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Whose Pregnancy Is It Anyway? The Intrusion of Abortion-Related Informed Consent Laws and Compelled Medical Treatment on the Doctor-Pregnant Patient Relationship

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I. Introduction

In January 2012, the Fifth Circuit Court of Appeals upheld a Texas law requiring women seeking an abortion to have a sonogram, hear a physician's detailed explanation of it, and listen to the fetal heartbeat. In *Texas Medical Providers Performing Abortion Services v. Lakey*, the Fifth Circuit saw no reason against requiring that the woman be fully informed of her decision through the provision of this purportedly medically necessary information because "[d]enying [the woman] up to date medical information is more of an abuse to her ability to decide than providing the information."[1] The Fifth Circuit concluded that such an informed consent disclosure is "the epitome of truthful, non-misleading information."[2] Yet Texas is not alone in having such an informed consent law for abortion procedures and, in fact, its law represents a growing trend among states. As of May 2012, twenty states require abortion providers to perform ultrasounds and seven of those states require providers to offer the women an opportunity to view the images.[3] Eleven states require verbal or written counseling materials to include information on ultrasound services.[4] There are no state laws requiring informed consent disclosures to the same invasive and/or graphic degree for other medical procedures.

While the expansion of a state's ability to regulate abortion through informed consent statutes has troubling implications, the compelled medical treatment of women who continue

[1] *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 572, 579 (5th Cir. 2012).
[2] 667 F.3d at 577.
[3] Guttmacher Inst., *State Policies in Brief: Requirements for Ultrasound*, (May 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (last visited May 4, 2012). The seven states are Alabama, Arkansas, Florida, Kansas, Louisiana, Mississippi, and Texas.
[4] *Id.*

their pregnancies to term is equally troubling. These are women who refuse, for whatever reason, to undergo cesarean sections ("c-sections") or other medical interventions that would, in their health care providers' opinion, be in the interest of the fetuses. Such situations arise, for example, when women refuse to undergo c-sections or induced labor in favor of natural childbirth, refuse artificial life-sustaining treatment until the fetuses are viable, or choose to delivery vaginally at home with midwives rather than undergo c-sections at hospitals. In response, health care providers and family members seek court orders to override the decisions of these women to benefit the fetuses.

This paper explores how the law treats pregnant women as incapable of making decisions by infringing on their right to consent to or to refuse medical treatment during their pregnancies. The Supreme Court recognizes that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[5] Yet the law does not appear to recognize such a right for pregnant women; instead, it creates tension over what roles family members, health care providers, legislatures, and courts have in the women's reproductive decision-making.

Part II of this paper outlines how the Supreme Court decisions in *Planned Parenthood of Southeastern Pennsylvania v. Casey* and *Gonzales v. Carhart* chipped away at pregnant women's decision-making capabilities and opened the door for states to enact restrictive abortion-related informed consent laws.[6] *Casey* and *Carhart* broadened the constitutional standard – from "strict scrutiny" in *Roe v. Wade* to "undue burden" – for reviewing such laws so that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over

[5] *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).
[6] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Gonzales v. Carhart*, 550 U.S. 124 (2007).

abortion, even if those measures do not further a health interest."[7] Part III outlines four appellate level court decisions addressing whether pregnant women can refuse to undergo medical treatment.[8] In those instances, third-parties sought to compel the treatment of pregnant women who choose to continue their pregnancies but who exercise their right to refuse the treatment proposed by their health care providers.

Finally, Part IV argues that the law has intruded on the traditional doctor-pregnant patient relationship by transforming it into a power struggle of competing maternal-fetal-third party interests during all stages of pregnancy. In *Casey* the Supreme Court stated that "[a]bortion is a unique act. It is an act fraught with consequences for others: for the *woman* who must live with the implications of her decision; for the *persons who perform and assist* in the procedure; for the *spouse*, *family*, and *society* which must confront the knowledge that these procedures exist…."[9] Now there is room for outsiders to second-guess the decision-making capacity of pregnant women – as if to say, "is that your final answer?" – and invade the doctor-pregnant patient relationship. Specifically, many states have adopted informed consent laws that direct the conversation between doctors and their pregnant patients who seek abortions. Federal appellate court decisions in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds* and *Lakey* provide two recent examples.[10]

This paper concludes that the law is regulating pregnant women's right to consent to or refuse medical treatment beyond the traditional notions of compelling state interests in protecting

[7] 505 U.S. at 886; *Roe v. Wade*, 410 U.S. 113 (1973).
[8] *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981); *In Re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994); *In re A.C.*, 573 A.2d 1235 (D.C. 1990); *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F.Supp.2d 1247 (N.D.Fl. 1999).
[9] 505 U.S. at 852 (emphasis added).
[10] *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (en banc); *Lakey*, *supra* note 1.

life. In so doing, the law has intruded on the traditional doctor-pregnant patient relationship and transformed it into a power struggle of competing maternal-fetal-third party interests.

