therapeutic value all its own. The informed and consenting patient, aware of the risk, is not so shocked should the risk turn up in his case and, if patient-physician rapport is high, is much less likely to sue his doctor in the first instance.[65]

The actual practice of medicine, where the patient's rule applies (or might be thought to soon apply), however, may often have been far different from the practice anticipated as physicians reacted to the possibility of informed consent actions. In his article on informed consent, Weisbard writes:

> This apprehension has resulted in some physicians feeling a need to disclose virtually all conceivable risks associated with treatment. These perceived "requirements," in addition to their often criticized burdensome quality to physicians, can lead to a formalistic recitation of a near-endless

patient would have done. Scott v. Bradford, 606 P.2d 554 (Okla. 1990), *cert. denied*, 409 U.S. 1064 (1972). *See* Seidelson, *supra* note 27, at 624, for a discussion of causality, its standards of proof, and their relation to the purposes of informed consent.

62 Seidelson, *supra* note 27, at 623-24. Does this fifth requirement introduce subjectivity? Consider Nelson's discussion on Indiana law, *supra* note 59, especially on Revord v. Russell, 401 N.E.2d 763 (Ind. Ct. App. 1980). Despite this discussion, requiring proof of what the patient actually would have done can be seen not as a lessening of the reasonable person test, but as a requirement that that test be related to actual events. It therefore tends to prevent litigation on abstract principles not related to the plaintiff's actual intentions. This may be a better reading of subjectivity factors in cases such as *Revord* which expressly followed *Canterbury* on the standard in determining what is material to require that the patient be informed. *Id.* at 766-67.

63 The number of exceptions was expanded in Sard v. Hardy, 379 A.2d 1014, 1022-23 (Md. 1977). The additional exceptions are closely consistent with the *Canterbury* holding with one exception: the patient need not be informed of risks after requesting not to be informed.

64 Seidelson, *supra* note 27, at 641.

65 Wilkinson v. Vesey, 295 A.2d 676, 690 (R.I. 1972) (quoting R. CRAWFORD MORRIS & ALAN R. MORITZ, DOCTOR AND PATIENT AND THE LAW (5th ed. 1971)).

> parade of risks so mind-numbing (and perhaps so frightening) as to overwhelm the patient's capacity to assimilate significant information. The law's concern with risk disclosure, as it is (mis)understood and put into practice, may defeat rather than enhance the patient's capacity to utilize significant information to make sound decisions.[66]

Predictably, he writes that this has resulted in

> the use of informed consent forms, characterized primarily by their lengthy recitals of potential risks and by their general unintelligibility to most patients. These forms are typically presented to patients for signature the night before the procedure is to be performed, with limited opportunity for individualized discussion. So the law is served, the physician is protected from legal liability, and patient autonomy is "respected."[67]

If this remains the present practice, then a de facto restoration of the professional rule, if not the repeal of *Schloendorff*, has occurred. Using paperwork, true consultation with the patient is avoided and the physician able thereby to fully control the direction of treatment. Such practice,

66 Weisbard, *supra* note 27, at 756. Unduly burdensome informed consent forms specifying each possible risk are not required. Thus, in Hill v. Ohio Univ., 610 N.E.2d 634 (Ohio Ct. Cl. 1988), it was held as a matter of law that nondisclosure to the patient of a "miniscule risk" of tissue atrophy from an injection, used after commonly accepted methods to treat allergic rhinitis had failed, did not establish that the physician had not informed the patient correctly of risk since a reasonable person in plaintiff's position would very likely have proceeded with treatment. *Id.* at 637.

Concentrating solely on the release instrument ignores the role of the physician to effectively provide information to assist the patient in reaching a decision. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). The release instrument itself is only evidence of consent and is not conclusive on the issue of whether consent was given. Sard v. Hardy, 379 A.2d 1014 (Md. 1977); Estrada v. Jaques, 321 S.E.2d 240 (N.C. Ct. App. 1984). In *Estrada*, a plaintiff suffering from a gunshot wound gave written consent to surgery, but was not informed of all risks required by the applicable statute. To prove that actual consent was given, the physician was required to show conclusively "(1) the circumstances surrounding the consent, (2) the risks inherent in the procedures offered, (3) the standard in the community for obtaining consent and (4) that the standard was met under the circumstances." *Id.* at 252. Once the physician proved these elements, the burden shifted to the plaintiff. In *Estrada*, to give valid consent, the plaintiff not only had to know the procedures offered, but also their "'usual and most frequent risks and hazards'.... Estrada could only understand *what the surgeons told him.*" *Id.* at 253 (citing N.C. GEN. STAT. § 90-21.13(a)(2) (1981)).

The court in Boruski v. United States, 803 F.2d 1421 (7th Cir. 1986), applying Illinois law, upheld the efficacy of a written release in a flu vaccination suit where the instrument showed adequate statistical information on risks, was written in simple language, and the warning allowed the patient to make up the patient's mind. Furthermore, the patient had had an opportunity, which was acknowledged by the patient at the time, to review the instrument before signing. *Id.* at 1426-28. If we read *Estrada* and *Boruski* together, when written releases provide in a simple manner information necessary to understand the elements of the informed consent, then the releases will be upheld. If a patient is not told of relevant risks and alternatives, however, and causally related problems later develop, then the release will be of little value to the defendant. This implies further that risks and alternatives particular to the patient must be carefully explained and that form release instruments may often be insufficient. The *Estrada* community-standard test, if applied to abortion, however, ought to be the standard of the entire medical community, not simply the standard of an abortion provider in order to avoid self-creating immunity by the provider. The approaches of these two cases may offer a workable directive, under current abortion-rights concepts, on what the provider should inform the pre-abortion patient.

67 Weisbard, *supra* note 27, at 763; *see also infra* note 137 on abortion practice.

however, calls into question the sufficiency of any release document signed by a patient. To claim otherwise is to place form ahead of substance.[68]

Weisbard asked whether informed consent can continue as a workable approach to patient involvement in health care decisions. It is unlikely, however, that patients will have their role in decision making formally abolished. Counseling of the type anticipated by the Rhode Island court would arguably cause even over-legalized procedure to become workable. We can expect, therefore, that the standard of obtaining informed consent in most areas of medical practice will require detailed written acknowledgement by the patient of relevant and serious risks of a procedure together with alternatives to proposed treatment. This normally will be accompanied by individualized pre-release counseling on these factors conducted in a manner designed to draw out the patient's true intent. This counseling will also buttress the release instrument.[69]

II. DAMAGES LIMITATIONS

Even if an informed consent violation in an abortion situation were proved, however, damages principles may be argued as preventing recovery for abortion-caused psychological injury. Formerly common, but now diminished, was the principle that a plaintiff may not recover for an emotional injury unless the injury arose from, or was at least contemporaneous with, a physical impact.[70] Courts now typically employ a test which allows recovery for emotional injury with no physical impact only if accompanied by both a severe causal occurrence and a resulting physical injury.[71] These limitations spring from the need to prevent intentionally false or imagined claims, to have reliable proof of causation of injury, and to require that there be foreseeability of the risk in a course of conduct.[72] The term physical injury, however, has been described to include not only injuries with demonstrable physical cause, but also emotional conditions which are ca-

68 Fraud, deceit, duress, and other actions will no doubt occur to attorneys for women who have not been properly advised of both abortion options and alternatives to the procedure.

69 Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), emphasized that at times a physician must be a teacher to instruct the patient on risks and options, which requires more than simply presenting information.

70 FOWLER V. HARPER ET AL., 3 THE LAW OF TORTS § 18.4 (2d ed. 1986). Harper et al. noted that the impact requirement "is distinctly the minority rule today" and set out detailed authority for this position. *Id.* at 687; STUART M. SPEISER ET AL., 4 THE AMERICAN LAW OF TORTS §§ 16.7-8 (1992). Speiser et al. concluded much the same, referring to the impact rule memorably as "atavistic primitivism." *Id.* at 992.

Limitations on recovery for negligently inflicted emotional injury do not normally apply to damages caused by intentional and outrageous conduct. RESTATEMENT (SECOND) OF TORTS § 435A (1963).

71 3 HARPER ET AL., *supra* note 70, at § 18.4; SPEISER ET AL., *supra* note 70, §§ 16:7-8. By focusing on cause of injury and specific conduct to be prevented, the new test brings rationality and moral judgment to the law. Contextually, the change to the physical damages rules was made primarily in bystander cases (plaintiffs suffered emotional-psychological harm after observing another being negligently injured) and near-miss actions (plaintiffs perceived narrowly escaped death or terrible injury due to defendants' negligence). Emotional injury not having a severe cause is therefore not generally compensable.

72 3 HARPER ET AL., *supra* note 70, at § 18.4; *see also* SPEISER ET AL., *supra* note 70, §§ 16:7-8. With abortion, it follows that if the procedure is deemed minor, or if a woman's reaction to the loss of a pregnancy is thought to be of small consequence, then no recovery under the physical damages test could be allowed for emotional harm since it was not foreseeable.

pable of being objectively proved.[73] As knowledge of psychological injury expands, we may, therefore, expect that previously unprovable causal relationships will be subject to objective demonstration.

