
ARTICLES

UNINFORMED CONSENT

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ABSTRACT

Since the Supreme Court decided Planned Parenthood of Southeastern Pennsylvania v. Casey in 1992, there has been a race to the bottom to use the doctrine of so-called “informed consent” to coerce pregnant women into becoming mothers by giving birth to a child. Pregnant women are handed glossy brochures with four-week-old fetuses magnified into portrayals of living children and falsely told that their decision to terminate their pregnancy is likely to lead to increased risks of breast cancer, depression, and future fertility problems. Childbirth, by contrast, is romantically portrayed as a risk-free, wholly positive experience, consistent with pregnant women’s natural destiny as mothers.

This race to the bottom is inconsistent with standard tort principles that apply to medical procedures, but courts have tolerated it because of their stereotypical conception of the pregnant person as a “mother” and the fetus as an “unborn child.” This Article argues that an equality-based conception of reproductive rights can help unmask the gender-based stereotypes that underlie this race to the bottom.

Constructively, this Article argues that informed consent is possible within abortion jurisprudence. The Down syndrome proinformation campaign has been a successful part of such a movement. Unfortunately, the current rush by states to criminalize an individual’s decision to terminate a pregnancy after a prenatal diagnosis of Down syndrome is the latest coercive step that is unraveling such important advances in informed consent.

Pregnant people, like all patients, are entitled to receive fair and balanced information to make informed decisions about their personal autonomy. It is

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important to recognize their right to decide whether to become parents rather than to conceptualize them as already being “mothers” due to their pregnancy.

CONTENTS

INTRODUCTION	434
I. PREGNANT PEOPLE AS “MOTHERS”	437
II. MISINFORMATION AS A TOOL OF COERCION	448
III. TORT LAW AS LEGAL RECOURSE.....	452
A. <i>Informed Consent</i>	453
1. Erroneous Information	456
2. Too Much Information.....	460
B. <i>Wrongful Birth</i>	474
1. The Harm to Decisional Autonomy.....	474
2. The Harm from Pregnancy, Childbirth, and Childrearing	476
IV. LACK OF INFORMED CONSENT AS A CONSTITUTIONAL VIOLATION: CHOICE CANNOT INCLUDE COERCION	480
A. <i>Reconceptualizing Pregnancy-Related Constitutional Law</i>	481
B. <i>Applying Heightened Scrutiny to Abortion</i>	484
CONCLUSION: GENUINE INFORMED CONSENT	486

INTRODUCTION

Pregnant people, who typically identify as women,¹ are not “mothers” merely because they are pregnant.² The fetus is neither a “person,” a “child,” nor an “unborn child.” Yet, state legislatures, the U.S. Congress, and the U.S. Supreme Court have gotten away with calling pregnant women “mothers” throughout our nation’s history. Even liberal Supreme Court Justices have characterized pregnant women as mothers in decisions upholding their right to terminate their pregnancies. Oddly, scholars have largely ignored this ubiquitous characterization. This Article argues that characterizing pregnant women as mothers is at the heart of the erosion of their right to choose to terminate a pregnancy. Abortions are highly restricted to coerce pregnant people, who are assumed to be women, to fulfill their supposed inherent destiny as “mothers.”

While there has been much discussion about the impact of *Planned Parenthood of Southeastern Pennsylvania v. Casey*³ on states’ abilities to create restrictive barriers to abortion services,⁴ scholarship has largely ignored the impact of that decision on states’ uses of so-called “informed consent” rules to coerce individuals into continuing their pregnancies. The *Casey* Court affirmed

¹ Not all pregnant people are women. They may be gender nonbinary or transgender men. The gender stereotype that all pregnant people are already “mothers,” however, is one that has historically been applied to women who are pregnant. I do not know how the stereotypes discussed in this Article would apply to nonbinary persons or men who are pregnant, although I suspect that they would also be considered “mothers” irrespective of their gender identity. See Paula Coccozza, *The Story of One Man’s Pregnancy: ‘It Felt Joyous, Amazing and Brilliant,’* GUARDIAN (Mar. 22, 2018, 2:00 AM), <https://www.theguardian.com/lifeandstyle/2018/mar/22/story-one-mans-pregnancy-trans-jason-barker> [<https://perma.cc/K88U-XK4F>] (“Once, in hospital, the nurses called Barker ‘Mum’. But after racking his brains, that is the single misstep he can recall.”). Because state legislatures have crafted the limitations described in this Article on the assumption that all pregnant people are women and that a pregnant person’s natural destiny is that of a “mother,” I will often refer to pregnant people as pregnant women in this Article.

² Of course, many pregnant people, including those who choose to terminate their pregnancies, are mothers because they have previously given birth to, adopted, or helped raise a child. When the courts and legislatures characterize pregnant women as mothers, they are doing so only on the basis of their current pregnancy. In other words, they conceptualize the fetus as an “unborn child,” which then makes the pregnant woman a “mother,” even if she has not previously given birth to a child, adopted a child, or participated in raising a child.

³ 505 U.S. 833 (1992) (holding that abortion restrictions should be judged under “undue burden” standard instead of strict scrutiny).

⁴ See, e.g., Jason Del Rosso, *It’s a Trap: The Constitutional Dangers of Admitting Privileges for Both Women and Abortion Providers*, 24 B.U. PUB. INT. L.J. 195, 198 (2015) (discussing admitting privilege laws after *Casey*); Katherine Godich, *Iowa’s Unconstitutional Ban on Tele-Medicine Abortions*, 19 J. GENDER RACE & JUST. 351, 352 (2016) (discussing application of *Casey* to telemedicine abortions); Cynthia D. Lockett, *The Beginning of the End: The Diminished Abortion Right Following Carhart and Planned Parenthood*, 11 J. GENDER RACE & JUST. 337, 360-67 (2008) (anticipating the end of legal abortion); Jeffrey Roseberry, *Undue Burden and the Law of Abortion in Arizona*, 44 ARIZ. ST. L.J. 391, 392 (2012) (discussing cumulative effect of post-*Casey* restrictions on abortion rights in Arizona).

the right of states to use these informed consent rules to persuade pregnant women to carry their pregnancies to term rather than terminate them.⁵ Since the *Casey* decision in 1992, there has been a race to the bottom as states try to force physicians and other medical personnel to pummel pregnant people with information in the name of informed consent—information that really has nothing to do with consent.⁶ Rather than treating pregnant people like patients who are entitled to receive appropriate medical information to make an informed decision about whether to choose a particular medical procedure over a variety of other options, many states treat them as mere vessels, reflecting the states' own attitudes about women's proper destiny as mothers.

States insist that pregnant people be handed glossy brochures with images of four-week-old fetuses that are magnified into portrayals of living children.⁷ They are told that their decision to terminate their pregnancy is likely to lead to increased risks of breast cancer, depression, and future fertility problems. Childbirth, by contrast, is romantically and inaccurately portrayed as a risk-free, wholly positive experience, consistent with pregnant people's "natural destiny" as mothers. Under the guise of informed consent, states intrude into these individuals' balanced decision-making processes by portraying pregnant people as if they are already mothers, rather than individuals who are entitled to decide whether they want to become parents.

Unsuccessful arguments have been made that such informed consent rules violate individuals' liberty interest by imposing an undue burden in their path to reproductive freedom and that such rules violate physicians' First Amendment interests by forcing doctors to utter words that are inconsistent with their own views on how to best treat their patients.⁸ But neither of those arguments goes to the heart of the problem. The state is using its regulatory power to convey information to pregnant people in a way that is designed to persuade them to remain pregnant rather than to inform them about their available options. If the state wants to broadcast commercials to proclaim its views opposing abortion, it may certainly do so.⁹ But it should not be allowed to coercively use the mechanism of what it describes as "informed consent" to try to mislead

⁵ *Casey*, 505 U.S. at 883 (plurality opinion).

⁶ See Callie Beusman, *A State-by-State List of the Lies Abortion Doctors Are Forced to Tell Women*, VICE (Aug. 18, 2016, 11:15 AM), <https://www.vice.com/en/article/nz88gx/a-state-by-state-list-of-the-lies-abortion-doctors-are-forced-to-tell-women> [https://perma.cc/27G9-HGJV].

⁷ See *infra* Section III.A.2.

⁸ The Court in *Casey* rejected both of these claims. *Casey*, 505 U.S. at 884 (plurality opinion).

⁹ See *id.* at 916 (Stevens, J., concurring in part and dissenting in part) ("The State may promote its preferences by funding childbirth, by creating and maintaining alternatives to abortion, and by espousing the virtues of family; but it must respect the individual's freedom to make such judgments.").

individuals into making a medical decision that is nearly always more medically dangerous than abortion.¹⁰

Both tort law and equal protection principles dictate that states should not be able to misuse the essential process of informed consent to deliberately *misinform* individuals to induce them to make a particular medical decision. From a tort perspective, the state is deliberately engaging in medical malpractice through a misuse of what it labels as “informed consent.” It forces people to hear or read inaccurate, misleading, or irrelevant information that is intended to persuade or even scare them into carrying a fetus to term rather than to inform them about the genuine and significant medical risks associated with their various options. When individuals choose to terminate a pregnancy after being exposed to these scare tactics, they should be able to recover for the psychological injury caused by the informed consent statutes’ information requirements. Further, individuals who decide to carry the fetus to term rather than terminate their pregnancy based on such coercive and misleading information should have a cause of action against the state for wrongful birth.

Because elected state court judges in states with coercive informed consent statutes are unlikely to expand tort law to provide a remedy, constitutional law must also be an available remedy. From an equal protection perspective, exactly one class of members of the community—pregnant people—are treated this way because the state deliberately mischaracterizes them as “mothers”¹¹ when they, in fact, have a constitutional right to decide whether to become mothers. Using coercion and deceit, legislatures treat these people as if they are not deserving of the right to make an informed decision about whether to become mothers. And even courts, which purport to follow *Roe v. Wade*¹² and its progeny, support the right of legislatures to treat pregnant people as mothers rather than as individuals entitled to make informed decisions about whether to remain pregnant.

This Article examines the harm flowing to individuals from these so-called “informed consent” statutes to argue that these statutes violate basic tort and equal protection principles. Part I will discuss the flagrant description of pregnant people as “mothers” in the Court’s constitutional law jurisprudence, even when the issue in those cases is whether individuals have the right to choose whether to terminate their pregnancies. Part II will discuss the deliberate misinformation campaigns that many states have launched for the purpose of persuading, rather than informing, individuals about their medical choices so that they will retain their status as “mothers.” This Part will show how existing abortion and First Amendment jurisprudence is ineffective at responding to this problem. Part III will present a tort perspective to argue that both informed

¹⁰ See *Roe v. Wade*, 410 U.S. 113, 149 (1973) (“Mortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth.”).

¹¹ See *infra* Part I.

¹² 410 U.S. 113 (1973).

consent and wrongful birth causes of action need to be updated to reflect the harm that flows from these coercive practices. A stereotypical view of pregnant people as mothers has infected tort law with a stingy understanding of the harm that results when they are coerced into giving birth. Part IV will argue that we should also understand the coercive use of informed consent as an equal protection violation because there is no instance in which nonpregnant men, when confronted with various medical decisions, are subject to such coercion. This coercion only exists because of the stereotypical assumption that pregnant people are already mothers who are not entitled to make a reasoned decision about their own well-being. Legislating on that basis is unconstitutional under the core rationales for the heightened scrutiny standard that protect individuals from sex-based stereotypes.

This Article, however, does not mean to suggest that informed consent has no place in respectful reproductive practices. In some states, for example, as discussed in Part V, the disability rights community has pushed state legislatures to enact proinformation laws that convey balanced information to pregnant people who have been told that their fetus is likely to have Down syndrome so that they can make an informed decision about how to structure their lives, including whether to terminate the pregnancy. But other states have also enacted statutes that entirely ban individuals who have had a Down syndrome prenatal diagnosis from choosing to terminate the pregnancy of the “unborn child,” entirely undoing the benefits of the proinformation movement and, in fact, making it difficult for individuals even to procure genetic information to guide their decision-making process. The actions of these states reveal the charade of a concern for informed consent because these states preclude pregnant people from both learning about a prenatal diagnosis and then, if they choose, terminating a pregnancy. Information, rather than coercion, needs to be the basis for genuine informed consent. Information, rather than coercion, allows pregnant people to decide whether to become mothers.

I. PREGNANT PEOPLE AS “MOTHERS”

As Rosalind Petchesky has documented, “the primacy and necessity of woman as Mother has been a continuous ideological thread in antiabortion pronouncements since the nineteenth century.”¹³ Although this Article often uses the expression “pregnant person,” there is little doubt that society’s prejudices and stereotypes against pregnant people are extended to them because, regardless of their gender, they are considered to be women. The time-honored conception of a pregnant woman as a mother included the expectation that she would even choose to die to save her “child” as proof of her “absolute

¹³ ROSALIND POLLACK PETCHESKY, *ABORTION AND WOMAN’S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM* 344 (rev. ed. 1990).

dedication.”¹⁴ Thus, it is not surprising that legislatures are returning to banning abortions with virtually no exceptions¹⁵ as the antiabortion movement has gained increased strength in the twenty-first century. These states conceptualize any exceptions to the antiabortion principle as situations in which a “mother” is killing her “child.”¹⁶

While it may not be surprising that state legislatures that ban abortions describe the pregnant person as a “mother” and the fetus as an “unborn child,” it is surprising that the characterization of the pregnant person as a mother can even be found in the Supreme Court’s pro-choice jurisprudence, beginning with Justice Blackmun’s famous 1973 opinion in *Roe v. Wade*.¹⁷ In *Roe*, the Texas statute at issue used the term “mother” several times to implement its rules. If a person died during an abortion, her status was described as “mother.”¹⁸ If an abortion was necessary to save the pregnant person’s life, she was described as a “mother,” even though she had an abortion.¹⁹ And, if someone killed the fetus after the fetus was viable, then the person who killed the fetus was described as having killed a “child” of a “mother.”²⁰

But Justice Blackmun sometimes adopted similar language to describe the interest of the pregnant person in deciding whether to terminate the pregnancy. While characterizing the individual as a pregnant woman in the first trimester of pregnancy, Justice Blackmun describes her as a “mother” when considering her constitutional interests in the second and third trimester of pregnancy:

(b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the *mother*, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to *maternal health*.

(c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even

¹⁴ *Id.* at 344 (“If it were to become an accepted principle of moral teaching on motherhood to permit a mother whose life was endangered simply to ‘sacrifice’ the life of her child in order to save her own, motherhood would no longer mean absolute dedication to each and every child.” (quoting 3 BERNARD HÄRING, *THE LAW OF CHRIST: MORAL THEOLOGY FOR PRIESTS AND LAITY* 209 (Edward G. Kaiser trans., 1966))).