II. *Casey* and *Carhart*: Opening the Door to Restrictive Abortion-Related Informed Consent Laws and Closing the Door on Pregnant Women's Decision-Making Capacity

A. Background

Although the Constitution does not expressly provide any right of privacy, the Supreme Court has acknowledged that such a right emanates from the "penumbras" of the Bill of Rights and cannot be invaded "absent a showing of a compelling subordinate state interest."[11] This right extends to intimate and personal decisions such as marriage, contraception, education, and child rearing.[12] The Constitution also protects "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[13] That is, until the state demonstrates an interest in any of the four compelling interests that prevail over the individual right: preserving life, protecting the interests of third parties, preventing suicide, or maintaining the ethic integrity of the medical profession so compelling that it overrides the right of the individual.[14]

In *Roe*, the Court recognized the state's interest in protecting the life of a fetus and identified viability as the "compelling point" permitting state intervention.[15] Until that point was reached, "the attending physician, in consultation with his patient, [was] free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."[16] Twenty years later, however, that compelling point began to disappear and state informed consent laws began to prevail over the individual right. Even though it affirmed the

[11] *Griswold v. Connecticut*, 381 U.S. 479, 497-98 (1965).
[12] *See Eisenstadt v. Baird*, 405 U.S.438 (1972); *Carey v. Population Servs. Int'l, Inc.*, 431 U.S. 678 (1977).
[13] *Eisenstadt*, 405 U.S. at 453 (emphasis in original).
[14] *Superintendent of Blechertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).
[15] 410 U.S. at 113.
[16] *Id.* at 163.

central holdings of *Roe*, the Court established in *Casey* that "the State has legitimate interests from the *outset of the pregnancy* in protecting the health of the woman and the life of the fetus that may become a child."[17] With *Carhart* the compelling point disappeared in favor of the state's interest.[18]

B. *Casey* and *Carhart*

In *Casey*, the Court started to chip away at the *Roe* "compelling point" framework and strict scrutiny standard of review governing abortion regulations.[19] The State could "enact rules and regulations designed to encourage [the pregnant woman] to know that there are philosophical and social arguments of great weight" for continuing the pregnancy.[20] The pre- and post-viability distinction no longer applied. States could express their preference for life by regulating pre-viability abortions if the restrictions did not impose an "undue burden" on the women's right to access the procedure.[21] The Court ambiguously described the undue burden standard as "shorthand for the conclusion that the state regulation has the purpose or effect of placing a *substantial obstacle* in the path of a woman seeking an abortion of a nonviable fetus."[22] Requiring informed consent disclosures of state-produced materials and warnings provided states with a means to express their preference for life. So long as the disclosed information was "truthful and not misleading" then it was relevant to the patient's decision to have an abortion.[23]

In *Casey*, the Pennsylvania Abortion Control Act of 1982, 18 Pa. Cons. Stat. §§ 3203-3220, required that a pregnant woman give her informed consent prior to undergoing an abortion procedure, receive State-published materials at least 24 hours prior to the procedure, and undergo

[17] 505 U.S. at 846 (emphasis added).
[18] 550 U.S. at 135.
[19] 505 U.S. at 872-73 (stating that the trimester framework is flawed because it "misconceives the nature of the pregnant woman's interest; and in practice it undervalues the State's interest in potential life" as stated in *Roe*).
[20] *Id.*
[21] *Id.* at 878-79.
[22] *Id.* at 877 (emphasis added).
[23] *Id.* at 882.

a mandatory 24-hour waiting period.[24] The materials included the health risks of abortion and childbirth as well as the "probable gestational age of the unborn child."[25] The woman had to confirm in writing that she received this information and was made aware of printed materials "describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion."[26] The woman also had to confirm spousal notification barring any medical emergencies.[27]

Planned Parenthood challenged the Act for violating abortion providers' First Amendment rights not to provide risk information in a manner proscribed by the state.[28] The Court rejected this argument as the providers' First Amendment rights "[were] implicated but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State."[29] That reasonable licensing and regulation extended to the health and safety of a woman seeking an abortion as it did for other medical procedures.[30] Thus the Court viewed the real constitutional issue as concerning "whether the State can resolve these philosophical questions in such a definitive way that a woman lacks all choice in the matter" except for instances of rape, incest, or medical emergency.[31] The Court believed that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest."[32]

[24] *Id.* at 881.
[25] *Id.*
[26] *Id.*
[27] *Id.* The Act also imposed certain reporting requirements on abortion providers.
[28] *Id.* at 884.
[29] *Id.* (internal citation omitted).
[30] *Id.* at 878.
[31] *Id.* at 851.
[32] *Id.* at 886.

In this way *Casey* assumed that women lack the capacity to make medical treatment decisions. Gone were the days of *Roe* when health care providers could use their medical judgment, free from state regulation, to assist pregnant women.[33] Gone were the days of private conversation between doctor and pregnant patient. Abortion was now "a unique act…. fraught with consequences for others: for the *woman* who must live with the implications of her decision; for the *persons who perform and assist* in the procedure; for the *spouse, family*, and *society* which must confront the knowledge that these procedures exist…."[34] The Court now framed abortion as an act involving multiple third-parties with claims in the decision-making process. Informed consent disclosures were necessary to "reduc[e] the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."[35]

Fifteen years later, *Carhart* provided the Court with an opportunity to affirm *Casey* and prop wide open the door for states to expand their abortion-related informed consent laws. There the Court upheld the Partial-Birth Abortion Ban Act of 2000 ("PBABA") banning the intact "dilation and evacuation" technique most often used during the second trimester.[36] The Court reiterated that the government "has a significant role to play in regulating the medical profession" and that "[t]he government may use its voice and regulatory authority to show its profound respect for the life within the woman."[37] The State has a legitimate interest in ensuring that the pregnant woman understands the exact nature of the procedure.[38] PBABA did not

[33] 410 U.S. at 163.
[34] 505 U.S. at 852 (emphasis added).
[35] *Id.* at 882.
[36] 550 U.S. at 135.
[37] *Id.* at 128.
[38] *Id.* at 159.

impose an undue burden because it furthered legitimate government interests in protecting the life of a fetus and the emotional well-being of a pregnant woman.[39]