Exceptions to the rule requiring underlying physical injury have been formulated in health care cases. The Iowa Supreme Court, for example, has allowed recovery against health care providers for emotional injury caused largely by injurious remarks during labor to a mother and father whose baby was thought to be stillborn, but was then discovered to have been born alive.[74] The patient's statements that she needed help were not acted upon. The court, while observing that the parent's claim for damages normally would not be allowed in the absence of physical injury, stated specifically with respect to health care providers that "an exception exists . . . where the nature of the relationship between the parties is such that there arises a duty to exercise ordinary care to avoid causing emotional harm."[75] The North Carolina Supreme Court in *Johnson v. Ruark Obstetrics*,[76] in a claim for damages for a stillborn baby, reached a similar result when it allowed for potential recovery for "severe emotional distress"[77] where the distress was foreseeable without requiring physical impact or physical injury.[78]

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73 In Petition of United States, 418 F.2d 264 (1st Cir. 1969) (admiralty action), plaintiff recovered for psychiatric injury occurring when he was swept to sea as his ship sank. This lead to "severe neurosis of an anxiety reaction type with depressive features . . . that . . . is chronic in nature . . . ." *Id.* at 267. For further general background, see Towns v. Anderson, 579 P.2d 1163 (Colo. 1978), which abolished the impact rule and allowed medical evidence of emotional or psychological injury. The court cited the RESTATEMENT (SECOND) OF TORTS § 436(2) (1965), which stated:

> If the actor's conduct is negligent as creating an unreasonable risk of causing bodily harm to another otherwise than by subjecting him to fright, shock, or other similar and immediate emotional disturbance, the fact that such harm results solely from the internal operation of fright or other emotional disturbance does not protect the actor from liability.

The court also cited Comment (c) to § 436A: "On the other hand, long continued nausea or headaches may amount to physical illness, which is bodily harm; and even long continued mental disturbance, as for example in the case of repeated hysterical attacks, or mental aberration, may be classified by the courts as illness, notwithstanding their mental character."

Applied to abortion, long continued disturbances such as sleeping disorders, anniversary reactions, or obsessive-compulsive behavior could by analogy be seen as bodily harm, with correct proof of severity. *See supra* notes 7-8 and 10.

74 Oswald v. LeGrand, 453 N.W.2d 634, 636-37 (Iowa 1990).

75 *Id.* at 639. The court cited Iowa cases allowing recovery for negligence with telegrams "announcing the death of a close relative" and for negligence in handling a funeral. *Id.* The court also cited Geibel v. United States, 667 F. Supp. 215 (W.D. Pa 1987), which is of doubtful value, but also Taylor v. Baptist Medical Ctr., 400 So. 2d. 369 (Ala. 1981), which allowed recovery for emotional injury in a breach of contract case. Recovery could be allowed if the defendant's relationship to plaintiff was "so coupled with matters of mental concern or solicitude, or with the feelings of the party to whom the duty is owed, that a breach of that duty will necessarily or reasonably result in mental anguish or suffering." *Id.* at 374.

76 395 S.E.2d 85 (N.C. 1990) (denying motion for summary judgment on liability).

77 *Id.* at 95-96. A comparison of *Johnson* to *Petition of United States*, discussed *supra* note 73, shows both courts headed in the same direction of allowing recovery for provable emotional injury of consequence to the victim.

78 *Johnson*, 395 S.E.2d at 93-94. The holding in *Johnson* was founded on a thorough discussion of North Carolina law regarding negligently inflicted emotional injury. The court held that damages arising from a contractual relationship could be recovered either in a breach of contract action or in a tort action if causation and foreseeability were present. *Id.* at 97. Further, "a plaintiff must also allege that severe emotional distress was the foreseeable and proximate result of such negligence in order to state a claim; mere temporary fright, disappointment or regret will

Damages issues have been thought to be crucial in several recent cases in which claims were brought by patients for abortion-caused damages. In *Martinez v. Long Island Jewish Hillside Medical Center*,[79] the plaintiff recovered against the medical center and genetic counselors who negligently told her that the baby would be born with microcephaly or anencephaly (small brain or no brain). The plaintiff relied on their statements and had a first trimester abortion. She subsequently learned that her aborted fetus had a normal head size, which caused her "mental anguish and depression."[80] The court considered whether recovery would be permitted in cases in which the plaintiff was not injured (implying that the abortion procedure was not physically injurious) and there was no intentional infliction of emotional distress. The court allowed the plaintiff to recover, stating that "the emotional distress for which she seeks recovery does not derive from what happened to the fetus; it derives from the psychological injury directly caused by her agreeing to an act which, as the jury found, was contrary to her firmly held religious beliefs."[81]

The Kansas Supreme Court, however, in *Humes v. Clinton*,[82] retained the use of the physical injury standard in considering a patient's claim for emotional injuries against an abortion provider. The patient had received no pre-operative advice on possible physical or psychological problems associated with having an abortion, but the court held that the failure to warn the plaintiff of possible harm did not give rise to a cause of action unless the patient had sustained physical injury. Subsequently, another New York case, *Ferrara v. Bernstein*,[83] allowed recovery for damages for emotional injury sustained when the plaintiff had a miscarriage after a failed abortion. The court justified the recovery by stating that the pain due to

not suffice." *Id.* The court continued: "'[s]evere emotional distress' means any emotional or mental disorder, such as, for example, neurosis, psychosis, chronic depression, phobia, or any other type of severe and disabling emotional or mental condition which may be generally recognized and diagnosed by professionals trained to do so." *Id.*

Foreseeability was to be determined on a case-by-case basis using factors which include "the plaintiff's proximity to the negligent act, the relationship between the plaintiff and the other person . . . and whether the plaintiff personally observed a negligent act." *Id.* at 98. A dissent by Justice Meyer argued for a foreseeability standard that would limit the class of potential plaintiffs and which would determine—instead of simply describe—foreseeability. *Id.* at 101 (Meyer, J., dissenting). The dissent further argued that extensions of recovery should be made only under cost-benefit analysis. *Id.* at 102. The majority and the dissent discussed damages in terms of the bystander doctrine, which may not logically be the correct damages concept to employ in an abortion situation. *See* Martinez v. Long Island Jewish Hillside Med. Ctr., 512 N.E.2d 538 (N.Y. 1987), discussed *infra* text accompanying notes 79-81. Regardless of whether a bystander approach is used, the issues raised in North Carolina may be expected to be encountered elsewhere and the discussion forms a framework for damages issues analysis.

Analogous holdings requiring foreseeability as a key to the recovery of damages for economic loss are also replacing tests requiring actual physical injury to the plaintiff or the plaintiff's property. *See* Fireman's Fund Am. Ins. Cos. v. Burns Elec. Sec. Serv., 417 N.E.2d 131 (Ill. App. Ct. 1980); Nelson v. Todd's Ltd., 426 N.W.2d 120 (Iowa 1988) (products liability cases).

79 512 N.E.2d 538 (N.Y. 1987).

80 *Id.* at 538.

81 *Id.* at 539.

82 792 P.2d 1032 (Kan. 1990).

83 582 N.Y.S.2d 673 (App. Div. 1992), *aff'd*, 613 N.E.2d 542 (N.Y. 1993).

the childbirth or miscarriage experience was a physical injury which would not have occurred if the abortion had been fully completed.[84]

Of these cases, *Johnson v. Ruark Obstetrics*, by requiring that there be foreseeability of emotional injury (a negligence concept which easily translates to the material risk of strict liability) and that recovery for this injury be limited to serious situations, provides a comprehensive approach to the question of whether damages for emotional harm should be awarded absent physical injury. Certainly, if the law seeks to prevent and redress foreseeable serious emotional injury stemming from informed consent violations, recovery in abortion situations ought not be limited to the unusual factual circumstances illustrated by *Martinez* and *Ferrara*. Recovery should require reliable proof of the psychological or emotional injury. Physical injury or impact tests will be of little use in categorizing claims since these elements arguably will be present in all abortions without informed consent. If, however, a physical injury standard is used, objective proof of severe emotional injury should be viewed as constituting proof of physical injury. Failing to allow recovery for psychological injury based on reliable proof will serve no goal except to immunize abortion providers from responsibility for poor practice in advising patients of perils and alternatives.

III. A Constitutional History of Abortion Consent

Shortly after *Canterbury v. Spence*,[85] the United States Supreme Court in *Roe v. Wade*[86] held that the Texas criminal statute[87] forbidding a woman from having an abortion, except to save her life, violated the woman's right to privacy guaranteed by the Fourteenth Amendment's "concept of personal liberty."[88] *Roe v. Wade*, together with its companion, *Doe v. Bolton*,[89] cast states as protectors of potential human life, but forbade them from preventing abortions in the first trimester of pregnancy. *Roe* also allowed

84 *Id.* at 676. In Lynch v. Bay Ridge Obstetrical & Gynecological Assocs., 532 N.E.2d 1239 (N.Y. 1988), the court allowed damages for an abortion undertaken by the patient because of incorrect medical advice. After being told that she was not pregnant, the patient took a drug known to create a risk of birth injuries. She subsequently discovered she was pregnant, and had an abortion because of the potential injury to the child. The dissent argued that the physical consequences of a "normal abortion" are not sufficient to allow recovery for emotional injury. *Id.* at 1242. This argument was rejected by the court, but illustrates the view that abortion is of little physical consequence, a perspective which dominated the opinions of the United States Supreme Court until *Casey*. *See infra* text accompanying notes 184-205. The *Lynch* dissent is echoed in *Ferrara*, 582 N.Y.S.2d at 678-80 (Murphy, J., concurring).