¹⁵ *See, e.g.*, *Robinson v. Marshall*, 415 F. Supp. 3d 1053, 1059 (M.D. Ala. 2019) (granting preliminary injunction against Alabama abortion law that imposed criminal liability on abortion providers for nearly all abortions, regardless of fetal viability). The only exception in the statute challenged in *Robinson* was when “the child’s mother has a condition that so complicates her medical condition that it necessitates the termination of her pregnancy to avert her death or to avert serious risk of substantial physical impairment of a major bodily function.” ALA. CODE § 26-23H-3(6) (2020).

¹⁶ ALA. CODE § 26-23H-3(6) (describing pregnant woman who terminates her pregnancy to avoid her own death as a “mother” who has killed her “child”).

¹⁷ *Roe*, 410 U.S. at 163.

¹⁸ *See id.* at 117 n.1 (describing Texas Article 1194).

¹⁹ *Id.* at 117 n.1 (describing Texas Article 1196).

²⁰ *Id.* at 117 n.1 (describing Texas Article 1195).

proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the *mother*.²¹

Those characterizations of pregnant people as “mothers” were not gratuitous. They were part of a framework that limited people’s reproductive rights as their pregnancies advanced. They also mimicked the way the Texas statute, which was invalidated as unconstitutional, conceived of the status of the pregnant person. In other words, the Texas statute was able to frame the Court’s conception of the pregnant person as a mother after the first trimester of pregnancy, even though the Court invalidated it.

In 1992, in *Casey*, the Court was asked to reverse the *Roe* decision and subject abortion regulations to mere rational basis scrutiny.²² Before answering that question, the joint opinion (which was authored by Justices O’Connor, Kennedy, and Souter) recited the *Roe* framework, using the word “mother”²³ to describe the status of the pregnant person as the Court had done in *Roe*.²⁴ Although a majority of the Court decided to reaffirm *Roe*, the joint opinion used gender stereotypes to describe pregnant people.²⁵ The opinion glamorized a pregnant woman’s relationship to a fetus while oddly criticizing the state for doing just that:

The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice.²⁶

The joint opinion started its description of the pregnant person’s “unique” situation by describing her as a “mother.” It then characterized her as inevitably providing a “bond of love” with the “child” that she might bear, describing this “sacrifice” on her part as “ennobling” her in the eyes of others. This followed earlier language that described individuals who have abortions as having to “live with the implications of her decision” in a context that suggested that those implications are only negative.²⁷ Implicitly, by choosing abortion over childbirth, the joint opinion suggested that pregnant people were making a troubling decision—one which we later learn that Justice Kennedy thinks they

²¹ *Id.* at 164-65 (emphases added).

²² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).

²³ *Id.* at 872 (plurality opinion).

²⁴ *See Roe*, 410 U.S. at 164.

²⁵ *Casey*, 505 U.S. at 879.

²⁶ *Id.* at 852.

²⁷ *Id.*

might regret²⁸—that caused them to miss the immutable bond between mother and child.

Further, the *Casey* Court left no doubt that it was acceptable for the state to use its resources to encourage individuals to make what it considers the correct choice—childbirth—over what it considers to be the wrong choice—abortion. The joint opinion overturned prior language from *City of Akron v. Akron Center for Reproductive Health, Inc.*²⁹ and *Thornburgh v. American College of Obstetricians and Gynecologists*³⁰ that required states to stay neutral in the choice between abortion and childbirth. Repudiating the holdings in those two cases, the joint opinion found that it was not unconstitutional for the state to use the doctrine of informed consent to “cause the woman to choose childbirth over abortion.”³¹ It was not unconstitutional for a state to provide individuals with slanted information for the purpose of encouraging them to accept their proper place in society as a mother. The state and the joint opinion, of course, did not express the choice in those terms. They hoped that the individual would agree to “protect[] the life of the unborn” by choosing childbirth over abortion.³² They hoped that the individual would stay pregnant rather than kill the “unborn child.” They considered pregnant people to be fragile creatures who could not be expected to make the right decision without this kind of coercion. *Casey* therefore reaffirmed *Roe* while also overturning *Akron* and *Thornburgh* by permitting state-sponsored coercion through the so-called doctrine of “informed consent” to persuade people to become mothers.

The real meaning of the *Casey* holding can be seen by reviewing the language in *Akron* and *Thornburgh* that the Court found unconstitutional. In *Akron*, the city ordinance required a doctor to tell a pregnant person that “the unborn child is a human life from the moment of conception.”³³ By calling the fetus an “unborn child,” the city was taking the position that the pregnant person was already a mother. Similarly, in *Thornburgh*, the state statute referred to the pregnant person as carrying a “child,”³⁴ again because the state considered the

²⁸ See *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (“While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”).

²⁹ 462 U.S. 416, 444 (1983) (holding that city ordinance requiring that women are told “the unborn child is a human life from the moment of conception” was unconstitutional because “much of the information required [was] designed not to inform the woman’s consent but rather to persuade her to withhold it altogether” (quoting *Akron, Ohio, Regulation of Abortions, Ordinance 160-1978*, § 1870.06(B)(3) (Feb. 1978))).

³⁰ 476 U.S. 747, 761-62 (1986) (holding that state law requiring state to inform women about assistance “to carry [their] child to term” was unconstitutional because, as in *Akron*, it was designed to persuade her keep the pregnancy and not to provide information).

³¹ *Casey*, 505 U.S. at 883 (plurality opinion).

³² *Id.*

³³ *Akron*, 462 U.S. at 444 (quoting *Akron, Ohio, Regulation of Abortions, Ordinance 160-1978*, § 1870.06(B)(3) (Feb. 1978)).

³⁴ *Thornburgh*, 476 U.S. at 761.

pregnant person to already be a mother. Thus, when the *Casey* decision overturned both *Akron* and *Thornburgh*, it facilitated the state's regulation of pregnant people as mothers rather than as individuals entitled to decide whether to become mothers.

The gender-based stereotyping about women's proper and inevitable role as mothers continued in Justice Kennedy's majority opinion in *Nguyen v. INS*.³⁵ Petitioner Nguyen was born on September 11, 1969 in Vietnam to a Vietnamese citizen mother and a U.S. citizen father.³⁶ His mother "abandoned"³⁷ him at birth; his father, Joseph Boulais, brought him to the United States in June 1975 and raised him.³⁸ In February 1998, when Nguyen was twenty-eight years old, Boulais took the additional step of obtaining an order of parentage based on DNA testing that showed he was the biological father.³⁹ Because that test was not done before Nguyen's 18th birthday, he was not eligible to be considered a U.S. citizen; he was therefore subject to deportation as a result of a criminal conviction.⁴⁰ Had Nguyen been raised by a U.S. citizen mother in the United States after having been born overseas, there would have been no requirement for her to establish maternity by his eighteenth birthday.⁴¹ Her maternity would instead have been presumed through the act of giving birth.⁴² Nguyen and his father challenged this rule as constituting unconstitutional sex discrimination.⁴³ They argued that the government could not justify the stringent rules that applied to fathers as compared to those that applied to mothers and that the government's administrative convenience arguments could not withstand a sex-based equal protection challenge.⁴⁴

The Court upheld the sex-based rule for defining the eligibility of a child for U.S. citizenship.⁴⁵ Justice Kennedy authored a 5-4 opinion for the Court (which

³⁵ 533 U.S. 53 (2001).

³⁶ *Id.* at 57.

³⁷ *Nguyen v. INS*, 208 F.3d 528, 530 (5th Cir. 2000), *aff'd*, 533 U.S. 53. The use of the word "abandoned" suggests that Nguyen's biological mother made a choice. Conceptualizing her decision as a choice ignores the historical context in which a Vietnamese woman would have given birth to a multiracial child at the end of the Vietnam War, soon after U.S. troops left the country. For further discussion, see *infra* note 54.

³⁸ *Nguyen*, 208 F.3d at 530.

³⁹ *Id.* at 531.

⁴⁰ *Id.* at 532.

⁴¹ *Id.* at 533.

⁴² *Nguyen*, 533 U.S. at 61-62.

⁴³ *Id.* at 85 (O'Connor, J., dissenting); see also *Nguyen*, 208 F.3d at 533 (noting that Nguyen argued that the challenged statute, Immigration and Nationality Act § 309, 8 U.S.C. § 1409, "makes it more difficult for male citizens to confer citizenship to their offspring born out of wedlock than for citizen mothers to confer citizenship").

⁴⁴ *Nguyen*, 208 F.3d at 533.

⁴⁵ *Nguyen*, 533 U.S. at 73.

was not joined by Justices O'Connor or Souter).⁴⁶ As in the *Casey* joint opinion, he engaged in a stereotypical characterization of pregnancy.

In the case of a citizen mother and a child born overseas, the opportunity for a meaningful relationship between citizen parent and child inheres in the very event of birth, an event so often critical to our constitutional and statutory understandings of citizenship. The mother knows that the child is in being and is hers and has an initial point of contact with him. There is at least an opportunity for mother and child to develop a real, meaningful relationship.⁴⁷

Aside from not acknowledging that not all women are pregnant by choice, that not all nonaborted pregnancies are wanted, and that many pregnancies are so difficult that pregnant women do not feel any sense of bond with the fetus within them, this paragraph continued the trope of conceptualizing pregnant women as “mothers” from the moment when they know “the child is in being.”⁴⁸ It also assumed that pregnant women always have an opportunity to develop a “relationship” with the fetus (which is described as a child).⁴⁹ Although Justice Kennedy’s opinion cast this relationship as only an “opportunity,” he implicitly suggested that a “good mother” is a person who would develop such a relationship while the “child” is in utero.

Further, Justice Kennedy’s opinion contained sex-role stereotypes about fathers as well as some basic misunderstandings regarding reproductive biology. In the case of mothers, Justice Kennedy explained that the parent-child “relation is verifiable from the birth itself.”⁵⁰ The courts have actually been mired in cases involving the issue of legal parentage where the parties used various forms of alternative reproductive practices.⁵¹ That statement therefore reflects a stereotype based on a deliberate indifference to the biological facts of reproduction. But, more importantly, it rests on an impermissible stereotype about the consequences of giving birth. Justice Kennedy concluded that the fact of giving birth is sufficient proof of a parent-child *relationship*, not just of biological maternity.⁵²

That generalization about all women was not even consistent with the context in which Nguyen was brought into this world. His father was a U.S. citizen stationed in Vietnam who impregnated a Vietnamese woman.⁵³ The Court’s

⁴⁶ *Id.* at 56.

⁴⁷ *Id.* at 65.

⁴⁸ *Id.*

⁴⁹ *See id.*

⁵⁰ *Id.* at 62.

⁵¹ *See* Richard Vaughn, *Children Born Abroad Via Surrogacy Denied U.S. Citizenship*, INT’L FERTILITY L. GRP. (Aug. 2, 2019, 5:58 PM), <https://www.iflg.net/children-born-foreign-surrogacy-denied-u-s-citizenship/> [<https://perma.cc/7PLB-FCJK>].

⁵² *See Nguyen*, 533 U.S. at 64.

⁵³ *Id.* at 57.

decision states that she “abandoned” her child at birth, suggesting that she may have been subject to various coercive practices in her own life that caused her not to welcome her status as mother. Discrimination against children born to Vietnamese mothers and U.S. servicemen was common in 1975, when Nguyen was born.⁵⁴ U.S. troops left Vietnam in January 1975, while Nguyen’s mother was about five months pregnant.⁵⁵ It is hard to know why she “abandoned” her son, but it is easy to imagine that she did not feel that her act of giving birth gave her an “opportunity” to develop a parent-child bond. For Justice Kennedy not to understand the possible coercive aspects of some women’s pregnancies, especially when such evidence was in front of the Court, speaks to the strength that sex-role stereotypes play when the Court considers cases involving pregnant women.

As to fathers, Justice Kennedy told us that the “uncontestable fact is that he need not be present at the birth. If he is present, furthermore, that circumstance is not incontrovertible proof of fatherhood.”⁵⁶ Drawing on old cases that insist that the mother’s biological relationship to the child “is clear,”⁵⁷ Justice Kennedy insisted that it is fine to give fathers three options to demonstrate paternity, which must be fulfilled by the child’s eighteenth birthday: “legitimation, paternity oath, and court order of paternity.”⁵⁸ Joseph Boulais, Nguyen’s biological father, argued that he should be allowed to introduce DNA evidence at any time to demonstrate that he was the biological father.⁵⁹ The Court concluded, however, that Congress was justified in relying on these three other methods of proving paternity in the interest of seeking to “foster the opportunity for meaningful parent-child bonds to develop.”⁶⁰ The Court implied that women inherently develop a meaningful relationship through the process of giving birth, and therefore Congress satisfied its objectives with respect to mothers by merely requiring them to give birth. The Court concluded, by contrast, that men, who may even be present at birth, have not demonstrated that they have had that opportunity unless they took various affirmative steps before the child’s eighteenth birthday.⁶¹ In other words, women were permitted to attain the status of a parent who could convey citizenship to their child by having an

⁵⁴ Of course, we have no way of knowing why Nguyen’s mother “abandoned” him at birth. She and her son may have faced significant hardship because of his multiracial heritage. See David Lamb, *Children of the Vietnam War*, SMITHSONIAN MAG. (June 2009), <https://www.smithsonianmag.com/travel/children-of-the-vietnam-war-131207347/> [<https://perma.cc/MWA4-8P8S>] (discussing mistreatment of children born overseas to Vietnamese mothers and U.S. servicemen).

⁵⁵ See *Vietnam War Timeline*, HISTORY (Feb. 26, 2020), <https://www.history.com/topics/vietnam-war/vietnam-war-timeline> [<https://perma.cc/M6J7-KAKY>].

⁵⁶ *Nguyen*, 533 U.S. at 62.

⁵⁷ *Id.* (quoting *Lehr v. Robertson*, 463 U.S. 248, 260 n.16 (1983)).

⁵⁸ *Id.* at 63.

⁵⁹ Brief of Petitioners, *Nguyen*, 533 U.S. 53 (No. 99-2071), 2000 WL 1706737, at *22.

⁶⁰ *Nguyen*, 533 U.S. at 70.

⁶¹ See *id.* at 64.

“opportunity” to develop a relationship by giving birth; men only attained the status of a parent who could convey citizenship to their child by having an actual relationship with the child as evidenced by a paternity claim before the child’s eighteenth birthday.

Notice what the Court does here to avoid finding in favor of the biological father. It starts by insisting that all women who give birth inevitably are the biological parent of a child and have the opportunity to develop a parent-child relationship.⁶² But then it is faced with the cold facts from a DNA test that Boulais was the biological father and that Nguyen’s own birth mother never raised him at all.⁶³ The Court does not want to permit Boulais to come forward after Nguyen’s eighteenth birthday to present those facts. So, it says that the cutoff at the age of eighteen was for the purpose of making sure that the father had developed a *relationship* with the child.⁶⁴ Women satisfy the biology *and* relationship test by giving birth even if the facts demonstrate that they took no steps whatsoever to develop that relationship.⁶⁵ Women benefit from a generalization about the inherent nature of giving birth; men are treated skeptically even when they have been present in the child’s life. Those generalizations were allowed to dictate the outcome in a case where neither the man nor the woman’s conduct fits these stereotypes of their respective sexes.