Thus the *Carhart* decision permitted states to regulate the conversation between health care providers and their pregnant patients. The Court noted acknowledged that

> [i]n a decision *fraught with emotional consequences* some doctors may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails…. Any number of patients facing imminent surgical procedures would prefer not to hear all the details, lest the usual anxiety preceding invasive medical procedures become the more intense.
>
> […]
>
> It is, however, this lack of information concerning the way in which the fetus will be killed that is of *legitimate concern to the State*….[40]

In this way the Court recognized that such regulation went beyond what health care providers were inclined – or legally required – to disclose to their patients. Other medical procedures did not require the same invasive and/or graphic degree of detail. Yet the parties outside of the doctor-patient relationship seemed to matter most because "[t]he State's interest in respect for life is advanced by the dialogue that better informs the *political and legal systems*, the *medical profession*, *expectant mothers*, and *society as a whole* of the consequences that follow from a decision to elect a late-term abortion."[41]

As Justice Ruth Bader Ginsburg pointed out in her dissent, the majority's reasoning against the necessity of a health exception contradicted its earlier reasoning in *Casey*.[42] In *Casey* proponents of the PA Act argued that the spousal notification provision was not an undue burden

[39] *Id.*
[40] *Id.* (citations omitted and emphasis added).
[41] *Id.* at 160 (emphasis added).
[42] *Id.* at 188-89 (Ginsburg, J. dissenting).

for almost 99 percent of women seeking abortions.[43] The Court rejected this argument and stated that the proper constitutional analysis should review the group affected by the statute, not the unaffected group.[44] Such an analysis revealed instances where spousal notification could lead to domestic violence. The Court reasoned that the existence of this possibility, however small in likelihood and however small the percentage of affected women, presented enough of a substantial obstacle and an undue burden to render the spousal notification provision unconstitutional.[45]

In contrast, the *Carhart* Court found that PBABA survived review because its opponents failed to show that the ban on intact D&E unduly burdened a "large fraction of relevant cases."[46] Justice Ginsburg pointed out that a "large fraction" was not the requisite determinant as established by *Casey*. Instead, the provision "'must be judged by reference to those [women] for whom it is an actual rather than an irrelevant restriction…. The very purpose of a health *exception* is to protect women in *exceptional* cases'"[47]

The *Carhart* Court also adopted a paternalistic tone when it observed that "[i]t is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learned, only after the event, what she did not know" in so far as the nature of the procedure.[48] The Court noted that the Act also protected the health of the mother given the medical uncertainty as to the health risks of the procedure.[49] Justice Ginsburg challenged this tone in her dissent when she noted that "[t]he solution the Court approves… is *not* to require doctors to inform women, accurately and adequately, of the different

[43] 505 U.S. at 894.
[44] *Id.* at 894.
[45] *Id.* at 894-95.
[46] 550 U.S. at 167-68.
[47] *Id.* at 188 (emphasis in original).
[48] *Id.* at 158.
[49] *Id.* at 161.

procedures and their attendant risks…. Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety."[50]

III. Pregnant Women Who Refuse Medical Treatment and the Powers That Compel Them

While the expansion of a state's ability to regulate abortion through informed consent statutes has troubling implications, the compelled medical treatment of women who continue their pregnancies to term is equally troubling. A competent adult generally may refuse medical treatment as "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body…."[51] This refusal can even apply in instances where treatment may prolong or save a person's life.[52] Yet the right to refuse medical treatment is not absolute for pregnant women, specifically with respect to c-sections. These situations arise, for example, when women refuse to undergo c-sections or induced labor in favor of natural childbirth, refuse artificial life-sustaining treatment until the fetuses are viable, or choose to delivery vaginally at home with midwives rather than undergo c-sections at hospitals Interestingly enough, c-sections accounted for 32.7% of all U.S. births in 2009.[53] Less than 1% of pregnant women opt for a birth outside of a hospital.[54] Most of this small minority uses a midwife birth attendant. In 2009, 20,489 of the 4.13 million U.S. births were attended by a midwife at home or a freestanding birth center.[55]

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[50] *Id.* at 184 (Ginsburg, J. dissenting).
[51] *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914); *see Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("[A] competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment…."); *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972) ("[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.").
[52] *In re Quinlan*, 355 A.2d 647, 663-65 (N.J. 1976).
[53] Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. "Method of Delivery (Cesarean and Vaginal Births), 2009," http://www.cdc.gov/nchs/vitalstats.htm. [last accessed May 5, 2012]. According to government statistics, c-sections accounted for 1,353,572 out of 4,130,665 births.
[54] Centers for Disease Control and Prevention. National Center for Health Statistics. VitalStats. "BFACIL by ATTEND (2009 Birth Data – State Detail)," http://www.cdc.gov/nchs/vitalstats.htm. [last accessed May 5, 2012]
[55] *Id.*

In such situations, health care providers and family members seek court orders to override the decisions of these women to benefit the fetuses. The following appellate cases illustrate how courts have acquiesced to or rejected such requests.