The illustration provided in the comment to § 436(2) of the Restatement (Second) of Torts did not permit recovery if a team of horses only frightened a woman in a near-miss situation. But if the team of horses so frightened her and caused her to miscarry, the physical injury she sustained sufficed to allow recovery. Restatement (Second) of Torts § 436 cmt. C, illus. 2 (1965). While this comment was meant to illuminate shock and emotional injury, *see supra* note 73, the use of a miscarriage as an underlying physical injury sufficient to allow recovery is unmistakable. The loss of a child (fetus) in abortion due to an informed consent violation would, accordingly, satisfy the physical injury requirement.

85 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

86 410 U.S. 113, 93 S. Ct. 705 (1973).

87 Tex. Penal Code Ann. §§ 1191-1194, 1196.

88 *Roe*, 410 at 153, 93 S. Ct. at 727.

89 410 U.S. 179, 93 S. Ct. 739 (1973).

the states little authority to restrain later abortions even after the fetus was "viable." Only upon fetal viability were states allowed to partially restrain the right to abortion.[90] States were allowed broad powers, however, which the Court set out in detail, to protect the physical health of women.[91] Obtaining an abortion was made a fundamental right. State limitations on that right were to be analyzed, consequently, under a strict scrutiny test in which only a compelling state interest would allow curtailment of the right to abortion.[92] In contrast, the standard used to review a state statute not involving a fundamental right provided that a statute attacked on due process grounds would be found constitutionally valid if it had a rational relationship to a legitimate state purpose.[93]

Regarding informed consent, in *Roe v. Wade* the Court quoted *Standards for Abortion Services of the Executive Board of the American Public Health Association,* which provided:

> a. Rapid and simple abortion referral must be readily available through state and local public health departments, medical societies, or other non-profit organizations.
> b. An important function of counseling should be to simplify and expedite the provision of abortion services; it should not delay the obtaining of these services.
> c. Psychiatric consultation should not be mandatory. As in the case of other specialized medical services, psychiatric consultation should be sought for definite indications and not on a routine basis.
> d. A wide range of individuals from appropriately trained, sympathetic volunteers to highly skilled physicians may qualify as abortion counselors.
> e. Contraception and/or sterilization should be discussed with each abortion patient.[94]

These standards contained no concept that harm could regularly come to women from abortions. Counseling which was to serve, as the verb went, to "expedite" the decision to abort thus had the purpose of overcoming any ambiguities of thought, morality, or sentiment the patient may have had about abortion. The absence of concern over a woman's psychological response to the stress of the decision was further reflected in Justice Blackmun's comments on the impact of pregnancy on a woman:

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be immi-

90 The *Roe v. Wade* trimester-viability test is almost universally known. Third trimester regulations (post-viability protection) were dependent on state action if the state "is interested," but could be overcome if abortion was "necessary to preserve the life or health of the mother." *Roe,* 410 U.S. at 163-64, 93 S. Ct. at 732.

91 *Id.* at 149-51, 93 S. Ct. at 725.

92 *Id.* at 155-56, 93 S. Ct. at 728.

93 *E.g.,* Williamson v. Lee Optical of Okla., 348 U.S. 483, 75 S. Ct. 461 (1955). The rational relationship test, if employed in abortion cases, would no doubt have allowed substantial state curtailment of unlimited subjectivity by patients in determining whether they should have abortions. *See* Justice Rehnquist's dissent in Roe v. Wade, 410 U.S. 113, 173, 93 S. Ct. 705, 737 (1973).

94 *Roe,* 410 U.S. at 144-45, 93 S. Ct. at 722-23.

> nent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.[95]

Justice Blackmun did, however, discuss with favorable reference the preambles to American Medical Association resolutions which "emphasize 'the best interests of the patient,' 'sound clinical judgment,' and 'informed patient consent,' in contrast to 'mere acquiescence to the patient's demand.'"[96] He nonetheless did not specify informed consent standards which states could employ in protecting the psychological health of women having abortions. Several reasons for this may exist. The petitioners were women who wanted to have abortions and, from a careful opinion-writing position, there was no reason to address informed consent since it was not raised by the parties. More likely, since the opinion was so legislative in character (as evidenced by the creation of the trimester system and the specific delineations of a state's right to protect women's physical health), the Court would have established patients' informed consent rights, beyond setting out those necessary to facilitate the abortion, had it thought it necessary to do so. Inferentially, if not expressly, the Court simply did not consider abortion to be a medical procedure with likely adverse psychological results for significant numbers of women. Consistently, Justice Blackmun saw the abortion decision as the physician's decision. In *Doe v. Bolton*, he wrote:

> [M]edical judgment may be exercised in light of all factors—physical, emotional, psychological, familial, and the women's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.[97]

The *Roe v. Wade* and *Doe v. Bolton* holdings were criticized by members of the Court. Justice White, joined by Justice Rehnquist, dissented, stating the Court was wrong to place the woman's subjective decision above the right to legislate in the area.[98] Justice Rehnquist also dissented separately, objecting both to legislation by the judiciary and to the compelling state interest standard that state legislation on abortion would thereafter have to meet.[99] Justice Stewart, concurring with the majority, observed that the standard to apply was the protection of liberty under the Fourteenth Amendment.[100] No one, Justice White perhaps excepted, saw a danger to women. The substantial exclusion of the patient from the abortion deci-

95 *Id.* at 153, 93 S. Ct. at 727.
96 *Id.* at 143, 93 S. Ct. at 722.
97 *Doe*, 410 U.S. at 192, 93 S. Ct. at 747.
98 *Id.* at 221-23, 93 S. Ct. at 762-63 (White, J., dissenting).
99 *Roe*, 410 U.S. at 171-77, 93 S. Ct. at 736-39 (Rehnquist, J., dissenting).
100 *Id.* at 167-71, 93 S. Ct. at 733-36 (Stewart, J., concurring).

sion process in *Roe v. Wade* and *Doe v. Bolton* soon, however, was attacked as paternalistic from a pro-abortion rights perspective, which paralleled the criticism leveled at the professional rule.[101]

Working without precisely articulated informed consent standards, several states and at least one state government subdivision, the City of Akron, Ohio, sought to require that physicians or abortion providers present detailed information to women for their consideration in reaching a decision on whether to have an abortion. Beginning with *Planned Parenthood of Central Missouri v. Danforth*,[102] and followed by *City of Akron v. Akron Center for Reproductive Health*,[103] *Thornburg v. American College of Obstetrics and Gynecologists*[104] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[105] majorities or pluralities on the Court attempted to describe and define informed consent in the abortion situation. In each of these cases, the Court analyzed criminal statutes or ordinances or medical licensing regulations which required that specified information be provided to potential abortion patients. It is an interesting comment on American justice that these cases were brought without the participation of the potential patients. Prior to *Casey*, it was assumed that the patient's position in abortion cases was articulated by the abortion provider and that opposition to the woman's right to an abortion, which was seen as a remnant of an obsolete morality, was represented by the states. Court challenges proceeded, almost oddly, with these participants assuming the roles that had been established for them in *Roe v. Wade*. This became critically important because due process rights, which the Court used to establish and maintain lawful abortion, limit governmental power and do not normally limit private action.[106] As states sought to expand their rights to require informed consent protection for women considering abortions, they were attacked on the grounds that their legislated protections were nothing more than *sub rosa* reassertions of state anti-abortion positions outlawed in *Roe v. Wade*. Had women been true parties (and not simply nominal parties) to actions seeking the recognition of informed consent rights in the abortion context, these counterarguments could not have been easily assertable.

In 1976, in *Planned Parenthood of Central Missouri v. Danforth*,[107] the Court upheld the constitutionality of a Missouri statute[108] which provided that a woman seeking an abortion during the first twelve weeks of preg-

101 *See* Asaro, *supra* note 27. Asaro does not argue that the Court's desire to protect women from graphic reality may have been on founded on pro-abortion views rather than paternalistic notions. She is, however, unflinching in her observations that Justice Blackmun's position disparages the rights of women. "Unfortunately, . . . Blackmun subsumed the woman's right to privacy within the ambit of the doctor-patient relationship, and ultimately subordinated her interest to the physicians." *Id.* at 53. "The physician emerges as independent and omniscient, championing his right to practice medicine." *Id.* at 61.

102 428 U.S. 52, 96 S. Ct. 2831 (1976).

103 462 U.S. 416, 103 S. Ct. 2481 (1983).

104 476 U.S. 747, 106 S. Ct. 2169 (1986).

105 505 U.S. 833, 112 S. Ct. 2791 (1992).

106 *See* Gilmore v. Montgomery, 417 U.S. 556, 94 S. Ct. 2416 (1974); District of Columbia v. Carter, 409 U.S. 418, 93 S. Ct. 602 (1973), *reh'g denied*, 410 U.S. 959, 93 S. Ct. 1410 (1973) (mem.).

107 428 U.S. 52, 96 S. Ct. 2831 (1976).