Generalizations that merely serve administrative convenience—or worse, serve sex-role stereotypes—are not supposed to pass muster under sex-based equal protection doctrine. To survive equal protection scrutiny, the majority opinion mischaracterized the options provided to citizen fathers as “minimal.”⁶⁶ But then, seemingly in recognition that this “minimal” test caused enormous hardship on a father and his son, the Court emphasized that “[n]one of [its] gender-based classification equal protection cases have required that the statute under consideration must be capable of achieving its ultimate objective in every instance.”⁶⁷ So, it is okay for a son to be subject to deportation based on a statute’s imprecision.

In fact, *Nguyen* is remarkably similar to some of the Court’s early sex discrimination cases in which it found that equal protection principles were violated when states acted on the basis of generalizations about men and women without giving individual men and women an opportunity to demonstrate that they deviated from the stereotype. For example, in *Reed v. Reed*,⁶⁸ the Court invalidated an Idaho statute that preferred men over women in administering an estate.⁶⁹ The Idaho legislature created this rule to avoid having to hold hearings

⁶² See *id.* at 62.

⁶³ See *Nguyen v. INS*, 208 F.3d 528, 530 & n.1 (5th Cir. 2000).

⁶⁴ See *Nguyen*, 533 U.S. at 62.

⁶⁵ See *id.*

⁶⁶ *Id.* at 70.

⁶⁷ *Id.*

⁶⁸ 404 U.S. 71 (1971).

⁶⁹ *Id.* at 77.

to determine who to appoint as an administrator and decided to use sex as a tiebreaker based on the conclusion “that in general men are better qualified to act as an administrator than are women.”⁷⁰ In upholding this rule, the Idaho Supreme Court said: “While this classification may not be entirely accurate, and there are doubtless particular instances in which it is incorrect, we are not prepared to say that it is completely without a basis in fact as to be irrational and arbitrary.”⁷¹ The U.S. Supreme Court then reversed the Idaho Supreme Court, concluding that using sex as a tiebreaker constituted “the very kind of arbitrary legislative choice forbidden by the Equal Protection Clause” despite the rationale to “avoid[] intrafamily controversy.”⁷²

In *Nguyen*, the federal government used a contrived set of rules to establish that men and women could satisfy both a biology standard and an opportunity-for-a-relationship standard.⁷³ All women were deemed to have the requisite relationship with a child based on giving birth; no man was deemed to have the requisite relationship unless he met particular rules by the child’s eighteenth birthday.⁷⁴ The only honest explanation for this differential treatment (aside from sexism) would be administrative convenience.⁷⁵ Boulais was given no opportunity to demonstrate that he deviated from the generalization for all men and that Nguyen’s mother had deviated from the generalization for all women.⁷⁶ Such administrative convenience was overturned in *Reed* for an estate valued under \$1,000 but was allowed to persist in *Nguyen*, in a context in which a young man was subject to deportation to a country that he barely knew.⁷⁷

Justice O’Connor’s dissent (which was joined by Justices Souter, Ginsburg, and Breyer) criticized some of the sex-role stereotypes present in the *Nguyen* majority opinion. She said,

A mother may not have an opportunity for a relationship if the child is removed from his or her mother on account of alleged abuse or neglect, or if the child and mother are separated by tragedy, such as disaster or war, of the sort apparently present in this case. There is no reason, other than stereotype, to say that fathers who are present at birth lack an opportunity for a relationship on similar terms.⁷⁸

Through the joint opinion in *Casey* and the majority opinion in *Nguyen*, Justice Kennedy contributed to the Court basing its decisions on a stereotypical way of thinking of women as always potential “mothers,” even when women are

⁷⁰ *Reed v. Reed*, 465 P.2d 635, 638 (Idaho 1970), *rev’d*, 404 U.S. 71 (1971).

⁷¹ *Id.*

⁷² *Reed*, 404 U.S. at 76-77.

⁷³ *See Nguyen v. INS*, 533 U.S. 53, 59-60 (2001).

⁷⁴ *See id.* at 60.

⁷⁵ *See id.* at 88 (O’Connor, J., dissenting).

⁷⁶ *See* Brief of Petitioners, *supra* note 59, at *9.

⁷⁷ *Compare Reed*, 404 U.S. at 75-76, *with Nguyen*, 533 U.S. at 57.

⁷⁸ *Nguyen*, 533 U.S. at 86-87 (O’Connor, J., dissenting).

fighting for their right to terminate a pregnancy or when men are fighting for their right to be respected as fathers.⁷⁹

Six years later in *Gonzales v. Carhart*,⁸⁰ Justice Kennedy further imprinted this stereotypical conceptualization of pregnant women as mothers in his opinion for the majority.⁸¹ The issue in *Gonzales* was the constitutionality of a federal statute that banned the intact dilation and extraction method (“D&E”) of performing an abortion—a method that might be used to perform a second-trimester abortion.⁸²

In banning this particular type of abortion procedure, Congress referred to the pregnant person as a “mother.”⁸³ The Act stated that it did *not* apply to a situation in which an intact D&E (which Congress called a “partial-birth abortion”) was “necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.”⁸⁴ In other words, in the situation in which Congress *allowed* pregnant people to choose to have an intact D&E to *terminate* their pregnancy, they would have to work with their physician to argue that they were a *mother* whose life was endangered through the use of an alternative abortion procedure. Further, in the definition section, when defining what the Act calls a “partial-birth abortion,” the Act twice describes the pregnant person who is having this abortion procedure as a “mother.”⁸⁵ Finally, Congress was clear that it considered the fetus to be a *child* at this stage in the individual’s pregnancy,⁸⁶ thereby clarifying its conception of individuals who were legally entitled to terminate their pregnancy as mothers.

The majority opinion upheld this statute because the “government may use its voice and its regulatory authority to show its profound respect for the life within the woman.”⁸⁷ But, of course, that was *not* what Congress said it was doing. It was expressing its respect for the life, which it considered to be a *child* within a *mother*. The Court sanitized Congress’s actual language to pretend that Congress

⁷⁹ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (describing women as mothers continuously through joint opinion); *Nguyen*, 533 U.S. at 53-72 (describing women as mothers because of the biological fact of birth and fueling the absentee-father stereotype).

⁸⁰ 550 U.S. 124 (2007).

⁸¹ *E.g., id.* at 143.

⁸² See *id.* at 132.

⁸³ 18 U.S.C. § 1531(a) (Supp. IV 2000).

⁸⁴ *Id.*

⁸⁵ *Id.* § 1531(b)(1)(A) (describing a “partial-birth abortion” as one in which the physician “deliberately and intentionally vaginally delivers a living fetus until . . . the entire fetal head is outside the body of the mother, or, in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother”).

⁸⁶ In its findings, Congress described the physician acting “directly against the physical life of a child” even though these abortions could only be performed on a nonviable fetus. See *Partial-Birth Abortion Ban Act of 2003*, Pub. L. No. 108-105, § 2(14)(J), 117 Stat. 1201, 1205.

⁸⁷ *Gonzales*, 550 U.S. at 157.

was appropriately thinking about the rights of pregnant people to choose whether to become mothers.⁸⁸

The conceptualization of pregnant people as mothers, however, was not the worst sexist trope found in *Gonzales*. The Court also characterized pregnant people as inherently having a bond with the fetus, making a painful decision to have an abortion, and sometimes having deep regret about their decision to terminate their pregnancy.

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.⁸⁹

In a scathing dissent, Justice Ginsburg called the Court on its deep sexism. She criticized the Court for invoking “an antiabortion shibboleth for which it concededly has no reliable evidence: Women who have abortions come to regret their choices, and consequently suffer from ‘[s]evere depression and loss of esteem.’”⁹⁰

Justice Ginsburg also tied the Court’s sexism to its lack of actual concern for women making decisions under conditions of genuine informed consent. She noted that

the Court worries . . . doctors may withhold information about the nature of the intact D&E procedure. The solution the Court approves, then, is *not* to require doctors to inform women, accurately and adequately, of the different 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.⁹¹

This protective, patriarchal view of women’s autonomy, she argued, is forbidden by the Court’s gender-based jurisprudence because it “reflects ancient notions about women’s place in the family and under the Constitution—ideas that have long since been discredited.”⁹²

⁸⁸ But the Court in *Gonzales* did not always refrain from describing the nonviable fetus as a “child.” For example, the majority opinion describes the intact D&E as involving a doctor as “pierc[ing] the skull and vacuum[ing] the fast-developing brain of her unborn child, a child assuming the human form.” *Id.* at 160. As Justice Ginsburg noted in her dissent, the majority opinion describes the fetus “as an ‘unborn child’ and as a ‘baby.’” *Id.* at 187 (Ginsburg, J., dissenting) (quoting *id.* at 134, 138 (majority opinion)).

⁸⁹ *Id.* at 159 (majority opinion) (citations omitted).

⁹⁰ *Id.* at 183 (Ginsburg, J., dissenting) (alteration in original) (quoting *id.* at 159 (majority opinion)).

⁹¹ *Id.* at 184 (citations omitted).

⁹² *Id.* at 185.

This journey through the Court's abortion and equal protection jurisprudence reveals that this conceptualization of pregnant people as "mothers" is deeply rooted in the Court's reasoning in such cases, even when the Court purports to protect an individual's right to decide whether to terminate a pregnancy or purports to apply sex-based equal protection doctrine. It can serve as a reminder that these lines of jurisprudence are closely linked—as the Court has slid sex-role stereotypes about motherhood into its equality jurisprudence, those same sex-role stereotypes can be found in its abortion jurisprudence. Further, as we will also see in Part III, these sexist tropes are basic to state courts' conceptualization of tort law. The conception of pregnant persons as mothers is a core, foundational, and sexist metaphor in U.S. law at all levels of jurisprudence.

II. MISINFORMATION AS A TOOL OF COERCION

The so-called informed consent laws require doctors to subject pregnant patients to a deliberate misinformation campaign that is designed to increase the likelihood that they will carry the fetus to term rather than terminate the pregnancy.⁹³ These tactics vary but can include, as will be discussed in Part III, conveying erroneous and misleading information as well as conveying too much information that is not relevant to the medical risks posed by abortions. Plaintiffs have sought to stop these efforts by using the Court's existing abortion and free speech jurisprudence.⁹⁴ Pregnant people, as plaintiffs, have not been able to stop these coercive practices by challenging the harm to them as patients. But, in some situations, doctors have been able to attain legal relief from forced speech.⁹⁵

One of the most egregious examples of these coercive practices comes from South Dakota. Its abortion statute, passed in 2005, requires a physician to inform a pregnant woman in writing of "[a] description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including: (i) Depression and related psychological distress; [and] (ii) Increased risk of suicide ideation and suicide."⁹⁶

In other words, irrespective of the physician's own assessment of whether the pregnant woman had a medical risk of depression or suicide related to her decision to terminate her pregnancy, the physician is required to disclose in

⁹³ See Katherine Shaw & Alex Stein, *Abortion, Informed Consent, and Regulatory Spillover*, 92 IND. L.J. 1, 11 (2016) ("Thus far, fourteen states have read *Casey* to sanction heightened informed-consent requirements for abortion. Those states are Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, North Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin. Though the terms of the statutes to some extent vary, in each state doctors must inform women about the risk of postabortion depression." (footnotes omitted)).

⁹⁴ See *id.* at 9 (noting scholars' arguments along similar lines).

⁹⁵ See *Stuart v. Camnitz*, 774 F.3d 238, 256 (4th Cir. 2014).

⁹⁶ S.D. CODIFIED LAWS § 34-23A-10.1(e) (2020).

writing that depression and suicide are “known medical risks” that are “statistically significant.”⁹⁷ By contrast, doctors are not required to convey information about the risk of suicide ideation and suicide for individuals who carry a fetus to term even if they conclude, based on the individual case, that the psychological risk of harm for going to full term is greater than the risk of harm for terminating a pregnancy.

Before discussing the state’s support for its position about suicide, it is important to remember the general mental health issues that pregnant people face. Some pregnant people may consider, but ultimately reject, a decision to have an abortion and then have a miscarriage. “About 10 to 20 percent of known pregnancies end in miscarriage.”⁹⁸ After a miscarriage, individuals may feel grief, guilt, or anxiety.⁹⁹ Further, it is not true that all people feel joy during their pregnancy or when they give birth. Pregnancy and birth can trigger depression in some people.¹⁰⁰ So, pregnancy itself may have significant implications for an individual’s mental health. Thus, in the United Kingdom, where government is less coercive about reproductive decisions, the National Health Service recommends that individuals with a known mental health condition consider discussing their mental health status with a doctor or a psychiatrist *before* becoming pregnant.¹⁰¹ In South Dakota, however, state officials insist that women considering whether to have an abortion be told only about the mental health risks of abortion and not those of going to term.

Planned Parenthood unsuccessfully attempted to persuade a court to rule that those requirements violated the *Casey* undue burden standard in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*.¹⁰² The Eighth Circuit’s analysis reflects how states are allowed to use pregnant people as pawns for implementing their policy choices. While *Casey* had approved the right of the state to insist that doctors convey certain *accurate* information¹⁰³ to

⁹⁷ *See id.*

⁹⁸ *Miscarriage*, MAYO CLINIC, <https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298> [<https://perma.cc/TAU2-ENZG>] (last visited Feb. 15, 2021).

⁹⁹ *See* Antonette T. Dulay, *Miscarriage (Spontaneous Abortion)*, MERCK MANUAL: CONSUMER VERSION, <https://www.merckmanuals.com/home/women-s-health-issues/complications-of-pregnancy/miscarriage> [<https://perma.cc/3JNT-XM2H>] (last updated Oct. 2020).

¹⁰⁰ *See Mental Health in Pregnancy*, NHS, <https://www.nhs.uk/conditions/pregnancy-and-baby/mental-health-problems-pregnant/> (last updated Feb. 19, 2021).

¹⁰¹ *Id.*

¹⁰² 686 F.3d 889 (8th Cir. 2012).

¹⁰³ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992) (plurality opinion) (“To the extent *Akron I* and *Thornburgh* find a constitutional violation when the government requires, as it does here, the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth, and the ‘probable gestational age’ of the fetus, those cases go too far, are inconsistent with *Roe*’s acknowledgment of an important interest in potential life, and are overruled.”).

pregnant people for the purpose of persuading them to carry their pregnancy to term, the Eighth Circuit's analysis even threw out the accuracy requirement.¹⁰⁴

While a physician would ordinarily only be required to disclose all statistically significant medical risks of an abortion procedure, the state of South Dakota specifically mandates that those disclosures state that medical risks include an increased risk of suicide.¹⁰⁵ To comply with the *Casey* accuracy requirement, then, one would expect the state to argue that scientific evidence demonstrates that having an abortion places a woman at a greater risk of contemplating or committing suicide as compared to similarly situated pregnant women who choose to remain pregnant in the expectation that they will give birth to a child.