I. Four Appellate Cases on the Right (or Lack Thereof) to Refuse C-Sections

The Supreme Court of Georgia ordered that a pregnant woman undergo a c-section in *Jefferson v. Griffin Spalding County Hospital Authority*.[56] There Jessie Mae Jefferson went to the hospital for pre-natal care during her thirty-ninth week of pregnancy.[57] The doctor informed Ms. Jefferson that she had a complete placenta previa which required a c-section to preserve the life of the fetus and her own life.[58] She refused to undergo the c-section, as well as blood transfusions, for religious reasons.[59] The hospital sought a court ruling as to whether the fetus had any legal right to the protection of the court.[60]

The Georgia Supreme Court found that George statute criminalized abortion and thus the state had a duty to protect the fetus.[61] This state duty outweighed any refusal made by Ms. Jefferson.[62] The court concluded that the lives of the mother and fetus were "inseparable" and thus it was "appropriate to infringe upon the wishes of the mother to the extent it [was] necessary to give the child an opportunity to live."[63] Thus the court ordered Ms. Jefferson to undergo a c-section despite her refusal.[64]

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[56] 274 S.E.2d 457 (Ga. 1981).
[57] *Id.* at 458.
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.* at 460.
[62] *Id.*
[63] *Id.* at 458.
[64] *Id.* at 460.

The Illinois Appellate Court arrived at a different conclusion in *In Re Baby Boy Doe*.[65] That case concerned "Doe," a "mentally competent" married woman who received regular prenatal care at a Chicago hospital.[66] Dr. James Meserow, a board-certified obstetrician/gynecologist affiliated with the hospital, examined Doe during her 35th week of pregnancy and recommended an immediate c-section or induced labor.[67] Doe refused on religious grounds and chose to proceed with natural childbirth.[68] Two weeks later, Doe revisited the doctor and again refused the procedure (along with her husband) on religious grounds.[69] Dr. Meserow and the hospital filed a petition seeking an appointed custodian for the fetus.[70] The trial court denied the petition.[71] Doe vaginally delivered a healthy baby boy a few weeks later.[72]

On appeal, the court addressed the issue of whether the rights of a viable fetus should be balanced against the rights of a competent pregnant woman who refuses medical treatment as invasive as a c-section "even in circumstances where the choice may be harmful to her fetus."[73] The appellate court found that Illinois common law protected the right of a competent individual to refuse medical treatment, including life saving or life sustaining procedures, even on religious grounds.[74] The state right of privacy also protected the rights to reproductive autonomy and bodily integrity.[75] The court could not countenance issuing an order whose "[e]nforcement could be accomplished only through physical force or its equivalent" and would require having the

[65] 632 N.E.2d 326 (Ill. App. Ct. 1994).
[66] *Id.* at 327.
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.* at 328.
[72] *Id.* at 329.
[73] *Id.* at 326.
[74] *Id.* at 330.
[75] *Id.* at 331 (citing *Family Life League v. Dep't of Public Aid*, 493 N.E.2d 1054 (Ill. 1986) and *Stallman v. Youngquist*, 531 N.E.2d 355 (Ill. 1988)). The court also drew upon Justice O'Connor's concurring opinion in *Cruzan* where she stated that "[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." 497 U.S. at 287 (O'Connor, J. concurring).

mother "fastened with restraints to the operating table, or perhaps rendered unconscious by forcibly injecting her with anesthetic, and then subject[ing her] to unwanted major surgery."[76] The rights of the competent pregnant woman prevailed.[77]

The District of Columbia Court of Appeals similarly concluded in *In re A.C.* that the rights of a fetus did not trump those rights of an individual (i.e., a pregnant woman) who had already been born.[78] In that case, "A.C." was a 27 year old married pregnant woman in remission from cancer.[79] Due to her medical history of multiple surgeries and cancer treatment, A.C. was referred to the high-risk pregnancy clinic at George Washington University Hospital.[80] The Hospital discovered an inoperable tumor in her right lung during the 25th week of pregnancy.[81] A.C. initially indicated that she wanted to have the baby.[82] When the doctors informed her that the illness was terminal, A.C. agreed to palliative treatment to sustain her life until the 28th week of pregnancy.[83] However, the following morning A.C. was ambiguous as to whether she still wanted to have the baby, saying "something to the effect of 'I don't know, I think so.'"[84]

The Hospital filed for a declaratory judgment to deliver the fetus by c-section before 28 weeks.[85] The trial court used a balancing test to weigh the state's interest in surgical intervention against A.C's perceived interest in not having the c-section performed. The trial court found that (1) A.C. would die within 48 hours, (2) she was pregnant with a viable fetus who had a 50 to 60 percent chance of survival if a c-section was performed, (3) the state had an "important and

[76] *Id.* at 335 (quoting *In re A.C.*, 573 A.2d at 1244 n. 8).
[77] *Id.* at 330-31.
[78] 573 A.2d at 1244.
[79] *Id.* at 1238.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.* at 1239.
[85] *Id.*

legitimate interest in protecting the potentiality of human life," and (4) the surgery would hasten the death of A.C. but its delay would increase the risk of death for the fetus.[86] In balancing these interests, the trial court ordered the c-section *even though* it was "of the view that it does not clearly know what [A.C.'s] present views are with respect to the issue of whether or not the child should live or die. She's presently unconscious…."[87] The decision was relayed to A.C. when she regained consciousness, but it was unclear whether she consented to the procedure.[88] The trial court reconvened later that day and again ordered that a c-section be performed even though it still could not determine her intent.[89]

The appellate court addressed two issues: (1) who had the right to decide the course of medical treatment for a dying patient who was pregnant with a viable fetus, and (2) how should a court proceed when a pregnant patient was incapable of making an informed decision as to a course of medical treatment for herself and her fetus.[90] The court began its analysis by expressing the "tenet common to all medical treatment cases: that any person has the right to make an informed choice, if competent to do so, to accept or forego medical treatment."[91] This doctrine of informed consent was based on an individual's right to bodily integrity whereby "courts do not compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person's health."[92] While such a right was not absolute in the face of the four widely-recognized countervailing state interests, there had to be a compelling