108 MO. ANN. STAT. §§ 188.010, 188.015(2), 188.020(2)-(4), 188.035, 188.040, 188.050, 188.060.

nancy must, before the abortion, certify in writing that she consented to an abortion and "that her consent is informed and fully given and not the result of coercion."[109] The statute was challenged on the grounds that it violated the constitutional guarantees established by *Roe v. Wade*, and that it was burdensome, vague, and overbroad.[110] Appearing to recognize the value of the right to informed consent in an abortion decision, Justice Blackmun, writing for the Court, stated:

> the decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. 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 written prior consent.[111]

The vagueness challenge focused on the meaning of the terms "informed" or "informed consent." The Court stated in a footnote that the terms meant "the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession."[112] The Court, while stating that it recognized the woman's right to make a decision upon her informed knowledge of risks and alternatives, thus relied on logic consistent with an abbreviated application of the professional rule rather than the patient's rule in setting out standards for states to follow in abortion informed consent procedures.[113] Again the protection of the physician was paramount and, while the opinion stated that it was upholding the statute, the powers it conveyed to the physician wrecked the stated purpose of the statute, which was to protect the right of the woman to be in charge of the abortion decision.

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109 *Danforth*, 428 U.S. at 65, 96 S. Ct. at 2839.

110 *Id.* at 66, 96 S. Ct. at 2839.

111 *Id.* at 67, 96 S. Ct. at 2840.

112 *Id.* at 67 n.8, 96 S. Ct. at 2840 n.8. From a professional rule perspective, sole reliance on the physician's discretion or judgment, as set out by Justice Blackmun, is unworkable to effect informed consent since the physician is required to disclose to the patient those risks which other physicians would reasonably disclose. *See supra* text accompanying note 33. Under the patient's rule, as expressed in *Canterbury*, the physician has to state all relevant risks and alternatives unless there is a medical reason not to do so, an exception which the *Canterbury* court carefully limited. *See supra* text accompanying note 48. If it is arguable, and I think it is not, that Justice Blackmun's abortion-consent rationale is an adoption of the *Canterbury* medical-reason exception, then the Court imposed that exception not because of particular patient needs, but because of the peculiar nature of the enterprise.

The Court's view, which made life choice a medical matter, carried a somber, albeit unwitting, echo of the Eichmann trial. In Chapter Five of *Eichmann in Jerusalem*, Hannah Arendt described the arguments of defendant's counsel, Robert Servatius, on the destruction of European Jews, that killing was a medical matter. She also observed the shocked initial disbelief of the presiding justice that in fact he had heard that argument. HANNAH ARENDT, EICHMANN IN JERUSALEM 69 (Penguin Books 1963).

113 Asaro argues that women's exclusion from the decision process is traced to the fact that most physicians are male. Asaro, *supra* note 27, at 51. But we should ask whether the patient exclusion would be any more justifiable if most physicians were female.

In 1983, in *City of Akron v. Akron Center for Reproductive Health*,[114] Justice Powell, writing for the Court, struck down as violative of the Fourteenth Amendment privacy interests expressed in *Roe v. Wade* a municipal ordinance[115] which set precise standards for physicians in providing information to prospective abortion patients.[116] The stated purpose of the ordinance was to prohibit an abortion unless the pregnant woman had "freely and without coercion" given "informed written consent."[117] To this end, the attending physician was required to tell the woman "of the status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information with respect to birth control, adoption, and childbirth."[118] The attending physician likewise was obligated to inform the patient of "particular risks associated with her own pregnancy," the method of abortion, and other relevant information that the physician determined would assist the patient in making her decision on whether to have an abortion.[119]

The Court stated that *Danforth*'s informed consent language was still valid,[120] and held that a state may not define life differently than it was defined in *Roe v. Wade*.[121] The Court stated that no restriction could be placed on a woman's decision "in consultation with her physician" to have an abortion in the first trimester.[122] Further, the Court found that the ordinance's informed consent language was not intended to inform a woman about her choice, but rather had the purpose of dissuading her from proceeding with an abortion.[123] Abortion was reaffirmed as a "fundamental right."[124]

The Akron ordinance imposed a twenty-four hour waiting period after giving written consent before an abortion could be performed so that a woman would have time for "careful consideration" before proceeding.[125] This provision was declared invalid on the grounds that the waiting period was "arbitrary and inflexible," and furthered no legitimate state interest.[126] The Court again stated the importance of giving "the physician adequate discretion in the exercise of his medical judgment."[127] The Court declared:

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114 462 U.S. 416, 103 S. Ct. 2481 (1983).

115 AKRON, OHIO, CODIFIED ORDINANCES, §§ 1870.03, 1870.05, 1807.06, 1807.07, 1807.16 (1978).

116 *Akron*, 462 U.S. at 442-52, 103 S. Ct. 2499-504.

117 *Id.* at 442, 103 S. Ct. at 2499.

118 *Id.* at 416, 103 S. Ct. at 2485.

119 *Id.* at 423, 103 S. Ct. at 2488.

120 *Id.* at 442-43, 103 S. Ct. at 2499-500.

121 *Id.* at 444-45, 103 S. Ct. at 2500.

122 *Id.* at 429-31, 103 S. Ct. at 2492-93.

123 *Id.* at 444, 103 S. Ct. at 2500.

124 *Id.* at 427, 103 S. Ct. at 2491.

125 *Id.* at 449-50, 103 S. Ct. at 2503. Many opinions on state-legislated waiting periods have been written, but because of the *Casey* holdings, discussed *infra* notes 184-205 and accompanying text, they do not form a part of this Article.

126 *Akron*, 462 U.S. at 450, 103 S. Ct. at 2503.

127 *Id.* (quoting Colautti v. Franklin, 439 U.S. 379, 387, 99 S. Ct. 675, 681 (1979)).

> In accordance with the ethical standards of the profession, a physician will advise the patient to defer the abortion when he thinks this will be beneficial to her. But if a woman, after appropriate counseling, is prepared to give her written informed consent and proceed with the abortion, a State may not demand that she delay the effectuation of that decision.[128]

The Court separately held that the requirement that the physician personally advise the patient was constitutionally invalid, and that the duty to inform the woman of risks could be delegated to nonphysician counselors.[129] The *Roe v. Wade* view, which did not perceive abortion as potentially psychologically damaging to women,[130] became even more intense as the Court characterized the ordinance's description of abortion as "a major surgical procedure" as a "dubious statement,"[131] and accepted the district court's finding that "an abortion generally is considered a 'minor surgical procedure.'"[132] Advice on medical consequences was termed a "parade of horribles."[133] Included in that parade was language from the ordinance stating "that abortion may leave essentially unaffected or may worsen any existing psychological problem she may have and can result in severe emotional disturbances."[134]

When *Akron* was decided, Ohio had not yet adopted the patient's rule. The Court chose not to use state law to ascertain the patient's rights, presumably ignoring the information that the state would normally require to be given in any other medical procedure.[135] The Court also did not adopt the view of the *Akron* district court that the protection of the woman, not the physician, was the proper focus of constitutional inquiry.[136] The Court's embrace of the concept that the physician is in charge of information to be given the prospective abortion patient was limited only by the minimal requirements of *Danforth*.[137] Informed consent in the criminal

128 *Id.* at 450-51, 103 S. Ct. at 2503.
129 *Id.* at 448-49, 103 S. Ct. at 2502.
130 See *supra* text accompanying notes 94-97.
131 *Akron*, 462 U.S. at 444, 103 S. Ct. at 2500.
132 *Id.* at 444 n.35, 103 S. Ct. at 2500 n.35.
133 *Id.* at 445, 103 S. Ct. at 2500.
134 *Id.* at 445 n.36, 103 S. Ct. at 2500 n.36.
135 Ohio adopted the patient's rule two years after *Akron* in Nickell v. Gonzalez, 477 N.E.2d 1145 (Ohio 1985). If the *Akron* decision had been founded on state law, the professional rule would have required at least a basic disclosure of risks to the patient. *See supra* note 112. Subsequent adoption of the patient's rule would have required reasonably complete disclosure of consequences, risks, and options to almost all potential abortion patients.

The *Akron* Court noted that abortion has "implications far broader than those associated with most other kinds of medical treatment" and states therefore have an interest in assuring that the patient's informed consent is secured. *Akron*, 462 U.S. at 443, 103 S. Ct. at 2499 (quoting Bellotti v. Baird, 443 U.S. 622, 649, 99 S. Ct. 3035, 3051 (1979)). The states' interest, however, does not extend to requiring that specific information be presented to the patient before the abortion decision. Logical analysis, if women considering abortion are to have informed consent rights, would compel the reverse conclusion.

136 Akron Ctr. for Reprod. Health v. City of Akron, 479 F. Supp. 1172, 1203 (N.D. Ohio 1979).
137 City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 429-30, 103 S. Ct. 2481, 2492-93 (1983). Speckhard noted that 92 percent of the 30 subjects in her study of women who had sustained significant stress after abortion found the informed consent procedure used by their clinic "inadequate." Dagg, *supra* note 1 (citing SPECKHARD, *supra* note 24). These "procedures" show that the clinics virtually abandon informed consent measures other than to obtain the pa-

law abortion context consequently fell in a range somewhere between euphemism and nullity. Although insulating abortion providers from criminal prosecution, the Court nonetheless recognized the abortion providers' responsibility to properly inform their patients on relevant factors. Inferentially, this would have allowed informed consent civil suits against them by patients who were ill-informed on abortion risks and subsequently developed adverse emotional or psychological conditions causally related to the abortion.[138]

Justice O'Connor, joined by Justices White and Rehnquist, argued in dissent that states should have the right to regulate abortion unless state restrictions became an undue burden on the right to have an abortion.[139] The dissent maintained that the trimester system, made obsolete by medical advances, was a poor way of allowing the states' interests to be "accommodated" with the woman's right. Further, the dissent argued that, under the undue burden standard, the state should be allowed to assert its interest in fetal life at all times including the first trimester.[140] Since Akron's informed consent provisions did not impose a drastic burden on abortion rights, the dissent argued that the statute should not be invalidated.[141] This, of course, advanced a lesser protection of the abortion right guarantee than did the fundamental rights test previously adopted.