What kind of evidence did the state have to support its requirement? It turns out that the state had no evidence that having an abortion was a statistically significant causal factor that increased a woman's risk of committing suicide. At most, some studies showed a correlation between women having abortions and women committing suicide; the court did not even pretend that the state demonstrated causation.¹⁰⁶

Because the state purportedly had the obligation to convey only *accurate* information under *Casey*, one might have thought that the state's inability to demonstrate that its assertions were scientifically founded would be fatal to its case. However, the court concluded that state-mandated information would be presumed accurate unless the *plaintiff* could demonstrate that it was inaccurate. In order to prevail, it therefore required plaintiff Planned Parenthood "to show that abortion has been ruled out, to a degree of scientifically accepted certainty, as a statistically significant causal factor in post-abortion suicides."¹⁰⁷ Because of the difficulty with proving a negative, Planned Parenthood could not meet this high standard. Thus, women who seek abortions in South Dakota have to be told that they are at an increased risk of committing suicide. According to the Eighth Circuit, such a required statement could be understood as a way for the state "to protect its populace."¹⁰⁸

One must wonder how one could possibly conceive of a state as "protecting" women by telling them the unverifiable fact that they will increase their risk of committing suicide if they decide to have an abortion. The Eighth Circuit did

¹⁰⁴ See *Rounds*, 686 F.3d at 904.

¹⁰⁵ See *supra* text accompanying note 96 (quoting state statute).

¹⁰⁶ *Rounds*, 686 F.3d at 904 ("While the studies all agree that the relative risk of suicide is higher among women who abort compared to women who give birth or do not become pregnant, they diverge as to the extent to which other underlying factors account for that link. We express no opinion as to whether some of the studies are more reliable than others; instead, we hold only that the state legislature, rather than a federal court, is in the best position to weigh the divergent results and come to a conclusion about the best way to protect its populace.").

¹⁰⁷ *Id.* at 900.

¹⁰⁸ *Id.* at 904.

not even probe the basis on which the state could make its “protection” argument. It accepted the unsupportable proposition that a state was trying to reduce its suicide rate by telling women who are contemplating an abortion that their choice of having an abortion will increase their risk of committing suicide. In reality, South Dakota is not trying to reduce suicide; it is trying to reduce the number of women who have abortions. This is about coercing women into becoming mothers through deceit and scare tactics; this is not about protecting their well-being.

While the Eighth Circuit allowed a state to force a physician to convey unverifiable information as fact to pregnant women, the Fourth Circuit affirmed a district court decision overturning a North Carolina law that imposed similar speech obligations on physicians performing abortions on the basis of the free speech doctrine.¹⁰⁹ In this case, North Carolina insisted that pregnant women seeking abortions have an ultrasound that would allow them to see an image of the fetus while the physician describes in detail “the presence, location, and dimensions of the unborn child within the uterus and the number of unborn children depicted.”¹¹⁰ Like other states that treat pregnant women coercively, the state conveyed its view that she was already a “mother” by describing the fetus as an “unborn child.” It was clear that the state was imposing this rule to coerce women into becoming mothers by going to term with their pregnancy.

As noted, the Fourth Circuit did not use *Roe*’s abortion framework to overturn these rules because it had to abide by the rule from *Casey* that it was permissible for the state to take steps to “increas[e] the likelihood that a woman will not follow through on the decision to have an abortion.”¹¹¹ Instead, it overturned the state statute under a free speech analysis. It was the *physicians* who were the injured party under this analysis, rather than the pregnant woman who had to lie on a cot while hearing excruciating details about her “unborn child.” In other words, she had to hear that she was a murderer in the eyes of the state legislature even though *Roe* theoretically protects her right to choose to terminate her pregnancy and the Court has never concluded that the fetus is a “person.” As the Fourth Circuit noted, the statute “threaten[ed] harm to the patient’s psychological health.”¹¹² But that harm was not the basis for the statute being found unconstitutional; it was the harm to the physician’s free speech rights that were the ultimate problem.

While the free speech argument was successful in the Fourth Circuit to protect the physicians from being coerced to utter certain speech, the Supreme Court has unfortunately been clear that it is more interested in protecting antiabortion health care workers than health care workers who perform abortions. In *NIFLA*

¹⁰⁹ See *Stuart v. Camnitz*, 774 F.3d 238, 255-56 (4th Cir. 2014).

¹¹⁰ *Id.* at 243 (quoting N.C. GEN. STAT. § 90-21.85(a)(2) (2011), *invalidated by Stuart*, 774 F.3d 238).

¹¹¹ *Id.* at 250.

¹¹² *Id.*

v. Becerra,¹¹³ the Court overturned a California statute that required pregnancy-related clinics to disseminate notice of the existence of publicly funded abortion services.¹¹⁴ While invalidating this law on free speech grounds, the Court reaffirmed the holding from *Casey* that required physicians to provide certain information such as the “probable gestational age of the unborn child”¹¹⁵ and information about the possibility of financial assistance for adoption and childbirth. The Court distinguished the statute at issue in *Casey* from the California statute in *NIFLA* because, supposedly, the speech mandated by Pennsylvania was “firmly entrenched in American tort law”¹¹⁶ as part of informed consent, whereas the California statute “d[id] not facilitate informed consent to a medical procedure.”¹¹⁷ Justice Breyer wrote a strong dissenting opinion, joined by Justices Ginsburg, Sotomayor, and Kagan, in which he argued that the Court was not evenhandedly applying the holding from *Casey* to its treatment of these antiabortion pregnancy centers. “If the law in *Casey* regulated speech ‘only “as part of the *practice* of medicine,”’ so too here.”¹¹⁸ But, in any event, the free speech doctrine does not provide a cause of action to the pregnant woman; it merely protects the medical staff from being forced to utter the state’s message. And the *Casey/Becerra* distinction seems to provide more speech protection when the state is endorsing an antiabortion rather than a pro-choice perspective, even though the application of free speech doctrine is supposed to be content neutral.

Thus, current constitutional law is not conceptualized to provide relief to pregnant women from these coercive state practices. While *Casey* is generally applauded for reaffirming *Roe*, its approval of coercive communications has led to a race to the bottom for states to see what kind of misinformation they can provide to women in an attempt to convince them to maintain their natural status as mothers.

III. TORT LAW AS LEGAL RECOURSE

Because of the unsatisfactory way that constitutional law frames the injury to women in these so-called informed consent cases, tort law might be considered a viable alternative. States themselves have labeled their abortion statutes as “informed consent” statutes; thus, it seems appropriate to ask whether those statutes can, in fact, be conceptualized as violating basic principles of tort law. Two available tort tools would be medical malpractice for lack of informed

¹¹³ 138 S. Ct. 2361 (2018).

¹¹⁴ *Id.* at 2378.

¹¹⁵ *Id.* at 2373 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 881 (1992) (plurality opinion)).

¹¹⁶ *Id.* (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990)).

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 2386 (Breyer, J., dissenting) (citation omitted) (quoting *id.* at 2373 (majority opinion)).

consent and a wrongful birth claim for the harm flowing from a coerced childbirth.

A. *Informed Consent*

Informed consent, as a modern negligence theory, defines the scope of the information that a physician is supposed to convey to the patient so that the patient may make an intelligent and informed choice as to whether to consent to treatment.¹¹⁹ Some states additionally only provide a cause of action for lack of informed consent when the unrevealed risks and dangers actually materialize and are the proximate cause of the injury to the patient.¹²⁰

The American College of Obstetricians and Gynecologists's Abortion Policy states, "Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships."¹²¹ It also states that patients should be "fully informed in a balanced manner about all options" and that the information provided must be accurate and unbiased.¹²² As we will see below, many state informed consent statutes can hardly be characterized as accurate or unbiased.

An odd aspect of informed consent in the abortion context is that the state, not the physician, typically provides the information through a brochure or pamphlet. The state is acting as if it has a role in the patient's decision-making process in a medical context. Further, the pregnant individual may be harmed from the misinformation but not in the way that the harm is traditionally conceptualized. Rather than being harmed from unrevealed risks, the patient is harmed from overrevealed or misleading risks, as discussed below.

The state statutes dictating "informed consent" in the abortion context are also very narrow in their conceptualization of what kind of information must be conveyed under the supposed rubric of informed consent. Although the state statutes and brochures differ, they never share the full range of medical options and the comparative risks of each option with women. They typically report all the purported negative risks of abortion (increased risk of breast cancer and

¹¹⁹ See 4A STUART M. SPEISER, CHARLES F. KRAUSE & ALFRED W GANS, AMERICAN LAW OF TORTS § 15:71 (Monique C.M. Leahy ed., 2020) ("[T]he patient should be told the diagnosis, the general nature of the contemplated procedure, the risks involved, the prospects of success, the prognosis if the procedure is not performed, and the alternative methods of treatment, if any.").

¹²⁰ See, e.g., *Scott v. Bradford*, 606 P.2d 554, 557 (Okla. 1979) ("[I]f the physician obtains a patient's consent but has breached his duty to inform, the patient has a cause of action sounding in negligence for failure to inform the patient of his options, . . . assuming there is injury.").

¹²¹ *Abortion Policy*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy> [<https://perma.cc/745R-NLMC>] (last updated Nov. 2020).

¹²² *Id.*

depression) along with the supposed sources of assistance for women who give birth (from adoption services to child support), but they never share the common medical risks associated with childbirth, including the risks of postpartum depression and of Cesarean births.¹²³

These state-required disclosures make it more difficult for physicians to fulfill their duty of obtaining genuine informed consent. The state's required materials create confusion for pregnant people even if their doctor performed the utmost due diligence to make sure their patients had only appropriate and accurate medical information. Further, the doctor cannot correct the problem of overinformation by providing even more information.¹²⁴ While the doctor has an obligation to provide patients with appropriate medical information to guide their decision, it seems unfair to conclude that doctors have breached their duty because they cannot effectively counteract the state's misinformation *campaign*. The appropriate defendant should be the state, not the doctor.

Because the state has affirmatively indicated that it is trying to inform an individual's "consent," it makes sense to conceptualize the state as having undertaken an affirmative duty based on a special relationship. The *Restatement (Third) of Torts* provides a nonexhaustive list of situations in which an actor is understood to have an affirmative duty of reasonable care.¹²⁵ Entities that have an affirmative duty have often voluntarily entered into a relationship with a person, such as a common carrier, and such an entity is in a superior position to protect that person.¹²⁶

In this context, the state could have allowed the physician or other health care worker to take care of the informed consent obligations under traditional principles of medical malpractice. But instead, the state has voluntarily intruded into that relationship and represented itself as an expert on the issue of pregnancy and abortion. Thus, one might argue that the state has a heightened duty to convey appropriate information as part of the informed consent process since it has voluntarily intruded into a pregnant individual's autonomy to make medical decisions. It has put itself in the position of a medical practitioner by requiring that doctors convey certain information under the doctrine of informed consent. The plurality in *Casey*, in fact, understood that the state was acting as a quasimedical entity when it upheld some state-mandated disclosures, concluding that they fit within the tort doctrine of informed consent.¹²⁷ It is therefore

¹²³ See *infra* Section III.A.2 (describing state brochures in detail).

¹²⁴ Doctors already struggle with the overinformation problem due to the myriad alternative medical options that patients may have when they seek treatment.

¹²⁵ RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 40 (AM. L. INST. 2012).

¹²⁶ *Id.* at cmt. h ("A relationship identifies a specific person to be protected and thus provides a more limited and justified incursion on autonomy, especially when the relationship is entered into voluntarily.").

¹²⁷ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992) (plurality opinion).

appropriate to ask whether the expansion of those mandated communications that have occurred in the post-*Casey* era still conform with the principle of informed consent.¹²⁸

There are two ways to conceptualize the problems with the state-mandated disclosures in the name of informed consent: First, one could say that the disclosures are improper if the information is objectively in error. Entities participating in the medical decision-making process should never convey misinformation as part of that process. Second, one could say that, even if the information is not inaccurate, it may be more information than a patient would benefit from hearing to make an informed decision. Overinformation can be a detriment to making an informed decision, especially when the information is conveyed in a misleading way by sharing the risks of one procedure and ignoring the more serious risks of another available option.

Each of these kinds of problems interfere with the core understanding of the nature of informed consent. In a classic and thoughtful informed consent case, then—D.C. Circuit Judge Robinson explained: “The scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient’s informational needs and with suitable leeway for the physician’s situation.”¹²⁹ Judge Robinson counseled against informed consent rules being interpreted in a way that might seem “paternalistic” because it is a “foundation[al] principle that the patient should and ordinarily can make the choice for himself.”¹³⁰

A challenge to using the law of informed consent to seek relief from these attempts to deliberately misinform pregnant people is that their harm may be primarily psychological rather than physical. The pregnant individual may, for example, choose to have an abortion but needlessly worry about increased risk of breast cancer or depression because the state provided misleading information about those risks. Negligence law usually requires proof of physical injury to recover damages for a lack of informed consent.¹³¹ But some courts have allowed recovery for infringements on the privacy and dignity interest alone. For example, in *Lugenbuhl v. Dowling*,¹³² the patient had specifically asked the doctor to use mesh in a cardiac incisional hernia repair because he believed that the use of mesh would lessen his risk of subsequent hernias.¹³³ The doctor did

¹²⁸ Even if one concluded that these required disclosures do not conform with the principles of informed consent, one would also have to conclude that a state is a potential defendant in such a tort suit under the principles of state immunity doctrine from tort liability. That issue will vary state by state and is beyond the scope of this Article.

¹²⁹ *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

¹³⁰ *Id.* at 789.

¹³¹ *See, e.g., Mink v. Univ. of Chi.*, 460 F. Supp. 713, 720 (N.D. Ill. 1978) (“However, the only injury alleged by the plaintiffs in this count is the increased risk of cancer to their children. This is insufficient to state a claim. There is no indication in the complaint that the plaintiffs were injured by the defendants’ breach of their duty to notify.”).

¹³² 96-1575 (La. 10/10/97); 701 So. 2d 447.

¹³³ *Id.* at p. 2; 701 So. 2d at 449.

not use mesh. Although the patient did suffer subsequent hernias, the Louisiana Supreme Court concluded there was insufficient evidence to demonstrate that the subsequent injury was caused by the failure to use mesh.¹³⁴ Nonetheless, the court concluded that the doctor's failure to respect his patient's clear instruction caused "damages to plaintiff's dignity, privacy and emotional well-being."¹³⁵ The court described the doctor's treatment of his patient as "patroniz[ing]."¹³⁶ The patient was allowed to attain relief under the informed consent doctrine even though he could not demonstrate that he faced the physical harm that he feared from the use of the nonmesh procedure.