[86] *Id.* at 1240.
[87] *Id.*
[88] *Id.* When the trial court reconvened to determine whether A.C. had consented to the c-section, Dr. Weingold testified that she "very clearly mouthed words several times, *I don't want it done. I don't want it done*." *Id.* at 1241 (emphasis in original).
[89] *Id.* at 1241.
[90] *Id.* at 1238.
[91] *Id.* at 1243.
[92] *Id.*

justification for overriding a competent individual's right to refuse medical treatment.[93] The court concluded that there was none as the rights of a fetus did not trump the rights of an individual who had already been born.[94] The court rejected the idea that pregnant women should be held to a different standard due to their pregnancies and quickly dismissed any possible state interest.[95] Furthermore, the appellate court found that the trial court should have used the substituted judgment standard, rather than the balancing test, in order to ascertain what A.C. would have done if she had been capable of making an informed decision.[96]

The appellate court also briefly reflected on the "practical consequences" of enforcing a court-ordered c-section.[97] If A.C. had refused to follow the court order then how might the court have forced her compliance? Clearly imprisonment or a daily fine would not be effective.[98] The only possible means to ensure compliance would be through

> physical force or its equivalent. A.C. would have to be fastened with restrains to the operating table, or perhaps involuntarily rendered unconscious by forcibly injecting her with an anesthetic, and then subjected to unwanted major surgery. Such actions would surely give one pause in a civilized society, especially when A.C. had done no wrong.[99]

Yet this is not unlike the means of enforcement that an appellate court permitted nine years later in Florida.

In *Pemberton v. Tallahassee Memorial Regional Medical Center, Inc.*, the District Court for the Northern District of Florida concluded that a competent pregnant woman was legally

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[93] *Id.* at 1245-46. The appellate court noted that "[w]e do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional. This is not such a case." *Id.*
[94] *Id.* at 1244.
[95] *Id.* at 1243-44.
[96] *Id.* at 1252. The appellate court also noted that "[w]henever possible, the judge should personally attempt to speak with the patient and ascertain her wishes directly, rather than relying exclusively on hearsay evidence, even from doctors. It is improper to presume that patient is incompetent. *Id.* at 1247. While this is a laudable approach, one has to wonder by what means the court imagined such an inquiry might take place, given the time-sensitive nature of such a situation and/or the unavailability of a patient due to hospitalization.
[97] *Id.* at 1244 n. 8.
[98] *Id.*
[99] *Id.* (internal citations omitted).

required to undergo a c-section because it "was medically necessary in order to avoid a substantial risk that her baby would die during delivery."[100] Laura Pemberton wanted to vaginally deliver her second child.[101] Ms. Pemberton could not find a physician who would perform such a delivery because she posed an increased risk of uterine rupture from a prior c-section.[102] So she chose to have a vaginal delivery at home with a midwife.[103]

After more than a day of labor, Ms. Pemberton became dehydrated and went to the emergency room at Tallahassee Memorial Regional Medical Center for fluids.[104] Dr. Wendy Thompson, a board-certified family practice physician, declined to provide fluids and advised Ms. Pemberton that she needed a c-section.[105] Ms. Pemberton refused to undergo the procedure and left the Hospital.[106] The Hospital sought a court order to compel the c-section and requested a hearing. The judge convened a hearing at the Hospital and sent a law enforcement officer to fetch Ms. Pemberton "by ambulance against her will."[107] After hearing testimony from several doctors that a vaginal birth would pose a substantial risk of uterine rupture and death of the baby, the judge ordered that a c-section be performed.[108]

Ms. Pemberton sued the Hospital for violating her substantive constitutional right of bodily integrity, right to refuse unwanted medical treatment, and right to make important decisions "regarding the bearing of children without undue governmental interference."[109] The District Court recognized Ms. Pemberton's "constitutional interests" but concluded that they did not outweigh the state's interest "in preserving the life of the unborn child."[110] The court

[100] 66 F.Supp.2d at 1248-49.
[101] *Id.* at 1249.
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] *Id.* at 1251.

relied upon *Roe*'s recognition that "by the point of viability – roughly the third trimester of pregnancy – the state's interest in preserving the life of the fetus outweighs the mother's own constitutional interests in determining whether she will bear a child."[111] The court pointed to the fact that no doctor was willing to attempt vaginal delivery at home or at the Hospital as a safety consideration falling under the auspices of the state's interests.[112] Therefore, the state's interest in the life of the fetus outweighed Ms. Pemberton's interest in her right to refuse unwanted medical treatment.[113]

IV. The Intrusion of Abortion-Related Informed Consent Laws and Compelled Medical Treatment on the Doctor-Pregnant Patient Relationship

In *Canterbury v. Spence*, the patient sought damages for personal injuries allegedly sustained as a result of an operation negligently performed, a negligent failure to disclose a risk of serious disability inherent in the operation, and negligent post-operative care.[114] The court found that the patient and his mother made out a *prima facie* case that the physician violated his duty to disclose the risk of paralysis from the operation. There the Court found that

> the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked… to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.[115]

Judge Robinson suggested that the standard is the uniform application of the negligence principle to medical practice. However, the negligence principle normally evaluates the conduct of a reasonable actor and not the expectations of a reasonable victim. Ironic that a doctrine developed to foster and recognize individual choice is measured by an objective standard.

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[110] *Id.*
[111] *Id.* (citing *Roe v. Wade*, 410 U.S. 113 (1973)).
[112] *Id.* at 1253.
[113] *Id.* at 1252. The court also denied Ms. Pemberton's procedural due process claims given the fetus' imminent birth and Ms. Pemberton's notice and an opportunity to be heard. *Id.* at 1254.
[114] *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).
[115] 464 F.2d at 787.