The concept that the Fourteenth Amendment forbids a state from requiring that a physician give a patient full information about an abortion, however, was again upheld in *Thornburgh v. American College of Obstetrics & Gynecologists*[142] in 1989. In *Thornburgh*, the Court struck down a Pennsylvania statute[143] which required the physician to inform the woman of "detrimental physical and psychological effects" of abortion, reasoning that the statute's effect would be to "increase the patient's anxiety, and intrude upon the physician's exercise of proper professional judgment."[144] License revocation, not criminal penalty, was imposed on physicians who violated the statute.[145] Criminal penalties were, however, imposed on any other persons required to give information.[146] Justice Blackmun, writing for the Court, reasserted the validity of the *Danforth* and *Akron* holdings and

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tient's signature on the form. The clinics often required the signature when the patient checked in without "explanations" or "time to read the printed form." Speckhard, *supra* note 24, at 70-71. This 1984 study arguably shows a perceived immunity from common informed-consent requirements. Incident to described clinic practices, punitive damages claims are not in the scope of this Article.

138 It is exceedingly doubtful that the Court was hinting at the possibility of a civil suit, given the emphasis on protection of the abortion provider. Nonetheless, the existence of the civil remedy inheres in the opinion, giving women standing to assert what states could not.

139 *Akron*, 462 U.S. at 452-53, 461-66, 103 S. Ct. at 2504 (O'Connor, J., dissenting).

140 *Id.* at 452-61, 103 S. Ct. 2504-09.

141 If adopted, this position would also have made early (including first trimester) counseling subject to state regulation. Requirements which did not create an "undue burden" on the right to have an abortion would thus be permitted.

142 476 U.S. 747, 106 S. Ct. 2169 (1986).

143 PA. CONST. STAT. §§ 3205 (informed consent), 3208 (printed information), 3210(b)-(c) (postviability abortions), 3211(a) (reporting requirements), 3214(a) & (h) (reporting requirements) (1982).

144 *Thornburg*, 476 U.S. at 764, 106 S. Ct. at 2180-81.

145 *Id.* at 759-60, 106 S. Ct. at 2178.

146 *Id.*

focused on a comparison of the abortion consent statute with other requirements of Pennsylvania's medical practice. He did not discuss informed consent comprehensively, but prevented its applicability by state action to abortion. Remarkably, Justice Blackmun argued that since Pennsylvania did not require a disclosure "of every possible peril of necessary surgery or of simple vaccination," that the statute had an anti-abortion character and thus a defective purpose.[147] Citing no authority, he observed that "compelled information is the antithesis of informed consent."[148]

The Pennsylvania statute also required abortion providers to permit patients to examine state-furnished materials which described the fetus and alternatives to abortion. Justice Blackmun found that portion of the statute "an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of informed consent dialogue between the woman and physician."[149] Finding that women should be protected against information, he found the required fetal development information to be "plainly overinclusive" which "may serve only to confuse and punish her and to heighten her anxiety, contrary to accepted medical practice."[150]

The Court was again far from unanimous, and a woman's supposed right to informed consent was finally taken up in the dissents. Chief Justice Burger professed amazement that Pennsylvania's informed consent provisions were not constitutional, stating:

> Can anyone doubt that doctors routinely give similar information concerning risks in countless procedures having far less impact on life and health, both physical and emotional than an abortion, and risk a malpractice lawsuit if they fail to do so?[151]

He then asked whether the Court had ruled "that the constitution *forbids* the communication of such critical information to a woman?"[152]

Justice White, joined by Justice Rehnquist, attacked the concept that abortion should be treated as a fundamental right.[153] This was partially based on the scientific observation that a fetus has the same type of genetic information as any other member of the human species. No easy line distinguished a fetus from a child or an adult.[154] A free society, Justice White argued, "does not presuppose any particular rule or set of rules with re-

147 *Id.* at 764, 106 S. Ct. at 2180-81. As in *Akron*, no discernable attempt was made to determine if, under state law, a woman would be entitled beforehand to reasonably full information on risks of necessary surgery. The Court's comparison of abortion information requirements to information required for a simple vaccination is a reduction to the absurd argument at gross variance with the Court's pronouncements in *Akron* and Bellotti v. Baird, 443 U.S. 622, 99 S. Ct. 3035 (1979), that abortion has broad and serious implications. The reference to "every possible peril" describes an informed consent standard which is nonexistent. As noted in *Canterbury*, all risks cannot be discussed. *See supra* text accompanying notes 36-52, especially note 44. Correct analysis normally would allow for latitude with this language. Its context, however, demonstrates that it is intended to be read nearly literally—if not literally.

148 *Thornburgh*, 476 U.S. at 764, 106 U.S. at 2180-81.

149 *Id.* at 762, 106 S. Ct. at 2179.

150 *Id.* None of the opinions attacked the truthfulness of the information required to be made available.

151 *Id.* at 783, 106 S. Ct. at 2190 (Burger, C.J., dissenting).

152 *Id.* at 783, 106 S. Ct. at 2190-91.

153 *Id.* at 785-98, 106 S. Ct. at 2192-98 (White, J., dissenting).

154 *Id.* at 792, 106 S. Ct. at 2195.

spect to abortion."[155] Inferentially, this was to be left to legislation.[156] On informed consent, Justice White cited *Canterbury*[157] and argued that a woman's freedom of choice should be preserved. The Pennsylvania statute, he concluded, did in fact promote choice and therefore was distinguishable from the informed consent provisions in *Akron*, which he viewed as state propaganda.[158]

Separately dissenting, and also joined by Justice Rehnquist, Justice O'Connor re-emphasized her dissent in *Akron* that state abortion statutes should be upheld if they promote, and are rationally related to, the states' basic interests in protecting maternal health or human life. Only if the statute imposed an undue burden on the abortion right would it then be subject to strict scrutiny, implying, of course, a consequent finding of unconstitutionality.[159] Applying the undue burden formulation, which she argued inhered in the abortion jurisprudence of the Court, Justice O'Connor stated that the Pennsylvania informed consent statute was valid. It did not contain the "parade of horribles" of *Akron* and risk information was required only when it was "medically accurate" to furnish it.[160] Since the physician also had to inform the patient of the risks of proceeding to 'term,' Justice O'Connor concluded, noting Justice White's argument on informed consent, that the information required by Pennsylvania was balanced.[161]

The majorities and pluralities of the Court, we may conclude, while using the language of informed consent from *Roe v. Wade* through *Thornburgh*, perceived abortion primarily politically. Consequently, truthful medical information to be given a woman considering an abortion was seen as an interference with her right, an intrusion into her privacy, and not valuable to help her reach a knowledgeable decision. By accepting the arguments of the abortion providers, the Court failed to provide for informed consent rights asserted not only in *Canterbury* and in *Cobbs v. Grant*,[162] but also carefully allowed for under the professional rule as shown by *Natanson v. Kline*.[163]

That terrible psychological health consequences could come from the abortion decision did not take hold on the Court. With this background it was logical that informed consent actions would not be brought. *Ferrara v. Bernstein*,[164] which allowed the patient damages for a negligently incomplete abortion, may not be viewed as an informed consent case.[165] *Martinez*

155 *Id.* at 793, 106 S. Ct. at 2196.

156 *Id.* at 794 n.3, 106 S. Ct. at 2196 n.3. The argument is succinct and ought to be read rather than further summarized.

157 *Id.* at 799, 106 S. Ct. at 2199 (citing Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972)).

158 *Id.* at 800, 106 S. Ct. at 2199.

159 *Id.* at 828-31, 106 S. Ct. at 2213-15 (O'Connor, J., dissenting).

160 *Id.* at 830, 106 S. Ct. at 2215. The statutory term "medically accurate" surely was an attempt to cure the *Akron* ordinance requirement that medical information which was irrelevant or incorrect as applied to a particular case still had to be conveyed to the patient.

161 *Id.*

162 502 P.2d 1 (Cal. 1972); *see supra* text accompanying notes 56-58.

163 350 P.2d 1093 (Kan. 1960); *see supra* text accompanying notes 32-34.

164 582 N.Y.S.2d 673 (1992).