An understanding of the harm that can flow from deliberate misinformation could also be helpful in the abortion context. Individuals who choose to have abortions could sue states for this needless infliction of mental anguish through the so-called informed consent statutes when they choose to terminate a pregnancy even after hearing this misinformation. Other individuals, however, could fit into a more classic understanding of informed consent by arguing that they chose childbirth over abortion due to such misleading or erroneous information. For those people, the challenge would likely be measuring their damages. As will be discussed below, courts have struggled with whether their damages should include the costs of pregnancy, childbirth, and raising a child. This Article argues for a broad conception of their injury analogous to the remedies that are possible in some jurisdictions after a failed sterilization procedure.

1. Erroneous Information

If the purpose of informed consent is to convey information that would help the patient make an informed medical judgment, then erroneous information does not serve that purpose. It may distract patients from considering the actual medical risks and cause them, instead, to make decisions based on unsubstantiated medical risks. Or it may cause them to experience needless anxiety as a consequence of making their medical decision.¹³⁷

For example, one tactic to persuade individuals to go to term rather than have an abortion is to tell them that having an abortion will place them at higher risk of breast cancer. The Texas brochure, which physicians are required to provide, states: "If you give birth to your baby, you are less likely to develop breast cancer

¹³⁴ *Id.* at p. 13-14; 701 So. 2d at 455.

¹³⁵ *Id.* at p. 14; 701 So. 2d at 455.

¹³⁶ *Id.*

¹³⁷ This problem could also be conceived as the tort of negligent misrepresentation. While misrepresentation can be its own separate tort, it is also common for misrepresentation to be an element of another tort. In the classic torts example, a battery is committed by feeding plaintiff poisoned chocolate where the person is induced to eat the chocolate, not knowing it is poisonous. We would still call it a battery even though there is an element of misrepresentation. See WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 105, at 683-84 (4th ed. 1971).

in the future. Research indicates that having an abortion will not provide you this increased protection against breast cancer.”¹³⁸ Upon examining the data linking abortion to breast cancer, the *Washington Post* gave this claim “Three Pinocchios” in 2016, but the statements remain in the state’s informational book that must be made available to all individuals seeking abortions in Texas.¹³⁹ And, like all the state statutes restricting an individual’s right to terminate their pregnancy, the state brochure describes the fetus as a “baby” from the moment of conception.¹⁴⁰

This kind of problem is not classically remedied by informed consent doctrine. In the typical informed consent case, patients are *not* told about a medical risk stemming from a procedure. They have the procedure, experience the harm that they were not told might occur, and then argue that the lack of informed consent induced them to consent to a risky procedure from which damage actually resulted.¹⁴¹

In the abortion context, however, a patient *is* told about a medical risk stemming from a procedure even though there is no evidence that the risk is actually the kind of statistically significant risk that doctors are obligated to convey to patients. Further, the so-called risk—in this example, breast cancer—is not one that the patient would experience during or immediately after the procedure. The patient might follow through and have the procedure despite being concerned about the risk. Even though undergoing the procedure did not statistically increase the likelihood that she would experience cancer, she now will have increased anxiety about that possibility for many years. The conveyance of the information itself, rather than the medical procedure, created a psychological harm.

If the policy underlying informed consent rules is to prevent patronizing doctors from making risk calculations for their patients, then it would seem that the same policy counsels in favor of creating a cause of action for the

¹³⁸ TEX. DEP’T OF STATE HEALTH SERVS., A WOMAN’S RIGHT TO KNOW: INFORMATIONAL MATERIAL 9 (2016), <https://hhs.texas.gov/sites/default/files/documents/services/health/women-children/womans-right-to-know.pdf> [<https://perma.cc/58SC-H4XR>] [hereinafter TEX. BROCHURE].

¹³⁹ Michelle Ye Hee Lee, *Texas State Booklet Misleads Women on Abortions and Their Risk of Breast Cancer*, WASH. POST (Dec. 14, 2016, 3:00 AM), <https://www.washingtonpost.com/news/fact-checker/wp/2016/12/14/texas-state-booklet-misleads-women-on-abortions-and-their-risk-of-breast-cancer/> [<https://perma.cc/4TG6-MM3U>] (claiming that the brochure’s cherry-picked information creates a misleading impression, resulting in the designation of “Three Pinocchios”).

¹⁴⁰ See, e.g., TEX. BROCHURE., *supra* note 138, at 2 (describing “baby’s weight” as less than one ounce at two weeks after conception).

¹⁴¹ See *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir. 1972); see also *Lugenbuhl*, 96-1575, p. 12; 701 So.2d at 454 (“Although the patient has the absolute right, for whatever reason, to prevent unauthorized intrusions and treatments, he or she can only recover damages for those intrusions in which consent would have been reasonably withheld if the patient had been adequately informed.”).

psychological harm from state-mandated deliberate misinformation. Concerns about breast cancer are common for women; it seems exceptionally cruel to provoke this kind of anxiety by delivering misinformation to women as part of their decision-making process. The harm is not that they may go to term rather than have an abortion; the harm is that they will face increased anxiety about a fake risk. A state should not be able to deliberately impose that kind of harm on pregnant women who choose to exercise their constitutional right to terminate their pregnancies.

While researchers have not precisely studied the psychological harm to pregnant women who choose to terminate their pregnancies despite being misinformed about a heightened breast cancer risk, some existing research helps demonstrate the existence of that harm. This research is based on women who have an *actual* risk of breast cancer and experience psychological distress in learning of that risk. Because they have an actual risk, it is not medical malpractice to inform them of the risk. In the informed consent context, however, pregnant people are being misinformed about a risk they do not actually have, and thus there is no medical reason for them to be exposed to psychological harm through the dissemination of false information.

Two pieces of research support the unsurprising conclusion that patients experience psychological distress when informed of a heightened breast cancer risk. First, of the individuals that choose genetic counseling to learn if they have a heightened risk of breast cancer, 6.4% of patients had a “distress response” to learning they have a heightened risk.¹⁴² Second, the medical literature supports the conclusion that the risk of anxiety and depression is higher among breast cancer survivors than among women who have never received a breast cancer diagnosis.¹⁴³

Because of those well-known results from medical studies, genetic counselors sometimes hesitate to report secondary findings of heightened risk from genetic profiles: findings regarding conditions for which the patient did not seek counseling. While most counselors do report secondary findings to patients, they are also aware of and concerned about secondary findings causing anxiety or other psychological harm.¹⁴⁴

¹⁴² See K.M. Broady, K.E. Ormond, E.J. Topol, N.J. Schork & Cinnamon S. Bloss, *Predictors of Adverse Psychological Experiences Surrounding Genome-Wide Profiling for Disease Risk*, 9 J. CMTY. GENETICS 217, 221 (2018).

¹⁴³ See Helena Carreira, Rachael Williams, Martin Müller, Rhea Harewood, Susannah Stanway & Krishnan Bhaskaran, *Associations Between Breast Cancer Survivorship and Adverse Mental Health Outcomes: A Systematic Review*, 110 J. NAT’L CANCER INST. 1311, 1313 (2018); Helena Carreira, Rachael Williams, Garth Funston, Susannah Jane Stanway & Krishnan Bhaskaran, *Risk of Anxiety and Depression in Breast Cancer Survivors Compared to Women Who Have Never Had Cancer: A Population-Based Cohort Study in the United Kingdom*, J. CLINICAL ONCOLOGY (May 26, 2019), https://ascopubs.org/doi/abs/10.1200/JCO.2019.37.15_suppl.1564 (finding statistically significant results in the first three years following diagnosis).

¹⁴⁴ Michael P. Mackley, Benjamin Fletcher, Michael Parker, Hugh Watkins & Elizabeth

In the abortion context, patients have generally not even asked about an increased breast cancer risk. They did not choose to engage in genetic profiling. And, further, there is no credible evidence that having an abortion raises one's breast cancer risk. Yet, some states require the pregnant person to receive that erroneous information and do not allow the doctor to evaluate the effect such information might have on a patient's emotional well-being.

A second type of misinformation found in some informed consent statutes is the statement that having an abortion will increase someone's level of depression or anxiety. Utah is one state that features such misinformation in its informed consent statute.¹⁴⁵ A study found that patients' endorsement of this piece of misinformation increased after being exposed to the state-mandated material.¹⁴⁶ Not surprisingly, patients seemingly assume that materials they receive from the state will be accurate and trustworthy.

States should face liability for deliberately imposing emotional harm on pregnant people as part of their medical decision-making. It is clear that such information will heighten a patient's anxiety and that the information serves no useful medical purpose since it is also inaccurate.

As discussed in Section III.A, it can be difficult to recover damages for emotional distress alone. A 2011 decision by the D.C. Court of Appeals, however, suggests how a successful cause of action in the health care context could be brought under the negligent infliction of emotional distress tort.¹⁴⁷ Plaintiff Terry Hedgepeth was erroneously told that he was HIV positive. Five years later, he learned that diagnosis was inaccurate.¹⁴⁸ He suffered from clinical depression and repercussions in his employment and personal life during those five years.¹⁴⁹ Reversing the Superior Court, the Court of Appeals concluded that Hedgepeth's claim "should not be barred simply because he was not put at risk of physical injury."¹⁵⁰ The court imposed a high standard of proof, requiring the plaintiff to show that "serious emotional distress is especially likely to be caused by the defendant's negligence."¹⁵¹

In *Hedgepeth*, the plaintiff sought testing to determine if he was HIV positive, and the doctor had a responsibility to conduct that testing nonnegligently. In the abortion context, the pregnant person is seeking abortion services. She has not

Ormondroyd, *Stakeholder Views on Secondary Findings in Whole-Genome and Whole-Exome Sequencing: A Systematic Review of Quantitative and Qualitative Studies*, 19 GENETICS MED. 283, 286 (2017).

¹⁴⁵ Nancy F. Berglas, Heather Gould, David K. Turok, Jessica N. Sanders, Alissa C. Perrucci & Sarah C.M. Roberts, *State-Mandated (Mis)Information and Women's Endorsement of Common Abortion Myths*, 27 WOMEN'S HEALTH ISSUES 129, 133 (2017).

¹⁴⁶ *Id.*

¹⁴⁷ See *Hedgepeth v. Whitman Walker Clinic*, 22 A.3d 789, 792 (D.C. 2011) (en banc).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

asked to learn about her susceptibility to depression or breast cancer. The state is gratuitously requiring misinformation to be conveyed to her for no appropriate medical reason. While not perfectly analogous to *Hedgepeth*, medical misinformation has the potential to cause significant emotional distress on pregnant women who choose to terminate their pregnancies despite this alarming misinformation about their prognosis.

2. Too Much Information

In a patient-centered approach to informed consent,¹⁵² the physician should provide information that the physician believes would be helpful to that particular patient in making her medical decisions. Because fetal development is irrelevant to the patient's medical risks from terminating her pregnancy, one could imagine that many pregnant patients would have no interest in hearing about fetal development. In a state that otherwise takes a patient-centered approach, it is contrary to that approach for patients to be flooded with information they do not consider relevant. It may make it hard for them to process the information that *is* relevant.

According to medical experts, overinformation harms or weakens a person's informed consent. Patients may be "overwhelmed by the complexity, uncertainty, or volume of information involved in the decision," making informed consent "impossible."¹⁵³ Thus, medical experts recommend providing patients with "digestible chunks" of information and only sharing what is "necessary for prevention of serious harms."¹⁵⁴

While there is no case law from the abortion context that considers the argument that it is inappropriate to flood patients with information when they are considering whether to terminate a pregnancy, such an argument has arisen in products liability law. The products liability argument is that too much information can be difficult to process cognitively, so overinformation can cause a consumer to be unaware of a product's defect.¹⁵⁵ In the field of psychology,

¹⁵² Courts are divided over whether they should use a patient-centered or physician-centered approach. *See generally* *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (introducing the patient-focused conception of informed consent). The informed consent statutes discussed in this Article are arguably inconsistent with either approach because they are dictating a physician-centered approach, irrespective of whether the physician or patient considers that information relevant to the medical, decision-making process. From a patient-centered approach, it limits a woman's autonomy to guide what kind of information she may find helpful. *See, e.g.,* *Sard v. Hardy*, 379 A.2d 1014, 1022 (Md. 1977) (applying a patient-centered approach to determining what information should have been disclosed before performance of tubal ligation).

¹⁵³ Johan Bester, Cristie M. Cole & Eric Kodish, *The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm*, 18 *AMA J. ETHICS* 869, 876 (2016).

¹⁵⁴ *Id.* at 875, 882.

¹⁵⁵ *See* Howard Latin, "Good" Warnings, Bad Products, and Cognitive Limitations, 41 *UCLA L. REV.* 1193, 1212 (1994); *see also* *Ford Motor Credit Co. v. Milhollin*, 444 U.S. 555,

studies have demonstrated that information overload, specifically information overload through irrelevant information, causes individuals to make worse decisions.¹⁵⁶

Let us keep in mind the states' tactics here. Many states, as will be discussed below, require pregnant people who are considering terminating their pregnancy to receive glossy brochures that detail fetal development with inaccurately large photos of the fetus. These brochures say little or nothing about the comparative health risk of abortion versus childbirth. These brochures are distributed to patients for the purpose of persuading them to go to term rather than terminate their pregnancy.

In addition to these glossy brochures, one has to assume (or hope) that the patient has also received balanced, accurate information about the medical risks of abortion and childbirth. But, remember, going back to *Casey*, the Supreme Court approved the state's requirement that medically irrelevant information about fetal development be provided to the individual considering abortion. The Court opened the door to these glossy brochures.

In the products liability context, Professor Howard Latin has argued that the duty to warn case law should be based on cognitive science's understanding of human behavior.¹⁵⁷ After reviewing the relevant cognitive science literature, he concluded that "'too much' information makes it more difficult for people to select the most important features for consideration. Under this view, 'too much' information can be just as much of an impediment to effective user comprehension of product hazards as 'too little' knowledge would be."¹⁵⁸ In this context, one can imagine that the same cognitive science research would lead to the conclusion that the states' glossy brochures impede rather than enhance the informed consent process because pregnant people are likely distracted from thinking about the genuine medical risks of choosing to terminate a pregnancy if they have to plow through dozens of pages of blown-up fetuses to receive that information.

A similar argument has been made in the medical informed consent context, in which doctors have argued that it is in their patients' interests for them to be given less, rather than more, information as part of the informed consent process. Doctors have used this argument to defend their decision not to share with a

568 (1980) ("*Meaningful* disclosure does not mean *more* disclosure. Rather, it describes a balance between 'competing considerations of complete disclosure . . . and the need to avoid . . . [informational overload].'" (alterations in original) (quoting S. REP. NO. 96-73, at 3 (1979))); *Liriano v. Hobart Corp.*, 700 N.E.2d 303, 308 (N.Y. 1998) ("Requiring too many warnings trivializes and undermines the entire purpose of the rule, drowning out cautions against latent dangers of which a user might not otherwise be aware.").