The informed consent doctrine functions to, among other things, protect individual autonomy, encourage doctors to carefully consider their decisions, avoid fraud and duress, and foster rational decision-making by the patient. It rests on the assumption that the health care provider has greater knowledge than the patient and a required information exchange best protects the patient. At the same time, it includes the patient in the decision-making process.

For example, The Joint Commission (TJC) requires hospitals to inform their patients that they "have the right to make decisions about [their] care, including refusing care" and have "the right to be listened to."[116] TJC defines informed consent as "your health care providers have talked to you about your treatment and its risks. They have also talked to you about options to treatment and what can happen if you aren't treated."[117] The Department of Health and Human Services (HHS) outlines the standards of care for hospitals participating in Medicare and/or Medicaid. Specifically, HHS requires providers to recognize the patients to "request or refuse treatment."[118] The American Medical Association and the American College of Obstetricians and Gynecologists (ACOG) have noted that the standard of informed consent applies to women throughout all stages of their pregnancies. The ACOG Committee on Ethics has explained that "[p]regnancy does not obviate or limit the requirement to obtain informed consent. Intervention on behalf of the fetus must be undertaken through the body and within the context of the life of the pregnant woman, and therefore her consent for medical treatment is required, regardless of the treatment indication."[119]

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[116]The Joint Commission, "Speak Up: Know Your Rights (2011), *available at* http://www.jointcommission.org/assets/1/ 18/Speakup _Rights.pdf.
[117] The Joint Commission, "Speak Up: Know Your Rights (2011), *available at* http://www.jointcommission.org/assets/1/ 18/Speakup _Rights.pdf
[118] *See* 42 CFR 482.13(b)(2).
[119] ACOG Committee on Ethics, *Maternal Decision Making, Ethics, and the Law: ACOG Committee Opinion No. 321* (2005), http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/ Maternal_Decision_Making_Ethics_and_the_Law

Nadia Sawicki provides a thoughtful analysis of the expansion of state abortion informed consent statutes.[120] She posits informed consent as a more nuanced, flexible and value-laden doctrine than the overly simplistic, static and neutral doctrine put forward by critics.[121] Specifically, Sawicki "calls into question the feasibility of a doctrine of informed consent that aspires to complete neutrality" and notes that "it is questionable whether even the most stringent procedures for assuring such neutrality can effectively be shielded from political and personal agendas."[122] Yet the courts have adopted informed consent as the measuring stick by which the regulation of abortion is expanded and restricted. Judicial intervention on the basis of informed consent renders nearly every decision a pregnant woman makes subject to scrutiny by her doctors and the courts.

In *Casey* and *Gonzales* the Supreme Court established that a state may require that physicians provide truthful, non-misleading information "relevant" to a woman's decision to have an abortion.[123] Such informed consent disclosures are permissible even when the information expresses a preference for life so long as it does not impose a substantial obstacle or an undue burden.[124] The *Casey* decision vaguely described what constitutes a "substantial obstacle," stating that "[r]egulations that do no more than create a *structural mechanism* by which the State… may express profound respect for the life of the unborn are permitted." It remains unclear how a state might express "profound respect" for life through a "structural mechanism" that does not pose a substantial obstacle to pregnant women.[125]

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[120] Nadia Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 Cornell J.L. & Pub. Pol'y 1, (Fall 2011).
[121] *Id.* at 28-29.
[122] *Id.*
[123] *Casey*, 505 U.S. at 882; *Carhart*, 550 U.S. at 159.
[124] 505 U.S. at 878-79 & 886; *Id.*
[125] The definition of a "mechanism" includes "a piece of machinery" and "a process, technique, or system for achieving a result." *See Mechanism Definition*, Webster-Merriam Dictionary, http://www.merriam-webster.com/dictionary/mechanism (last visited May 4, 2012).

Many states have taken *Casey's* lead by adopting structural mechanisms in the form of informed consent laws that direct the conversations between doctors and their pregnant patients prior to or at the time when abortions are performed.[126] Two recent federal circuit cases highlight how First Amendment and undue burden challenges fail unless the disclosure is untruthful, misleading, or irrelevant to the woman's decision.

In *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds,* the Eighth Circuit vacated a preliminary injunction of a South Dakota statue, S.D.C.L. § 42-23A-10.01, requiring that (1) a woman seeking an abortion receive certain information materials, (2) she give written informed consent prior to the procedure, and (3) the attending physician certify that she understands the information.[127] The information materials included a statement informing the woman

> … (b) That the abortion will terminate the life of a whole, separate, unique, living human being;
>
> (c) That the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota;
>
> (d) That by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated;
>
> (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected….[128]

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[126] *Karlin v. Foust*, 188 F.3d 446 (7th Cir. 1999) (finding that Wisconsin's informed consent statute, Wis. Stat. § 253.10, constitutional as it did not place a substantial obstacle in the path of a pregnant woman seeking an abortion); *Planned Parenthood Arizona, Inc. v. Amer. Ass'n of Pro-Life Obstetricians & Gynecologists*, 257 P.3d 181 (Ariz. Ct. App. 2011) (finding that an Arizona statute seeking an abortion receive certain information at least 24 hours before an abortion, except in instances of a medical emergency did not impose an undue burden). Furthermore, twenty-six states allow the production of specialty "Choose Life" license plates which cost between $25 and $70 on top of standard fees. Is this the ultimate "expression of a preference for life"? *See* Guttmacher Institute, "State Policies in Brief: 'Choose Life' License Plates," (May 1, 2012), *available at* http://www.guttmacher.org/statecenter/spibs/spib_CLLP.pdf. Half of the states donate a portion of the proceeds to specific anti-choice organizations or crisis pregnancy centers. *Id.* Ten states specifically prohibit donating a portion of the proceeds to agencies or organizations that provide abortion services, counseling or referrals. *Id.*

[127] 530 F.3d at 726.