165 *Ferrara* is useful, however, for its ruling that injuries caused by abortion providers which fall outside the scope of patient's executed release instrument are actionable. This ruling would

v. Long Island Jewish Hillside Medical Center[166] established that the patient could recover when her decision to have an abortion is based in part on objectively incorrect information on fetal development given to her by the provider. *Martinez*, like *Ferrara*, is essentially a malpractice case and not a traditional informed consent action in which significant risks and alternatives are not adequately disclosed to the patient.[167]

In 1989, with *Webster v. Reproductive Health Services*,[168] a plurality of the Court, not including Justice Blackmun, changed the Court's position that abortion was a fundamental right, holding that the right was a liberty interest protected by the Due Process Clause of the Constitution.[169] Although not dealing with informed consent, the Court's opinion was relevant to that topic. At issue was the constitutionality of a Missouri statute[170] which required a physician to perform a test to determine the viability of the fetus before undertaking an abortion.[171] The statute required this determination to be made irrespective of the trimester of pregnancy. If the fetus was viable, the statute prohibited abortion, unless the woman's life or health was in danger.[172] The Court ruled that the statute was constitutional under the liberty interest test in that it furthered the state's interest in "protecting potential human life throughout pregnancy."[173] Citing the *Thornburgh* dissents, the Court based its opinion on the right of the state, within the context of abortion rights, to protect the fetus throughout the pregnancy, both before and after viability, and abandoned the *Roe v. Wade* trimester analysis as being too rigid.[174]

The language of the opinions revealed a blunt and harsh debate with Justice Blackmun, joined by Justices Brennan and Marshall, charging that the change in standards had eroded protections of women's abortion rights.[175] He foresaw even more restrictive state regulation of abortion and accused the plurality of deception in stating that *Roe v. Wade* was valid

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therefore normally require that the abortion provider make the most careful, understandable warnings on emotional or psychological harm to a patient considering abortion in order to protect the provider from the claim in a legal action that a release stating or referencing those warnings is defective. *See supra* note 66. For a discussion of the impact of patient waivers of warnings, see *infra* text accompanying notes 207-08.

166 512 N.E.2d 538 (N.Y. 1987). In Hughson v. St. Francis Hosp., 459 N.Y.S.2d 814 (1983), the court held that a child had a valid cause of action against a physician for injuries sustained when the physician failed to obtain the mother's consent before trying to abort. Unfortunately, the record in this case presents virtually nothing on the type of injury or why the consent was invalid.

167 A case can be made, however, that the Court's emphasis on the plaintiff's religious propensity in deciding that she was entitled to damages created an informed consent case and that the damages issues format is subterfuge. Another case can be made that the holding is simply the product of a Court nibbling at the edge of controversy.

168 492 U.S. 490, 109 S. Ct. 3040 (1989).

169 *Id.* at 520, 109 S. Ct. at 3058.

170 MO. REV. STAT. §§ 1205.1(1)-(2), 1205.2, 188.029, 188.205, 188.210, 188.215 (1986).

171 *Webster*, 492 U.S. at 513-21, 109 S. Ct. at 3054-58.

172 *Id.* at 513, 109 S. Ct. at 3054 (quoting MO. REV. STAT. § 188.029 regarding viability testing); *id.* at 519, 109 S. Ct. at 3057 (quoting MO. REV. STAT. § 188.030 regarding the prohibition of abortions after viability unless required for the woman's life or health).

173 *Id.* at 519, 109 S. Ct. at 3057. The Chief Justice was joined in this section (II-D) only by Justices White and Kennedy. Justices Scalia and O'Connor each concurred separately.

174 *Id.* at 518-19, 109 S. Ct. at 3056-57.

175 *Id.* at 537-60, 109 S. Ct. at 3067-79 (Blackmun, J., concurring in part and dissenting in part).

when, he claimed, it had been abandoned.[176] The dissent stated that under *Roe v. Wade*'s trimester analysis, viability testing affecting second trimester abortions was impermissible and argued that the trimester system was essential to *Roe v. Wade* protections.[177]

Justice O'Connor, concurring, argued that in *Thornburgh* all members of the Court had agreed that states could protect potential life where viability is possible, and that the plurality opinion was therefore consistent with the fundamental guarantee of abortion in *Roe v. Wade*.[178] She renewed her *Akron-Thornbourgh* criticisms of the trimester system but nonetheless declined to review *Roe v. Wade*.[179] This position was methodically attacked by Justice Scalia, concurring, who observed that Justice Blackmun was correct in his conclusion that *Roe v. Wade* had been overruled.[180] He argued that either *Roe v. Wade* must serve as the foundation for abortion case analysis, or that another standard must. By ruling too narrowly on the constitutionality of the Missouri statute, Justice Scalia stated, the Court had failed to provide an adequate standard to apply in future decisions.[181] Justice O'Connor's opinions, however, beginning with her articulation of the undue burden test in *Akron* and her criticism of the trimester system, show that her primary goal was to achieve a "balanced" approach (explicitly stated in *Thornburgh*) in which the patient participated in an informed manner with the physician throughout to choose between abortion or childbirth.[182] In this process, as stated in *Webster*, a state's interest in protecting potential life would be substantially heightened at viability.[183] The balanced approach would also, of course, represent a consensus or balance of the divergent views on the Court.

In 1992, an intricately constructed plurality in *Planned Parenthood of Southeastern Pennsylvania v. Casey*[184] established Justice O'Connor's view of the law as the law, ruling that a Pennsylvania informed consent statute was constitutional.[185] The statute required that the physician inform a woman seeking an abortion at least twenty-four hours in advance of the procedure about the health risks of abortion and childbirth.[186] It further required the physician to inform the patient of the "probable gestational age of the un-

176 *Id.* at 538-39, 109 S. Ct. at 3067.

177 *Id.* at 541-46, 109 S. Ct. at 3069-72.

178 *Id.* at 522-31, 109 S. Ct. at 3059-64 (O'Connor, J., concurring in part and concurring in the judgment).

179 *Id.* at 525-27, 109 S. Ct. at 3060-61.

180 *Id.* at 532-37, 109 S. Ct. at 3064-67 (Scalia, J., concurring in part and concurring in the judgment).

181 *Id.* at 532-33, 109 S. Ct. at 3064.

182 *See supra* text accompanying notes 139-41 and 159-61.

183 *Webster*, 492 U.S. at 531, 109 S. Ct. at 3063-64 (O'Connor, J., concurring in part and concurring in the judgment). At the heart of the *Webster* revolt against Justice Blackmun's position was his over-reaching (within the pale of abortion rights) in *Thornburgh*. His opinion went beyond an analysis of the statute in question to accomplish a form of pre-emption, as it were, of informed consent law, barring informed consent in abortion. *See supra* text accompanying notes 142-50.

184 505 U.S. 833, 112 S. Ct. 2791 (1992) (plurality opinion). The plurality, of course, was formed by Justices O'Connor, Souter, and Kennedy.

185 *Id.* at 881-87, 112 S. Ct. at 2822-26.

186 *Id.* at 881, 112 S. Ct. at 2822. The statute, 18 PA. CONS. STAT. §§ 3203-3214 (1990), is reprinted in an appendix to the opinion. *Webster*, 505 U.S. at 902-11, 112 S. Ct. at 2833-38.

born child."[187] The physician or another qualified person had to inform the woman of the availability of materials published by the state. The materials described the fetus, provided information concerning medical assistance for childbirth, and listed resources that would be available if the woman chose to give birth to the child.[188] In order to obtain an abortion, the patient had to state in writing that she knew of these materials and that, if she wanted to view them, that they had been presented to her.[189] The Court stated:

> 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. If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.[190]

Casey thus ended the concept in the Court's jurisprudence that abortion was a minor procedure and, if any doubt lingered after *Webster*, repealed the trimester approach as flawed.[191] In reaching its decision, the Court did

187 *Webster*, 505 U.S. at 881, 112 S. Ct. at 2822 (plurality opinion).
188 *Id.*
189 *Id.*
190 *Id.* at 882, 112 S. Ct. at 2823.
191 *Id.* at 872-73, 112 S. Ct. at 2817-18. The Court found the trimester system "flawed" because it did not place enough value on the state's interest in "potential life," and because it did not recognize that the pregnant woman's interest in good counseling existed during all stages of pregnancy, not simply in the latter stage.

The importance of knowledgeable counseling may be illustrated by a hypothetical situation. Suppose a healthy professional woman who puts in long stressful working hours had an abortion after being counseled at a clinic about her fears that her demanding work hours might result in a damaged baby. After her abortion, to which she was encouraged by clinic representatives, she developed post-abortion trauma, which resulted in substantial economic loss. The clinic may be liable to her if it did not inform her that studies show virtually no correlation between long hours of stressful work and adverse pregnancy results in women of high status who were otherwise healthy. *See* Mark A. Klebanoff et al., *Outcomes of Pregnancy in a National Sample of Resident Physicians*, 323 NEW ENG. J. MED. 1040 (1990) (The applicability of the study to a particular situation, of course, would require expert medical evidence.)

Much more common is the idea that abortion should prevent unwanted children. Even if a patient identifies a child to be born as unwanted, studies have shown that about one-third of the mothers who gave birth to and kept these children had similar feelings about the children in interviews conducted a year later. *See* Nancy F. Russo, *Psychological Aspects of Unwanted Pregnancy and its Resolution*, *in* ABORTION, MEDICINE, AND THE LAW 593-94 (J. Douglas Butler & David F. Walbert eds., 4th ed. 1992) (citing studies). About the same portion of negative feelings about the children were noted at interviews conducted two years later. *Id.*

Problems with unwantedness, however, were correlated to external factors such as poverty, immaturity, educational disadvantage, and marital conflict. *Id.* at 595. These conditions, of course, are subject to improvement with assistance from public and private sources. I draw from this that the unwanted child is not so deemed because of the qualities of the child but because of the external circumstances in which the patient finds herself. Careful pre-abortion counseling on unwantedness would therefore explore areas of help in changing the unwanted external conditions, and prevent the patient from sustaining the loss of her child and consequent post-abortion psychological trauma.