¹⁵⁶ See, e.g., Anthony Bastardi & Eldar Shafir, *On the Pursuit and Misuse of Useless Information*, 75 J. PERSONALITY & SOC. PSYCH. 19, 24 (1998).

¹⁵⁷ Latin, *supra* note 155, at 1241.

¹⁵⁸ *Id.* at 1212. He also notes: "I have found no social science discussion of information overload which concludes that excessive information will not degrade the *quality*, as opposed to the likelihood, of consumer choice." *Id.* at 1214-15.

patient all possible alternative treatment options. Krista Sterken and her coauthors considered the proper scope of disclosures by physicians with regard to possible alternative treatment options.¹⁵⁹ They argued that “[o]ne of the potential costs associated with requiring disclosures about an excluded diagnosis is impaired medical decision-making. . . . Flooding a patient with low quality information can have a deleterious effect on the quality of decision-making.”¹⁶⁰ After reviewing empirical studies, they support a “less is more” approach to informed consent disclosures.¹⁶¹

By analogy, one could imagine that a doctor who performs abortions would prefer not to be required to hand a pregnant person the state’s mandated brochure as part of the informed consent process. The problem of too much information is different in the abortion context than in the products liability or traditional informed consent process because, in the abortion context, the disinformation problem arises from the state flooding the patient with information that the physician would consider medically irrelevant to the decision whether to terminate a pregnancy.¹⁶² A survey of some states’ “informed consent” materials can help make that argument clear. The medical risks of childbirth as compared to abortion are typically buried at the end of glossy brochures that provide fetal images (often described as an “unborn child”) that are larger than the actual fetus¹⁶³ and shown in isolation from a pregnant person’s body. In alphabetical order, here is a description of state brochures typically produced as required by “right to know” statutes.¹⁶⁴

¹⁵⁹ See Krista J. Sterken, Michael B. Van Sicklen & Norman Fost, *Mandatory Informed Consent Disclosures in the Diagnostic Context: Sometimes Less Is More*, 17 N.Y.U. J. LEGIS. & PUB. POL’Y 103, 106 (2014).

¹⁶⁰ *Id.* at 123-24 (“Although our market economy assumes that more information is better, evidence from decision-making research demonstrates conclusively that more information does not always improve decision-making; in fact, it can undermine it.” (quoting Judith H. Hibbard & Ellen Peters, *Supporting Informed Consumer Health Care Decisions: Data Presentation Approaches that Facilitate the Use of Information in Choice*, 24 ANN. REV. PUB. HEALTH 413, 416 (2003))).

¹⁶¹ *Id.* at 125.

¹⁶² That is why physicians brought free speech actions against the state when they were required to directly convey this inaccurate or irrelevant information through their own words. See *supra* Part II (discussing Fourth Circuit and Eighth Circuit opinions). To get around those free speech problems, the state conveys the speech through their glossy brochures as part of the so-called informed consent process.

¹⁶³ Most states use medical illustrations developed by Peg Gerrity. To see examples of these images, see *Pregnancy Images*, PEG GERRITY, <https://www.peggerrity.com/pregnancy-images/> [<https://perma.cc/7RM9-P3S8>] (last visited Feb. 15, 2021). The commonality of the illustrator suggests a concerted effort by these states to use distorted images as part of a national campaign to coerce women to go to term rather than have abortions.

¹⁶⁴ States, such as California and New York, that do not seek to coerce pregnant women into continuing with their pregnancies do not have any brochures at all on their state websites. They presumably expect physicians to comply with general principles about informed consent before terminating a woman’s pregnancy.

Alabama. The “Did You Know” brochure¹⁶⁵ is thirty-three pages in length and was required by Alabama Act No. 2002-419.¹⁶⁶ It begins with a description of the “developmental characteristics of an unborn child” and then discusses “abortion methods and risks.”¹⁶⁷ Pages five to fourteen include medical illustrations of the embryo in which the embryo is depicted larger than its actual size, ranging from two to thirty-eight weeks gestation.¹⁶⁸ These medical illustrations were done by Lennart Nilsson.¹⁶⁹ On page sixteen, the reader is then provided one page on the “risks of pregnancy” in which none of the risks is quantified.¹⁷⁰ Starting on page seventeen, the reader is provided seven pages of information on “abortion methods and risks.”¹⁷¹ None of these risks is quantified, although many of them are described as “common.”¹⁷² The final seven pages include discussion of adoption, the father’s duty to assist in the support of a child, and birth control options.¹⁷³ The brochure ends with a list of public resources available to assist with the costs of adopting or raising a child; there is no discussion of any providers in the state who might perform an abortion. So, in this thirty-three-page brochure, the information about the medical risks of childbirth are buried in the middle (on page sixteen) while the overwhelming bulk of the brochure is devoted to detailed discussion of the “unborn child” and the medical risks associated with abortion.

¹⁶⁵ See ALA. CODE § 26-23A-5(C) (2002), *invalidated by* Summit Med. Ctr. of Ala., Inc. v. Riley, 284 F. Supp. 2d 1350 (M.D. Ala. 2003); ALA. DEP’T OF PUB. HEALTH, DID YOU KNOW... 2 (2003) [hereinafter ALA. BROCHURE], <http://adph.org/HEALTHCAREFACILITIES/assets/DidYouKnowBooklet.pdf> [https://perma.cc/95P4-RRX5].

¹⁶⁶ The last sentence of Alabama Code Section 26-23A-5(C) was held unconstitutional as it violated the clinics’ free speech rights in *Summit Medical Center of Alabama, Inc. v. Riley*, 284 F. Supp. 2d 1350, 1360 (M.D. Ala. 2003), because it required clinics to contribute money to pay for the brochure. The brochure, however, is still available on the state’s website and can be distributed at abortion clinics so long as the clinic does not need to pay to produce the materials.

¹⁶⁷ See ALA. BROCHURE, *supra* note 165, at 3.

¹⁶⁸ *Id.* at 5-14.

¹⁶⁹ *But see supra* note 163.

¹⁷⁰ See ALA. BROCHURE, *supra* note 165, at 16.

¹⁷¹ See *id.* at 17-24.

¹⁷² *But see* NAT’L ABORTION FED’N, SAFETY OF ABORTION 1 (2006), https://prochoice.org/wp-content/uploads/safety_of_abortion.pdf [https://perma.cc/FV46-AJ94] (“Surgical abortion is one of the safest types of medical procedures. Complications from having a first-trimester aspiration abortion are considerably less frequent and less serious than those associated with giving birth.”). Abortions that are unsafe are *illegal abortions*. “Around the world, in countries where abortion is illegal, it remains a leading cause of maternal death. An estimated 68,000 women worldwide die each year from unsafe abortions.” *Id.*

¹⁷³ See ALA. BROCHURE, *supra* note 165, at 25-33.

Arizona. “A Women’s [sic] Right to Know” brochure¹⁷⁴ is twenty-three pages in length and was required by Arizona H.B. 2036 in 2012.¹⁷⁵ The fetus is described as an “unborn child” throughout the brochure.¹⁷⁶ It begins with six pages of medical illustrations of the fetus from four to forty weeks gestation.¹⁷⁷ While the description notes the actual size of the fetus (e.g., “less than 1/4 inch”), all the photos are three inches by three inches in size.¹⁷⁸ There are then six pages of discussion of the abortion procedure with an emphasis on health risks.¹⁷⁹ These include a full page of medical risks that may occur when a woman has an abortion with no quantification of those risks.¹⁸⁰ There are statistics about the mortality risks of abortion.¹⁸¹ About one and a half pages are devoted to the risks of childbirth.¹⁸² For both a vaginal and Cesarean birth, the last bullet point says “[r]arely, death” as a possible side effect.¹⁸³ After the discussion of the risks of childbirth, several pages inform the reader about the public assistance they may receive if they give birth; however, there is no mention of where to obtain a free or low-cost abortion.¹⁸⁴ An individual would have to read to page sixteen to learn anything about the medical risks of childbirth.

Georgia. “Abortion: A Woman’s Right to Know” brochure¹⁸⁵ is thirty-six pages in length and was required by the Georgia “Woman’s Right to Know” Act.¹⁸⁶ The brochure begins with fourteen pages of medical illustrations discussing fetal development from two to forty weeks gestation. The reader is then presented with an eight-page section titled, “Abortion Methods & Their Associated Medical Risks.”¹⁸⁷ The risk of death is not quantified; instead, a patient is told: “The risk of a mother dying as a result of an induced abortion increases with the length of pregnancy.”¹⁸⁸ This brochure describes the fetus as

¹⁷⁴ See ARIZ. DEP’T OF HEALTH SERVS., A WOMEN’S RIGHT TO KNOW 2 [hereinafter ARIZ. BROCHURE], <https://www.azdhs.gov/documents/prevention/womens-childrens-health/informed-consent/a-womans-right-to-know.pdf> [<https://perma.cc/NC98-S6SW>] (last visited Feb. 15, 2021).

¹⁷⁵ H.B. 2036, 50th Leg., 2nd Reg. Sess. (Ariz. 2012) (codified in scattered sections of ARIZ. REV. STAT. ANN. § 36 (2020)).

¹⁷⁶ See generally ARIZ. BROCHURE, *supra* note 174.

¹⁷⁷ *Id.* at 3-9.

¹⁷⁸ See *id.* at 4.

¹⁷⁹ *Id.* at 10-15.

¹⁸⁰ *Id.* at 13.

¹⁸¹ *Id.* at 14.

¹⁸² *Id.* at 16-17.

¹⁸³ *Id.* at 16.

¹⁸⁴ *Id.* at 18-21.

¹⁸⁵ See GA. DEP’T OF PUB. HEALTH, ABORTION: A WOMAN’S RIGHT TO KNOW 2 (2016) [hereinafter GA. BROCHURE], <https://dph.georgia.gov/womens-right-know-wrtk>.

¹⁸⁶ H.B. 197, 2005 Leg., Reg. Sess. (Ga. 2005) (codified at GA. CODE ANN. § 31-9A-1 to -8 (2020)).

¹⁸⁷ GA. BROCHURE, *supra* note 185, at 16.

¹⁸⁸ *Id.*

an “unborn child”¹⁸⁹ and the pregnant woman who has an abortion as a “mother.”¹⁹⁰ If the reader gets through the eight pages on the medical risks associated with an abortion, then she will find a page on the “[m]edical [r]isks of [p]regnancy and [c]hildbirth.”¹⁹¹ Death is described as a “rare event[.]”¹⁹² The brochure ends with resources that are available to help a woman give birth and raise a child. There is no discussion of any abortion resources. An individual who stops reading before page twenty-seven will miss the discussion of the medical risks of pregnancy and childbirth.

Indiana. “Abortion Informed Consent Brochure”¹⁹³ is fifteen pages in length and is required by the Indiana Code.¹⁹⁴ “At least eighteen (18) hours before the abortion[,] . . . the physician who is to perform the abortion . . . [is required to] provide[] the pregnant woman with a color copy of the informed consent brochure.”¹⁹⁵ The brochure includes over five pages of descriptions and medical illustrations of the fetus from two to forty weeks gestation.¹⁹⁶ Unlike those in other state brochures, these photos are a little smaller than two inches by two inches. The brochure includes four pages on the risks of having an abortion with death listed as one of the nonquantified possibilities. The brochure also contains about a half of a page describing “pregnancy risks,” with each of these risks statistically quantified.¹⁹⁷ An individual would only read about those risks if she got to page ten of the fifteen-page brochure.¹⁹⁸ Information about assistance with pregnancy, childbirth, and adoption is provided,¹⁹⁹ but there is no mention of how to access abortion services.

Kansas. “If You Are Pregnant” brochure²⁰⁰ is thirty-two pages in length and is required by the Kansas “Woman’s Right-to-Know Act.”²⁰¹ Its cover features a blown-up nine-week fetus.²⁰² It has eleven pages of medical illustrations and

¹⁸⁹ *Id.* at 20.

¹⁹⁰ *E.g., id.* at 11.

¹⁹¹ *Id.* at 22.

¹⁹² *Id.*

¹⁹³ *See* IND. STATE DEP’T OF HEALTH, ABORTION INFORMED CONSENT BROCHURE (2020) [hereinafter IND. BROCHURE], https://www.in.gov/isdh/files/Abortion_Informed_Consent_Brochure.pdf [<https://perma.cc/N67B-2TDV>].

¹⁹⁴ IND. CODE § 16-34-2-1.5 (2020).

¹⁹⁵ *Id.* § 16-34-2-1.1(a)(4).

¹⁹⁶ *See* IND. BROCHURE, *supra* note 193, at 2-6.

¹⁹⁷ *See id.* at 10.

¹⁹⁸ *Id.*

¹⁹⁹ *See id.* at 11-13.

²⁰⁰ *See* KAN. DEP’T OF HEALTH & ENV’T, IF YOU ARE PREGNANT [hereinafter KAN. BROCHURE], http://www.womansrighttoknow.org/download/Handbook_English.pdf [<https://perma.cc/S9PW-AJKF>] (last visited Feb. 15, 2021).

²⁰¹ H.B. 2253, 2013 Leg., Reg. Sess. (Kan. 2013) (codified at scattered sections of KAN. STAT. ANN. §§ 65, 76, 79 (2020)).

²⁰² *See* KAN. BROCHURE, *supra* note 200, at 1.

describes the fetus from two to forty weeks gestation.²⁰³ Unlike some other states, which have language accompanying the photos that use terms like fetus, embryo, or zygote, Kansas uses the term “unborn child” throughout its brochure.²⁰⁴ It also magnifies the images to show the skull in some cases to make the fetus appear more childlike.²⁰⁵ The brochure contains eleven pages on the medical risks of abortion.²⁰⁶ Under the long-term medical risks of abortion, it lists complications with future childbearing and breast cancer.²⁰⁷ The discussion under the heading “Breast Cancer” is somewhat balanced but one could imagine that this heading under the topic of “Long-Term Medical Risks” might cause a reader to assume that the breast cancer discussion will be fairly dire. Under the heading “Psychological Risk of Abortion,” the state only lists negative effects.²⁰⁸ If the reader reaches page twenty-eight of the Kansas brochure, then she may learn of the “medical risks of childbirth,” but she is reassured that “[c]ontinuing a pregnancy and delivering a baby is usually a safe, healthy process.”²⁰⁹ There is no reference to postpartum depression. And, of course, readers are told about adoption and childbirth resources but not about any abortion-related resources.²¹⁰

Louisiana. “Women’s Right to Know” brochure²¹¹ is twenty-four pages in length and was required by the Louisiana “Women’s Right to Know Law.”²¹² The brochure begins with ten pages of graphic three-inch-by-three-inch medical illustrations of the fetus from two to forty-one weeks gestation.²¹³ These images are next to descriptions that might state that the embryo is only one-sixth or one-half inch in length.²¹⁴ The word “baby” is used to describe these images beginning with week six when the embryo is only one-half inch in length.²¹⁵ There are then eight pages of descriptions of the medical risks of abortion.²¹⁶

²⁰³ *Id.* at 7-16.