[128] *Id.* at 726 (citing S.D.C.L. § 42-23A-10.01(1)(b)-(e)).

In addition, the statute required that a woman receive information about medical assistance benefits for bringing the pregnancy to term at least 24 hours prior to the abortion.[129] A physician who knowingly or recklessly failed to provide this information would be guilty of a misdemeanor.[130] Medical emergencies were the only exception to the statute.[131]

Planned Parenthood Minnesota, North Dakota, and South Dakota, along with its medical director Dr. Carole E. Ball, challenged the statute for, among other things, violating physicians' free speech rights "by compelling them to deliver the State's ideological message" and unduly burdening patients' right to an abortion due to an inadequate health exception.[132] The Eighth Circuit found that the statute was not facially unconstitutional as it did not prevent a woman from having an abortion nor did it compel doctors to engage in ideological speech.[133] Drawing upon *Casey* and *Gonzales*, the Eighth Circuit concluded that "[w]hile the State cannot compel an individual simply to speak the State's ideological message, it can use its regulatory authority to require a physician to provide truthful, non-misleading information relevant to a patient's decision to have an abortion…."[134]

In her dissent, Circuit Judge Diana Murphy compared the South Dakota informed consent provisions to other state laws consistent with *Casey*.[135] Circuit Judge Murphy found that the South Dakota provisions required physicians to make "unique statements… unrelated to the intended medical procedure" on "metaphysical matters about which there is no medical

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[129] *Id.* at 727.
[130] *Id.* (citing S.D.C.L. § 34-23A-10.2). S.D.C.L. § 34-23A-10.2 provides that the pregnant woman would not be penalized.
[131] *Id.* at 726 (citing S.D.C.L. § 42-23A-10.01). In which case, the physician would note in the patient's file that a medical emergency prevented the acquisition of informed consent. *Id.*
[132] *Id.* at 727.
[133] *Id.* at 735.
[134] *Id.*
[135] *Id.* at 740 (Murphy, J., dissenting) (citing *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 686 (7th Cir. 2002); *Karlin*, 188 F.3d at 481-82; *Barnes v. Moore*, 970 F.2d 12, 13 (5th Cir. 1992) (per curiam); *Eubank v. Schmidt*, 126 F.Supp.2d 451, 455 n.5 (W.D.Ky. 2000); *Utah Women's Clinic, Inc. v. Leavitt*, 844 F.Supp. 1482, 1486 (D.Utah 1994), *rev'd on other grounds*, 75 F.3d 564 (10th Cir. 1995)).

consensus."[136] Unlike the provisions of other informed consent statutes, the South Dakota statements contained ideological beliefs rather than medically relevant information.[137] Furthermore, the requirement that the physician-patient discussion be written down and included in the patient's medical record intruded upon the doctor-patient relationship.[138]

Recently in *Texas Medical Providers Performing Abortion Services v. Lakey*, the Fifth Circuit upheld Texas House Bill 15, codified in Tex. Health & Safety Code § 171.012, "relating to informed consent to an abortion."[139] H.B. 15 amends the 2003 Texas Woman's Right to Know Act and requires a doctor to perform and display a sonogram of the fetus, play the heartbeat of the fetus, explain to the pregnant woman the results of each procedure, and then wait 24 hours between the disclosures and performing the abortion.[140] The woman may decline to view the sonogram or hear the heartbeat, but she cannot decline to hear an explanation of the sonogram unless she qualifies for one of the three statutory exceptions.[141] She also must complete a form stating that she has received these materials, understands her right to view the sonogram and hear the heartbeat, and chooses to have an abortion.[142] The doctor must retain a copy of this form for seven years.[143] If the woman does not have an abortion, the doctor must provide her with information on establishing paternity and securing child support.[144] The plaintiff abortion providers challenged the statute for as violating the First Amendment and

[136] *Id.*
[137] *Id.* at 740-41.
[138] *Id.* at 748 (citing *Cruzan*, 497 U.S. at 340 n.12 (recognizing that "the special relationship between patient and physician will often be encompassed within the domain of private life protected by the Due Process Clause")).
[139] *Lakey*, 667 F.3d 570 (5th Cir. 2012) (quoting H.B. 15, 82nd Leg. Reg. Sess. (Tex. 2011)).
[140] *See* Tex. Health & Safety Code § 171.012(a)(4).
[141] 667 F.3d at 572 (citing Tex. Health & Safety Code § 171.0122(b), (c) & (d)).
[142] *Id.* (citing Tex. Health & Safety Code § 171.012(a)(5)).
[143] *Id.* (citing Tex. Health & Safety Code § 171.0121(b)(1)-(2)).
[144] *Id.* (citing Tex. Health & Safety Code § 171.0123).

compelling them to impart an "ideological message" that discourages women to have an abortion rather than serves a medical purpose.[145]

The Fifth Circuit drew upon the Supreme Court's decisions in *Casey* and *Gonzales* to find that informed consent laws do not impose an undue burden if they require "truthful," "nonmisleading," and "relevant disclosures."[146] The Fifth Circuit reasoned that reasonable state regulation of medical practice is not tantamount to compelling ideological speech in violation of the First Amendment.[147] Instead, the informed consent ensures that a woman understands the consequences of an abortion.[148] That the woman might then decide not to have an abortion does not render the Act invalid.[149] The court also found the required written consent acceptable as well since it is obtained for other medical procedures.[150]