Russo, it should be noted, devalues the concept of a post-abortion syndrome, *id.* at 617-19, but does so in part because "women are at higher risk for depression than men" and "are more likely to ruminate about things that bother them than to take instrumental action." *Id.* at 618.

If psychological reasons are employed as a basis for the decision to abort, then under one study psychological or psychiatric treatment, not abortion, could well produce good results for

not apply the *Webster* liberty interest test but used the undue burden test based on the "liberty interest" in the Fourteenth Amendment's Due Process Clause to determine whether state legislation limiting abortion rights was constitutional.[192] Following an elaborate defense of the *Roe v. Wade* abortion right, the Court observed that a woman has a right in the expression of her liberty interest to choose to terminate or to continue her pregnancy. The state, however, may assert its interests in "fetal life" if they do not become an "undue burden" on the liberty interest.[193] A state, therefore, can take steps to insure that the woman's choice is "thoughtful and informed."[194] The Court wrote:

> What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so. Regulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose.[195]

The physician did not have to comply with "the informed consent provisions 'if he or she can demonstrate by a preponderance of the evidence that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient.'"[196] On informed consent, the Court concluded: "Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure."[197] Without question, the Court found no undue burden on the abortion right which required further analysis under a heightened scrutiny standard. The Court then expressly overruled the informed consent provisions in *Akron* and *Thornburgh*.[198]

The Chief Justice and Justices White, Scalia, and Thomas concurred on the informed consent conclusions[199] but argued that, although abortion is a liberty interest protected by the Due Process Clause, the rational relationship test and not the undue burden-heightened scrutiny test

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the mother. Myre Sim & Robert Nessler, *Post-Abortive Psychoses: A Report From Two Centers*, *in* THE PSYCHOLOGICAL ASPECTS OF ABORTION (David Mall & Walter F. Watts eds., 1979). This study indicates that continuing counseling throughout pregnancy should be offered the prospective abortion patient needing psychological treatment to allow that patient to have her child.

192 *Casey*, 505 U.S. at 844-79, 112 S. Ct. at 2803-20.

193 *Id.* at 857-61, 112 S. Ct. at 2810-12. The undue burden analysis, it should be obvious, is meant to occupy an area between the strict scrutiny and rational relationship tests. The test allows the Court to find or tailor solutions to abortion rights disputes without twisting either the rational relationship or strict scrutiny standards. Deeper understandings of undue burden are set out in two recent articles: Alan Brownstein, *How Rights are Infringed: The Role of Undue Burden Analysis in Constitutional Doctrine*, 45 HASTINGS L.J. 867 (1994); Robin L. West, *The Nature of the Right to an Abortion: A Commentary on Professor Brownstein's Analysis of* Casey, 45 HASTINGS L.J. 961 (1994).

194 *Casey*, 505 U.S. at 872, 112 S. Ct. at 2818.

195 *Id.* at 877, 112 S. Ct. at 2821.

196 *Id.* at 883-84, 112 S. Ct. at 2824 (quoting 18 PA. CONS. STAT. § 3205 (1990)).

197 *Id.* at 884, 112 S. Ct. at 2824.

198 *Id.* at 883-85, 112 S. Ct. at 2824-25.

199 *Id.* at 969, 112 S. Ct. at 2868 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

should be followed.[200] Justice Blackmun, rejoicing in the perception that the Court did not further restrict abortion rights, continued to advance the strict scrutiny approach,[201] arguing that the Pennsylvania informed consent provisions (which he thought slanted) were unconstitutional as not furthering "maternal health." Justice Blackmun cited *Thornburgh* strictures against imposing informed consent requirements on physicians as requiring his conclusion.[202]

Justice Stevens, seeing the abortion decision as a matter of conscience, argued that the state may not "inject" information into the woman's decision, thus devaluing the role that states have in protecting women's health.[203] This was an articulation of the previous majority view which saw this information as an impediment to political rights and not as fundamental or helpful to women's medical care. He stated that fetuses are not persons, comparing their situation to that of Haitians at sea trying to become "persons" under American law.[204]

The plurality's formulation of the law allowed patients' rights to be considered throughout the process. Making objective information on fetal development available, and allowing for waiting periods to consider that information, were permissible, and even desirable, to help a patient decide on a course of action. The patient's decision on whether to have the abortion, and indeed on whether her fetus was human, was to be subjective and unreviewable. In short, the Court placed women's rights as patients paramount to the interests of those who would protect women from accurate information.[205]

IV. The Action Emerges

It is inescapable that one great consequence of *Casey* is that women considering abortions undeniably now have the same rights constitutionally to informed consent on abortion risks and alternatives that patients have for other procedures in their respective jurisdictions. These rights do not depend on the implementation of a statute similar to Pennsylvania's. The Court in *Casey* approved informed consent rights in abortion by eliminating or limiting, as a matter of constitutional law, restrictions on those rights established in *Roe v. Wade* and upheld through *Thornburgh*. The anal-

200 *Id.* at 966, 112 S. Ct. at 2867.

201 *Id.* at 922-23, 112 S. Ct. at 2844 (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part). Comparing *Webster* with *Casey*, Justice Blackmun was excited to write, "But now, just when so many expected the darkness to fall, the flame has grown bright." *Id.* at 922, 112 S. Ct. at 2844.

202 *Id.* at 929-32, 112 S. Ct. at 2847-49.

203 *Id.* at 914-18, 112 S. Ct. at 2839-41 (Stevens, J., concurring in part and dissenting in part).

204 *Id.* at 915 n.3, 112 S. Ct. at 2840 n.3. This illustration confuses citizenship and resident alien status with personhood.

205 This protects not only women, but also tends toward protecting the interest of the fetus which presumably is to live. The legal term "fetus" is, of course, a well known term which allows the woman considering abortion—and indeed the society—to try to be emotionally distanced from the act. The term has been used in this Article because this is the term courts have used. It is, however, not commonly used even by government agencies advertising assistance or information to improve pre-born infant health. In those usages, the term "baby" is used. This indicates a general cultural perception that only those unborn babies are legally human or prehuman who are declared so by their mothers. This dovetails with the *Casey* holding.

ysis, applicable to statutory informed consent rights in Pennsylvania, likewise prevents contraction of informed consent rights arising under the patient's or professional rules. Put differently, the Supreme Court's mandated substantive law restricting informed consent, set out from *Roe v. Wade* through *Thornburgh*, is now non-existent and a jurisdiction's general law of informed consent applies in the absence of a specific statute on abortion rights.

Counseling is immediately affected. The purpose of first trimester counseling in *Roe v. Wade* was so bluntly aimed at sensitively accomplishing abortions that it was put beyond state review. With the abolition of the trimester system and the approval of the integrated approach to treatment throughout pregnancy, counseling at any stage now must be conducted by giving reasonably full information on all factors medically relevant to the patient's decision to avoid the charge under informed consent law that material information was kept from the patient.

Casey itself obviously proceeded under a view of patient rights consistent with the patient's rule. It would be incorrect, however, to argue that *Casey* requires that all patient abortion decisions be determined under that standard. Nothing in *Casey* requires that conclusion. In jurisdictions employing the professional rule, or some hybrid of the two rules, an abortion patient's rights to information will be determined under the laws of that jurisdiction applicable to all procedures. Distinctions between the two approaches, while critical to the formulation of a court action for damages caused by a violation of informed consent rights, will be insignificant in determining standards of medical practice. As will be recalled from *Natanson*, the professional rule requires that the patient be given enough information to make an informed consent. This implies that a physician's withholding of important information on the risks of potential harmful psychological and emotional consequences arising from an abortion, absent significant justifying factors, will be viewed in professional rule jurisdictions as usurping the patient's right to informed consent. Therefore, we may expect a generally uniform response in both patient and professional rule jurisdictions to the problems of how and to what extent the patient should be informed of potential emotional and psychological problems.

This requires, of course, barring an immediate peril requiring surgery, that time be taken to determine these risks for each patient and to allow her to evaluate them. A significant waiting period, therefore, is now necessary between the time a woman enters an abortion clinic and the time the abortion is performed so that the abortion provider can obtain a valid history of her health, develop her psychological profile, and interview her to assess the risks of serious psychological harm. The provider should then fully discuss the risks and applicable alternatives as they apply to the patient and ascertain her informed intent before proceeding with the abortion, if that is her decision. Given the high proportion of psychological injuries from abortions, foreseeable psychological injury normally would be thought to be present in treating a patient considering abortion, until it is ruled out in competent preprocedure screening. If in this process the patient demonstrates an increased likelihood of developing an adverse psy-

chological consequence from an abortion, then she should be carefully advised of the heightened risks to her psychological health before she decides on the procedure.[206]

A provider may rely on a referring physician or service to acquire relevant information and to do psychological testing and counseling for the prospective abortion patient. All providers and referring entities will need to make sure who in the chain of referral has the primary responsibility to inform the patient of the risks and alternatives relevant to the decision. Care will have to be taken by the provider that the referrer properly informs the woman if the referrer is to do this. Similarly, a referrer of abortion patients may have liability to the patient if it undertakes counseling and does not adequately explore risks and alternatives with the patient, or if it refers a patient to an abortion provider when it knows or should know that the provider does not properly inform patients of relevant risks or allow time for proper evaluation.