²⁰⁴ *E.g., id.* at 3.

²⁰⁵ *E.g., id.* at 12-14.

²⁰⁶ *Id.* at 17-22, 24-27.

²⁰⁷ *Id.* at 26.

²⁰⁸ *Id.* at 27. Other states, such as Arizona, are more balanced in discussing the possible psychological effects and make statements such as: “Women may have both positive and negative feelings after having an abortion.” *See, e.g.,* ARIZ. BROCHURE, *supra* note 174, at 15.

²⁰⁹ KAN. BROCHURE, *supra* note 200, at 28.

²¹⁰ *See id.* at 30.

²¹¹ *See* LA. DEP’T OF HEALTH & HOSPS., ABORTION: WOMEN’S RIGHT TO KNOW [hereinafter LA. BROCHURE], <http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf> [<https://perma.cc/G8YZ-8FHR>] (last visited Feb. 15, 2021).

²¹² Act 411, 2011 Leg., Reg. Sess. (La. 2011) (codified at LA. STAT. ANN. § 40:1061.17(2020)); Act 569, 2014 Leg., Reg. Sess. (La. 2014) (codified at LA. STAT. ANN. § 40:1061.16, .19, .23 (2020)).

²¹³ *See* LA. BROCHURE, *supra* note 211, at 5-14.

²¹⁴ *Id.* at 6.

²¹⁵ *Id.*

²¹⁶ *Id.* at 15-22.

There is also a suggestion that breast cancer may be a heightened risk for women who have abortions and a suggestion that a woman seeking to terminate her pregnancy should discuss a “family history of breast cancer or clinical findings of breast disease” with her doctor before making an abortion decision.²¹⁷ With respect to pregnancy, a page and a half of material begins at page twenty-two with the reader reassured that “continuing a pregnancy and delivering a baby is usually a safe, healthy process.”²¹⁸ There is no information provided on how to obtain an abortion, but it mentions resources to assist women who go to term with their pregnancies.²¹⁹

North Carolina. “A Woman’s Right to Know” brochure²²⁰ is twenty-eight pages in length and is required by the North Carolina “A Woman’s Right to Know Act.”²²¹ It contains three-inch-by-three-inch medical illustrations of the fetus from two to forty weeks gestation.²²² Even though the description, for example, of a six- to eight-week embryo says that the embryo is less than one-fourth inch in length, the displayed image is three inches in length (twelve times the actual size of the embryo).²²³ Discussion of the abortion procedure does not begin until page seventeen. The brochure then discusses all the possible medical risks of having an abortion for four pages.²²⁴ The brochure says that for women who choose medical abortions, “three of 1000 will have a major complication requiring hospital admission, surgery or blood transfusion.”²²⁵ The brochure then offers a comparison between the risks of abortion and delivery.²²⁶ While

²¹⁷ *Id.* at 21.

²¹⁸ *Id.* at 22.

²¹⁹ *See id.* at 24.

²²⁰ N.C. DEP’T OF HEALTH & HUM. SERVS., A WOMAN’S RIGHT TO KNOW (2015) [hereinafter N.C. BROCHURE], <https://www.wrtk.ncdhhs.gov/library/doc/AWomansRightToKnow-Web.pdf> [<https://perma.cc/U4DR-DZWR>].

²²¹ 2011 N.C. Sess. Laws 405 (codified at N.C. GEN. STAT. § 90-21.80 to .92 (2020)).

²²² N.C. BROCHURE, *supra* note 220, at 4-15.

²²³ *Id.* at 6.

²²⁴ *Id.* at 17-20.

²²⁵ *See id.* at 18. In fact, researchers have found that only 1 in 10,000 women who have had any kind of abortion make emergency room visits following the abortion and, of those women, half were sent home with no medical treatment at all. *See* Lisa Rapaport, *Few U.S. Women Have Serious Complications After Abortions*, REUTERS (July 11, 2018, 5:38 PM), <https://www.reuters.com/article/us-health-abortion-safety/few-u-s-women-have-serious-complications-after-abortions-idUSKBN1K1300> [<https://perma.cc/S6XP-BBKX>]. Only 1 in 5 “involve[] a major complication that require[s] an overnight hospital stay, a blood transfusion or surgery.” *Id.*; *see also* Laura Kurtzman, *Major Complication Rate After Abortion Is Extremely Low, Study Shows*, UNIV. CAL S.F. (Dec. 8, 2014), <https://www.ucsf.edu/news/2014/12/121781/major-complication-rate-after-abortion-extremely-low-study-shows> [<https://perma.cc/4R4B-Z54S>] (reporting low rates of complications for women receiving abortions under state-funded Medicaid program). In other words, the accurate figure would be 1 in 50,000 (0.00002%) rather than 1 in 10,000 (0.0001%) for all kinds of abortions.

²²⁶ *See* N.C. BROCHURE, *supra* note 220, at 21-22.

acknowledging that the mortality rate for abortion is lower than the mortality rate for childbirth, the brochure emphasizes “that women undergoing abortion should be informed about the subsequent risk of depression” and that “[t]here is evidence induced abortion may lead to an increased risk of premature birth in a later pregnancy.”²²⁷

North Dakota. “Information About Pregnancy and Abortion” brochure²²⁸ is eighteen pages in length and is required by North Dakota Century Code.²²⁹ The fetus is described as an “unborn child.”²³⁰ It includes two-inch-by-two-inch medical illustrations of the fetus from four to forty-two weeks gestation. Although the description may say, for example, that the “fetus is about the size of a brussel sprout,”²³¹ the actual photos make the fetus appear much larger. A comment at the bottom of these pages reads, “Pictures do not represent the actual size of the developing child.”²³² Unlike most states, the risks of pregnancy and childbirth are discussed *after* the six pages of fetal development. And these risks are quantified. Abortion is not discussed until page sixteen. When the medical risks of abortion are mentioned, there is a heading with the phrase, “Breast cancer.”²³³ The text acknowledges that three professional organizations have concluded that there is no relationship between induced abortion and increased breast cancer risk, but it also states that “other studies suggest there is an increased risk.”²³⁴ One could imagine that the header and reference to “other studies” might give a reader an inaccurate sense of the breast cancer risk. The mental health discussion, unlike that in North Carolina’s brochure, does state that “[f]eelings can be both positive and negative.”²³⁵

²²⁷ *Id.* at 22. The premature birth finding has been widely criticized, but the brochure devotes extensive discussion to the consequences of premature births, such as increased risk of having a child born with severe developmental disabilities. It does not, however, mention recent studies that have found no relationship between a history of induced abortion and low-birth-weight babies in subsequent birth. *See generally* LI KE, WEIYAN LIN, YANGQI, LIU, WEILIN OU & ZHIFENG LIN, ASSOCIATION OF INDUCED ABORTION WITH PRETERM BIRTH RISK IN FIRST-TIME MOTHERS (2018), <https://www.nature.com/articles/s41598-018-23695-7> [<https://perma.cc/D6Q5-LRNF>]. The purpose of the discussion appears to be to persuade and confuse rather than to offer balanced information to inform consent.

²²⁸ The brochure now is only available upon request to the state department of health’s website. *See Information About Pregnancy and Abortion*, N.D. HEALTH, <http://www.ndhealth.gov/NutrPhyAct/InformationAboutPregnancyandAbortionOrderForm.aspx> [<https://perma.cc/VGQ7-MZMX>] (last visited Feb. 15, 2021); N.D. DEP’T OF HEALTH, INFORMATION ABOUT PREGNANCY AND ABORTION (2016) [hereinafter N.D. BROCHURE] (on file with author).

²²⁹ N.D. CENT. CODE § 14-02.1-02.1 (2019).

²³⁰ N.D. BROCHURE, *supra* note 228, at 2.

²³¹ *Id.* at 6.

²³² *Id.* at 5-10.

²³³ *Id.* at 17.

²³⁴ *Id.*

²³⁵ *Id.* at 18.

Oklahoma. “A Woman’s Right to Know” brochure²³⁶ is twenty pages in length and was required by an Oklahoma statute.²³⁷ The fetus is described as an “unborn child.”²³⁸ The brochure includes three-inch-by-three-inch medical illustrations of fetal development from two to forty weeks gestation, even when the textual description says that the embryo is less than one-fourth inch or about one-half inch in length.²³⁹ The brochure then turns to an over nine-page discussion of the medical risks associated with abortions with very detailed discussion of all aspects of each type of abortion procedure. Then, on page seventeen, the brochure includes the heading, “Is There a Link Between Breast Cancer and Abortion?”²⁴⁰ The discussion that follows is inconclusive, merely telling the reader that studies “have reached differing conclusions.”²⁴¹ The brochure contains no bibliography, so a reader has no easy ability to locate these different studies, nor are the positions of professional organizations mentioned. The brochure also has a one-and-a-half page discussion of the possible complications of childbirth. But, unlike in the abortion discussion, there is no graphic discussion of vaginal birthing or Cesarean birth. While the brochure is graphic and detailed, it includes no statistical evidence of the likelihood of any of the complications from abortion or childbirth.

Texas. “A Woman’s Right to Know” brochure is twenty-one pages²⁴² and is not statutorily required. Like with most states, it uses medical illustrations from Peg Gerrity.²⁴³ Texas uses two-inch-by-two-inch illustrations from four to forty weeks gestation and describes these as images of a “baby.”²⁴⁴ It follows the six pages of illustrations with ten pages of discussion of topics such as “[a]bortion risks” and “[a]bortion procedures and side effects.”²⁴⁵ Under the header “Mental Health Risks,” there is only discussion of negative feelings such as “depression or thoughts of suicide.”²⁴⁶ There is also the header “Breast Cancer Risk,” which begins with the sentence: “Your pregnancy history affects your chances of getting breast cancer.”²⁴⁷ While “research” is mentioned, the brochure provides no citations, and the reader is merely told “doctors and scientists are actively studying the complex biology of breast cancer to understand whether abortion

²³⁶ OKLA. STATE BD. OF MED. LICENSURE & SUPERVISION, A WOMAN’S RIGHT TO KNOW (2015) [hereinafter OKLA. BROCHURE], http://www.awomansright.org/pdf/AWRTK_Booklet-English-sm.pdf [<https://perma.cc/XJ84-7GTH>].

²³⁷ OKLA. STAT. tit. 63, § 1-738.8 (2020).

²³⁸ *E.g.*, OKLA. BROCHURE, *supra* note 236, at 6.

²³⁹ *Id.* at 3-8.

²⁴⁰ *Id.* at 17.

²⁴¹ *Id.*

²⁴² TEX. BROCHURE, *supra* note 138.

²⁴³ *Id.* at cover; *see also* GERRITY, *supra* note 169.

²⁴⁴ *See* TEX. BROCHURE, *supra* note 138, at 2-7.

²⁴⁵ *See id.* at 8-17.

²⁴⁶ *Id.* at 8.

²⁴⁷ *Id.* at 9.

may affect the risk of breast cancer.”²⁴⁸ On pages eighteen and nineteen, there is a discussion of pregnancy and childbirth.²⁴⁹ Whereas the abortion discussion includes a photo of a Black woman looking downward in a depressive state, the childbirth discussion includes a photo of a White woman holding a White infant with a big smile on her face.²⁵⁰ This misleading and inaccurate portrayal of information, with its racial subtext, has continued despite complaints by medical experts and others arguing that “important sections – such as those connecting abortions to the likelihood of breast cancer and infertility – are wrong.”²⁵¹

West Virginia. “Information on Fetal Development, Abortion and Adoption” is a seventeen-page brochure²⁵² and is required by the West Virginia “Women’s Right to Know Act.”²⁵³ There are eight pages of medical illustrations of the developing embryo.²⁵⁴ Some of the medical illustrations are from Peg Gerrity.²⁵⁵ At twelve weeks, when the fetus is about three-and-one-half inches in length, the brochure magnifies the fetus’s hand as a two-inch-by-two-inch image.²⁵⁶ Abortion risks are described but not quantified. For example, the reader is told that “[c]omplications associated with an abortion may make it difficult to become pregnant in the future or carry a pregnancy to term.”²⁵⁷ After over five pages of discussion of the medical risks of abortion, the reader is provided with less than a one-and-a-half-page discussion of vaginal delivery and Caesarean delivery.²⁵⁸

Wisconsin. “A Woman’s Right to Know” brochure is twenty-eight pages²⁵⁹ and is required by a Wisconsin statute.²⁶⁰ It includes two-inch-by-two-inch illustrations from two to forty weeks gestation. These are followed by six pages of material on abortion methods and their associated medical risks. None of the medical risks are quantified. There are fewer than two pages on the medical risks of pregnancy and childbirth with no discussion of the birthing process. The

²⁴⁸ *Id.*

²⁴⁹ *See id.* at 18-19.

²⁵⁰ *Id.* at 16, 19.

²⁵¹ *See* Caroline Cournoyer, *Abortion Doctors in Texas Must Give Patients Medically Inaccurate Information*, GOVERNING (July 27, 2016), <https://www.governing.com/topics/health-human-services/tt-texas-abortion-booklet.html> [<https://perma.cc/JQ9K-M6Q5>].

²⁵² W. VA. DEP’T OF HEALTH & HUM. RES., INFORMATION ON FETAL DEVELOPMENT, ABORTION AND ADOPTION [hereinafter W. VA. BROCHURE], <http://www.wvdhhr.org/wrtk/wrtkbooklet.pdf> [<https://perma.cc/3Y9A-BW3J>] (last visited Feb. 15, 2021).

²⁵³ W. VA. CODE § 16-2I-3 (2020).

²⁵⁴ *See* W. VA. BROCHURE, *supra* note 252, at 2-9.

²⁵⁵ *Id.* at cover, 6, 7.

²⁵⁶ *Id.* at 3.

²⁵⁷ *Id.* at 10.

²⁵⁸ *Id.* at 10-17.

²⁵⁹ WIS. DEP’T OF HEALTH SERVS., A WOMAN’S RIGHT TO KNOW. . . [hereinafter WIS. BROCHURE], <https://www.dhs.wisconsin.gov/publications/p4/p40074.pdf> [<https://perma.cc/P8C9-AJ6U>] (last visited Feb. 15, 2021).