The Fifth Circuit also rejected the plaintiffs' objections to the provision of sonograms and the fetal heartbeat and found that they were "medically necessary."[151] Just as the *Casey* decision was vague as to what qualifies as a "substantial obstacle" in an undue burden, the *Lakey* court was vague as to how information about the development of the fetus is medically relevant. The *Lakey* court believed that withholding current medical information was "more of an abuse of [the woman's] ability to decide than providing the information."[152] The court points to the "gravity of the decision" as requiring informed consent and the provision of relevant medical information.[153] Yet how is it not a substantial obstacle or an undue burden when the *Lakey* court

[145] *Id.* at 574.
[146] *Id.* at 576.
[147] *Id.*
[148] *Id.*
[149] *Id.*
[150] *Id.* at 578.
[151] *Id.* at 579.
[152] *Id.*
[153] *Id.*

acknowledges that "discouraging abortion is an acceptable effect of mandated disclosures"?[154]

Lakey is distinguishable from *Casey* in that it interferes with the doctor-patient relationship. In *Casey*, the Court acknowledged that "constitutional right of privacy between a pregnant woman and her physician."[155] The *Casey* statute contained a provision that a physician need not comply if he or she could reasonably believed that giving the information would adversely effect the physical or mental health of the patient.[156] Thus a physician could exercise his medical judgment.[157]

The provision of "truthful," "nonmisleading," and "relevant disclosures" comes into play both with *Lakey* and *Rounds*. Courts are willing to uphold the statute provided that the medical information is sound and no different from what might be disclosed for other medical procedures. Contrast the *Lakey* statute with the Iowa informed consent statute. Pursuant to Iowa Code § 147.137 (1975), informed consent consists of a consent in writing which

> 1. *Sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks*, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.
>
> 2. Acknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.
>
> 3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.[158]

In contrast, the *Lakey* statute provides that informed consent to an abortion occurs only when the physician provides the following "medical" information to the pregnant woman, including

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[154] *Id.*
[155] 505 U.S. at 883.
[156] *Id.* at 883-84 (citing 18 Pa. Cons. Stat. § 3205).
[157] *Id.* at 884.
[158] Iowa Code Ann. § 147.137 (1975) (emphasis in original).

(A) the physician's name;
(B) the particular medical risks associated with the particular abortion procedure to be employed, including, when medically accurate:
(i) the risks of infection and hemorrhage;
(ii) the potential danger to a subsequent pregnancy and of infertility; and
(iii) the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer;
(C) the probable gestational age of the unborn child at the time the abortion is to be performed; and
(D) the medical risks associated with carrying the child to term….[159]

One has to wonder how Justice Ginsburg would rule in the instance of *Lakey* as the statute pertains to informed consent. As previously noted, in her *Gonzales* dissent Justice Ginsburg was concerned that the Supreme Court had prevented women from making a choice as to what procedure they underwent.[160] In *Lakey*, the statute does not prevent women from making a choice as to medical treatment but instead compels doctors to inform them of the consequences of the abortion procedure.

V. Conclusion

According to the Guttmacher Institute, states enacted a record number of reproductive health and rights-related provisions in 2011.[161] In March 2012, an Oklahoma state judge issued a permanent injunction preventing the enforcement of a similar mandatory ultrasound and detailed descriptions law, finding that "it improperly is addressed only to patients, physicians and sonographers concerning abortions and does not address all patients, physicians and sonographers concerning other medical care where a general law could clearly be made applicable."[162] That same month the Virginia legislature approved a law requiring a woman

[159] Tex. Health & Safety Code Ann. § 171.012 (2011).
[160] 550 U.S. at 188-89 (Ginsburg, J. dissenting).
[161] Guttmacher Inst., *States Enact Record Number of Abortion Restrictions in 2011* (Jan. 5, 2012), http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html (last visited May 4, 2012).
[162] Amy Gallegoa, *Oklahoma judge rules pre-abortion sonogram law unconstitutional*, amednews.com (Apr. 9, 2012), http://www.ama-assn.org/amednews/2012/04/09/gvsb0409.htm (last visited May 6, 2012).

seeking an abortion to undergo an ultrasound at least 24 hours prior to the procedure, be given an opportunity to see the image, and have the abortion provider keep a copy of the image in the woman's medical record for seven years.[163] The original version of the law would have required women to undergo transvaginal sonograms if the ultrasound failed to determine the age of the fetus.[164] As of May 2012, seven states require abortion providers to perform ultrasounds and offer the women an opportunity to view the images.[165]

Yet there are no laws requiring informed consent disclosures of the same invasive and/or graphic degree for other medical procedures. The law is regulating pregnant women's right to consent to or refuse medical treatment beyond the traditional notions of compelling state interests in protecting life. In so doing, the law has intruded on the traditional doctor-pregnant patient relationship and transformed it into a power struggle of competing maternal-fetal-third party interests.

[163] *Id.*; *see also* Matthew Ward, *Virginia Senate passes ultrasound law minus vaginal probe*, Reuters (Feb. 29, 2012), http://www.reuters.com/article/2012/02/29/us-abortion-virginia-idUSTRE81S0DR20120229 (last visited May 6, 2012).
[164] Gallegoa, *supra* note 2.
[165] Guttmacher Inst., *State Policies in Brief: Requirements for Ultrasound*, (May 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (last visited May 4, 2012). The seven states with ultrasound and image viewing requirements are Alabama, Arkansas, Florida, Idaho, Kansas, Louisiana, Mississippi, and Texas.