Abortion providers will likely assert that abortion patients can waive the warnings.[207] A waiver of the warning itself normally will serve, however, as a warning to the provider to explore why the receipt of information is sought to be waived. This predictably will necessitate even more careful study of that patient to make sure that the grounds for the waiver are reasonable since the physician and not the patient has the duty to make sure that the patient understands the procedure. This careful approach could, for example, be very helpful in determining whether the patient was being pressured to have an abortion.[208]

None of this involves specific state action and inevitably it will be asked whether a state may statutorily expand or contract a woman's informed consent rights in abortion procedures. The answer, based on her right to equal protection of the law, is that any limitation of a patient's right to information in the abortion decision will be almost certainly struck down, absent a compelling reason for that limitation, if she would be entitled to this information when considering another type of procedure. Expansions of her right also may be viewed with skepticism by courts, if those expansions are tailored to argue with her choice and not to inform the patient. Regulations based on validly informing the patient of risks, alternatives and relevant informed choice factors, however, absent a reactionary movement on the Court to limit women's rights, will be found constitutional. Here undue burden analysis would have to be carefully followed.[209]

206 If abortions come to be done by medication rather than surgery, and a clinic, as we understand it, is bypassed, the practitioner will no doubt have to determine risks which predictably will require referrals to those with expertise in determining psychological risk. In parental bypass decisions (not a subject of this Article), courts may wish to have informed consent counseling conducted by third parties without tort immunity in order to preserve any action a pregnant minor may acquire for improper informed consent advice. To avoid later questions, preservation of the minor's rights should be done by specific order.

207 *See supra* text accompanying note 58.

208 *See supra* note 23.

209 If a jurisdiction has pre-*Casey* statutes establishing abortion informed consent rights which are lesser in scope than those rights formulated under *Casey*, these provisions should be interpreted as conveying rights recognized in *Casey* or should be amended to explicitly provide those rights. Otherwise, pregnant women may raise equal protection challenges, claiming the provisions improperly restrict their rights to knowledge that would enable them to make an informed

In civil actions, defendants will have the same defenses as in other informed consent cases. We may expect, however, that in some jurisdictions attempts will be made to exclude all recovery for psychological damages on the grounds that there is neither an accompanying physical impact nor resulting physical injury. Courts, however, probably will allow recovery where damages were foreseeable and there is objective proof of emotional injury caused by informed consent violation since recovery would not be based on speculation or fraud. Recovery probably will be allowed, however, only where the psychological impact on the woman is substantial. Compensation based exclusively on short-term sense of loss, repression, or guilt very predictably will be disallowed. Given the ability of American courts to respond to social problems (as illustrated by the development of privacy and products liability law), however, it will be improvident to assume that the rules requiring physical injury or impact to accompany emotional injury will serve as a barrier to the redress of objectively provable damages in what is surely a national tragedy in women's health.

Abortion informed consent cases, due to the diversity of views on abortion, however, may tell us more about the triers of fact than about justice. Even so, courts should be able to develop a sufficient portrait of the plaintiff to submit the question of the adequacy of informed consent for objective determination. The ultimate factual question will be whether a reasonable person in the plaintiff's situation, with full right to have an abortion, would have undertaken it had she been informed properly of the probability of psychological harm to her. Here the factors on which the decision was based, which may be seen as subjective, would be relevant on what a reasonable person with these views would have done.

Information on fetal development will be included in counseling as part of providing reasonably full information to the patient because attach-

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decision. Similarly, if a state agency or employee refers patients for abortion and does not insist that full information on risks and alternatives be made available to the patient, numerous violations may be present. These include illegal state action to deprive her of due process and equal protection of the law. Consider also the applicability of § 1983 actions for local governmental activity depriving the patient of relevant information. *See* Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 914-18, 112 S. Ct. 2791, 2839-41 (1992) (Stevens, J., concurring in part and dissenting in part) (discussing the need to avoid state regulation of reproductive choice).

Sometimes it is difficult to see state control or exploitative action in practices which are generally accepted or acquiesced to by society. A perspective on the exploitation of women in abortion can be discovered by analogy in Karen A. Getman, Note, *Sexual Control in the Slaveholding South: The Implementation and Maintenance of a Racial Caste System*, 7 HARV. WOMEN'S L.J. 115 (1984).

A quick way to grasp the practical impact of *Casey* on abortion practice is to compare choices accorded women in the Model Women's Informed Choices Act, Renfer et al., *supra* note 27, with the rights of women set out later in *Casey*. The reader will find that the Model Act, presumably written with the idea of expanding protection, is actually less protective of the right to an informed decision.

Consider also legislation outlawing the collection of money for a surgical or pharmaceutical procedure until relevant psychological-social evaluations of the patient are completed (or correctly waived) and explained to the patient, unless serious medical factors require the procedure to be completed earlier. The proposed statute would allow the woman to consider the abortion decision without economic pressure. The dimension of the problem is implied in SPECKHARD, *supra* note 137.

ment to the fetus has been a substantial factor in post-abortion trauma.[210] If after the abortion a woman comes to believe that her fetus was in fact human, then logically an internal conflict has been created in which she suffers trauma, having come to believe that she has killed or allowed the killing of her child. Studies have focused on risk factors such as pressure, self-esteem, and maturity of character in determining the likelihood of post-abortion psychological trauma.[211] While these are surely significant, it is moral realization, by definition, that is at the heart of the traumatic reaction. Accordingly, basic and understandable facts concerning fetal development, genetic structure, infant qualities, and alternatives to abortion should be fully presented to the patient so that she will not have a cruel surprise after the abortion.[212] Given the risks of subsequent emotional injury, correctly offering this information would limit attacks that the consent given to the abortion was uninformed and therefore invalid. While offering this information may not be required in unusual cases, providing it and lucidly explaining it (unless it is validly declined) has a further advantage in that women will be treated as persons competent to handle difficult ethical problems. No doubt dissentient voices will claim this information inspires the trauma and requires providers to disclose a new parade of horribles. They will seek accordingly to have the courts restrict the scope of information which must be offered.[213] This is an argument for the second-class status of women, indeed, for their fragility, and is irresponsible in the face of the vast destruction caused by post-abortion psychological trauma. Tailored but reasonably complete advice on risks may, of course, lead to fewer abortions, but those abortions will be the product of factually informed choice.[214] Statistical decline in post-abortion trauma incidence

210 *See* SPECKHARD, *supra* note 24. *Casey* stated that the Pennsylvania approach allowed counseling to proceed with "profound respect for the life of the unborn." Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 877, 112 S. Ct. 2791, 2821 (1992) (plurality opinion). This counseling process will be thought not to apply in any jurisdiction unless the informed consent law of the jurisdiction allows it. If counseling nonetheless proceeded on a contrary theory, without respect for the life of the unborn, could this have actionable consequences? Consider whether the absence of "respect" in counseling could foreseeably cause psychological trauma. Could counseling which treated the unborn child as crude and disposable tissue be itself actionable if the damages are caused later, when the reality of fetal qualities become known to the post-abortion patient? If so, consider actions for injurious statements in health care resulting in damages. *See* Oswald v. LeGrand, 453 N.W.2d 634 (Iowa 1990); *see also* Riedisser v. Nelson, 534 P.2d 1052, 1054 (Ariz. 1975) (holding that if a patient gives consent under factual mistakes on inherent risks of the proposed procedure, the consent is still valid in the absence of fraud). Would consistent and marked failure to give scientifically accurate information on unborn life and its development then give rise to actionable fraud?

211 *See supra* text accompanying notes 13-23.

212 *See* SPECKHARD, *supra* note 24 (discussing attachment to the fetus).

213 A study by Alfini indicated that patients appreciated "straightforward and perhaps even harsh" information about risks of angiography, and that this did not create greater fear in them. Ralph J. Alfini, *Informed Consent: A Study of Patient Reaction*, 216 JAMA 1325 (1971). Alfini also discusses the informed consent forms used in the study. These forms contain explicit but succinct information about risks of serious injury or death and discuss the frequency of certain risks, with some risks being described as "rare" and "more rarely." Also, the forms provide the ratios of cases with serious complications to all cases in the relevant group. *Id.* at 1329. This is the type of data from which Supreme Court members, based on virtually nondiscussable personal beliefs, sought to protect women considering abortions.

214 Wood & Durham, *supra* note 27, at 792, also address the constitutional abortion rationale. They argue that the constitutional right of privacy is not based on subjectivity but rather on rational choice. *Id.* That a rational choice approach forms the basis for the subsequent undue

may not occur, but if it does, a substantial victory in women's health will result. Even if the incidence of post-abortion trauma does not decline, at least women sustaining injury will have been carefully offered information on emotional-psychological consequences of abortion prior to the abortion relevant to each particular situation. These women will generally be unable to attribute in court the lack of informed perception of risks as the cause of their injuries. In any event, the former decrepit abortion consent rationale, based on a tolerance, if not an encouragement, of patient ignorance is ended.

burden-liberty interest analysis in *Casey*, however, cannot be maintained. The term informed choice thus must be left as permitting a subjective decision by the patient; objective rationality, expressed in the duty to offer to fully inform the patient with correct information, is imposed on the provider.