²⁶⁰ WIS. STAT. § 253.10 (2020).

reader is reassured at the beginning of this discussion with the statement: “Women choosing to have their baby can usually expect their pregnancy and delivery to be a safe process.”²⁶¹ By contrast, the first sentence discussing abortion risks states: “An abortion is a medical procedure that always involves risk to the woman.”²⁶² The discussion of medical risks is therefore not balanced.

At this point, readers may feel like a pregnant person in one of these twelve states. They have been inundated with highly specific information, and they may be having trouble gleaning the pertinent, relevant information. They have had an opportunity to experience the effects of overinformation.

Table 1 below summarizes how the states bury relevant medical data in their so-called informed consent brochures and how they, in most cases, also include inaccurate or misleading information. Rather than providing informed consent to help the patient choose among medical alternatives, these brochures must be considered strident propaganda that is thrust on patients as they contemplate whether to terminate their pregnancy.

Table 1. Summary of State Brochures.

State	Total Number of Pages	Number of Pages Containing Fetal Illustrations	Page Where Pregnancy Information Begins	Inaccurate or Misleading Information
Alabama	33	9	16	Fetus called an “unborn child”
Arizona	21	6	16	Fetus called an “unborn child”
Georgia	38	14	28	Pregnant woman called a “mother”
Indiana	16	5	10	Pregnant woman called a “mother” in description of abortion procedures
Kansas	32	11	28	Fetus called an “unborn child”; discusses breast cancer risk of abortion and suggests that psychological impact of having an abortion is always negative

²⁶¹ WIS. BROCHURE, *supra* note 259, at 22.

²⁶² *Id.* at 16.

Table 1. Summary of State Brochures (cont'd).

State	Total Number of Pages	Number of Pages Containing Fetal Illustrations	Page Where Pregnancy Information Begins	Inaccurate or Misleading Information
Louisiana	24	10	22	Fetus called a "baby"; discusses breast cancer risk of abortion
North Carolina	36	12	21	Overstates medical risks of abortion
Oklahoma	22	6	18	Discusses breast cancer risk of abortion
Texas	24	6	18	Discusses breast cancer and mental health risks of abortion
West Virginia	20	8	15	Medical risks of abortion in comparison to childbirth are misleading
Wisconsin	30	9	22	Medical risks of abortion in comparison to childbirth are misleading

Notice the pattern of these state brochures. About one-third of the pages are devoted to medical illustrations of the fetus, which is sometimes called a "baby" or "unborn child." These graphic depictions are followed by detailed discussions of the process of having an abortion, sometimes including medically misleading or erroneous information. If a reader wades through all of that material, she then will typically see a page or so of positive descriptions of childbirth, with no discussion of the process of childbirth and very limited mention of any health risks. Although the phrase a "woman's right to know" suggests that these brochures are designed to benefit pregnant women in their decision-making process, it is much more likely that these brochures would obscure and confuse their decision-making process.

While *Casey* may have opened the door to states mandating certain information as part of the informed consent process, it is hard to describe these glossy brochures as furthering that purpose. They do not conform to basic tort principles regarding the way that information should be conveyed to inform a patient of various treatment or health care options that are available to them.

Because the states have deliberately placed themselves in the medical context by insisting that pregnant people receive this deliberately misleading and overwhelming information, patients should be able to recover under tort law for this intrusion into their medical autonomy. Although tort law is usually used as a basis for damages from physical harm, pregnant people should be allowed to use tort law to enjoin the state from intruding into their decision-making process under the guise of informed consent, because the theory underlying modern

informed consent doctrine is that of patients' right to choose appropriate medical treatment.²⁶³

Despite most states labeling these glossy brochures as a "Woman's Right to Know," the true purpose of these brochures is to use irrelevant and emotional appeals to induce women to "choose" their natural destiny as mothers. The popular press is full of stories on the pressures on young women to become pregnant and have children. These discussions revolve around "when" rather than "if."²⁶⁴ After conducting a national survey of 1,200 American women of reproductive age who did not bear children, researchers in 2012 concluded that "[r]ather than assume that women without children are missing something, society should benefit from valuing a variety of paths for adult women to have satisfying lives."²⁶⁵ Yet, authors such as Ellen Walker find it necessary to write entire books querying how women can possibly feel "complete" if they do not raise children.²⁶⁶

Thus, the appropriate way of understanding the state-mandated brochures is that they are just one part of the enormous societal pressure on women to fulfill their natural and appropriate destiny by giving birth to a child. By calling the fetus "an unborn child" and sometimes directly calling the pregnant individual a "mother," the state is being clear that the only appropriate ethical decision is for pregnant people to fulfill their destinies by continuing with their pregnancies to term.

Imagine the outcry if a state decided to replace the medical illustrations of supersized fetuses on the cover of these brochures with photos of women writhing in pain during childbirth. Or a photo of a woman happily leaving an abortion facility after terminating a pregnancy. Such images are unthinkable because these brochures are not really a patient's right to acquire balanced and helpful medical information about the medical risks of abortion versus childbirth; they are about the state's right to coerce women to remain pregnant. If tort law could be deployed to challenge these coercive state practices then

²⁶³ See generally Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985) (discussing the importance of protecting patient autonomy while also recognizing gaps and flaws in the current legal regime).

²⁶⁴ See Helena Pozniak, *Time to Change Destiny: When Will We Stop Giving Women Deadlines?*, TELEGRAPH (Mar. 5, 2019, 11:47 AM), <https://www.telegraph.co.uk/women/societal-pressures/choosing-to-have-a-family/> [<https://perma.cc/UW57-UWVR>] (reporting on interviews with four women who experience pressure from family, friends, and society to get married and have children).

²⁶⁵ See University of Nebraska-Lincoln, *Child-Free Women Feel Intense Pressure to Have Kids, but Rarely Stress Over It*, SCIENCE DAILY (Oct. 9, 2012), <https://www.sciencedaily.com/releases/2012/10/121009121807.htm> [<https://perma.cc/TJ8W-CGDV>].

²⁶⁶ ELLEN L. WALKER, COMPLETE WITHOUT KIDS: AN INSIDER'S GUIDE TO CHILDFREE LIVING BY CHOICE OR BY CHANCE (2011); see also Ellen Walker, *Direct and Subtle Pressure to Have Children—How Can a Childfree Wannabe Cope?*, PSYCH. TODAY (Apr. 6, 2011), <https://www.psychologytoday.com/us/blog/complete-without-kids/201104/direct-and-subtle-pressure-have-children-how-can-childfree-wanna-1> [<https://perma.cc/SKH3-J5L2>].

pregnant people could make more truly informed decisions about whether to seek to carry their pregnancy to term.

B. *Wrongful Birth*

An alternative tort theory would be for wrongful birth. The argument would be that the patient went to term and gave birth to a child instead of making an informed decision whether to terminate the pregnancy. The state deliberately inundated the pregnant individual with misleading and excessive information to feed into societal norms about women's proper place as a mother.

The wrongful birth cause of action should be understood as encompassing two kinds of injuries: (1) the decisional injury in losing control over choice and procreation through coercive state materials and (2) the physical, financial, and psychological harm from being pregnant, giving birth, and raising a child.

Existing tort law does a terrible job of understanding either of these injuries because it presumes that a wrongful birth cause of action should only be available when an individual gave birth to a disabled child and is willing to testify that she would have chosen to terminate the pregnancy if she had received accurate prenatal information. Professor Sofia Yakren has correctly argued that wrongful birth claims should be reframed "as a loss of choice and control over procreation."²⁶⁷ But this Article also argues that we should end the precondition that wrongful birth claims can only be brought if the child is born disabled. All individuals deserve the right to procreative choice irrespective of whether the state's coercive practices cause them to give birth to a typical or disabled child.

1. The Harm to Decisional Autonomy

Pregnancy is a medical event that is supposed to present people with various choices.²⁶⁸ They can decide to terminate the pregnancy. They can decide to have a planned Cesarean birth. They can decide to use natural childbirth and forego any medication. They can decide to become sterilized as part of the immediate aftercare of childbirth. They can decide to relinquish the baby they might bear to adoption. Or, if they are a surrogate, they can decide to comply with various contractual arrangements to relinquish the child to another person or couple. They have many medical and legal decisions to make within a relatively short span of time. They have the right, like any patient, to make those decisions in a noncoercive environment. When they make a decision to give birth on the basis of a lack of informed consent, Yakren has correctly reframed the tort as "deprivation of reproductive choice" rather than "wrongful birth."²⁶⁹ A focus on

²⁶⁷ Sofia Yakren, "Wrongful Birth" Claims and the Paradox of Parenting a Child with a Disability, 87 *FORDHAM L. REV.* 583, 622 (2018).

²⁶⁸ See *Pregnancy Options*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-options> [<https://perma.cc/WV5E-NM35>] (last visited Feb. 15, 2021).

²⁶⁹ Yakren, *supra* note 267, at 622-23.

decisional autonomy would help the tort of wrongful birth escape from its historical gender stereotypes.

Professor Wendy Hensel identifies the importance of understanding the wrongful birth tort as potentially protecting decisional autonomy but then falls short of insisting that the tort be implemented in a way that truly protects that interest.²⁷⁰ First, Hensel observes that wrongful life and wrongful birth claims are conceptually different—wrongful life “identifies the impaired child’s life as the operable injury,” and wrongful birth identifies the injury as “the parents’ lost choice over the future of the pregnancy.”²⁷¹ From a disability perspective, she acknowledges that disability rights activists could accept the legitimacy of a wrongful birth claim while rejecting a wrongful life claim.²⁷² But she then rejects that possible distinction, arguing that the wrongful birth tort “makes clear that the impaired child, not the reproductive choice of the mother, is the true injury at stake.”²⁷³

Unfortunately, Hensel draws the wrong conclusion from her research. She is correct to argue that tort law should not be theoretically grounded on the premise that individuals who give birth are only injured when they give birth to a disabled child. The cure for that problem is to *broaden* the wrongful birth tort rather than eliminate it. The wrongful birth tort should, as Yakren argues, be reframed so as to protect an individual’s decisional autonomy. Giving pregnant people a cause of action when they have been coerced into childbirth should not depend on the argument that they gave birth to a disabled child.

Most jurisdictions recognize a cause of action for the individual’s medical expenses and emotional distress damages associated with pregnancy and childbirth when the defendant doctor’s negligence resulted in the birth of a healthy child despite the parents’ deliberate efforts to avoid pregnancy.²⁷⁴ These cases involve, for example, negligent sterilizations.²⁷⁵ And recovery in some of these cases even includes the expense of childrearing, irrespective of whether the child is born disabled.²⁷⁶

²⁷⁰ See Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 144-45 (2005).

²⁷¹ *Id.* at 164.

²⁷² *Id.* at 165 (discussing arguments offered by disability scholar Adrienne Asch).

²⁷³ *Id.*

²⁷⁴ *Id.* at 151.

²⁷⁵ See, e.g., *Custodio v. Bauer*, 59 Cal. Rptr. 463, 466, 468 (Ct. App. 1967) (overturning dismissal of case in which woman seeks damages following a failed sterilization procedure); *Burke v. Rivo*, 551 N.E. 2d 1, 6 (Mass. 1990) (allowing recovery to parents of a child born after the physician unsuccessfully performed a sterilization procedure including costs of raising child to adulthood); *Girdley v. Coats*, No. 17117, 1991 WL 116734, at *1 (Mo. Ct. App. July 3, 1991) (holding that damages may be sought for childrearing expenses following improperly performed sterilization procedure). *But see Szekeres v. Robinson*, 715 P.2d 1076 (Nev. 1986) (rejecting tort recovery following the birth of a child after failed surgical sterilization).

²⁷⁶ See, e.g., *Burke*, 551 N.E.2d at 6; *Girdley*, 1991 WL 116734, at *3.

If tort law recognizes the decisional autonomy of people who have chosen to be sterilized, then it should recognize the decisional autonomy of people who are considering their options while pregnant. Individuals who have made decisions to go to term premised on misleading or inaccurate information should be able to bring a wrongful birth cause of action for their attendant medical expenses and their physical and emotional harm. And, as discussed next, their damages should include the cost of childrearing irrespective of whether the child is disabled.

2. The Harm from Pregnancy, Childbirth, and Childrearing

If individuals make a decision to go to term because they have been misinformed about the mental health or breast cancer risks from having an abortion or about the comparative lack of risk from pregnancy and childbirth, their injury is the full experience of pregnancy, childbirth, and recovery from childbirth, as well as the costs of raising *any* child, disabled or not. In justifying the wrongful birth tort, Yakren inappropriately emphasizes the additional costs of raising a disabled child.²⁷⁷ But pregnancy, childbirth, and childrearing are expensive irrespective of whether the child is disabled. All people have the right to make such a decision in a noncoercive atmosphere. Individuals who do not terminate a pregnancy out of a misconception that abortion would have increased their risk of breast cancer are entitled to full recovery irrespective of whether their children have heightened medical bills.

Courts have been hesitant to endorse a wrongful birth cause of action because of their reluctance to recognize abortion as a legal choice for pregnant people and because of their conceptualization of all pregnant people as mothers. In *Procanik ex rel. Procanik v. Cillo*,²⁷⁸ the New Jersey Supreme Court explained this historical reluctance in describing the holding from a previous case:

Prevailing policy considerations, which included a reluctance to acknowledge the availability of abortions and the mother's right to choose to terminate her pregnancy, prevented the Court from awarding damages to a woman for not having an abortion. Another consideration was the Court's belief that "[i]t is basic to the human condition to seek life and hold on to it however heavily burdened."²⁷⁹

Nonetheless, in *Berman ex rel. Berman v. Allan*,²⁸⁰ the New Jersey Supreme Court recognized the right of an individual to recover for a wrongful birth claim when she was deprived of medical information that would have allowed her to choose to terminate a pregnancy.²⁸¹ The court permitted recovery for the parents'

²⁷⁷ Yakren, *supra* note 267, at 601-02.

²⁷⁸ 478 A.2d 755 (N.J. 1984).

²⁷⁹ *Id.* at 759 (alteration in original) (quoting *Gleitman v. Cosgrove*, 227 A.2d 689, 693 (N.J. 1967)).

²⁸⁰ 404 A.2d 8 (N.J. 1979).

²⁸¹ *Id.* at 14.

emotional suffering, premising the holding on the fact that the child was born with Down syndrome.²⁸² Nonetheless, the court considered it to be an inappropriate windfall to allow the parents to recover the monetary expenses involved in raising a disabled child, emphasizing “all the benefits inhering in the birth of the child—*i.e.*, the love and joy they will experience as parents.”²⁸³ So, even in a case affirming an individual’s right to terminate a pregnancy, the court presumed that a parent receives more love and joy from giving birth to a child than living a life without an additional child in the household. And, unfortunately, the court could only frame the issue with respect to raising a *disabled* child. The court could not even conceive that parents might want to recover damages of any sort if they gave birth to a *nondisabled* child.

While some courts have recognized a wrongful birth action premised on the argument that the individual lost the opportunity to have an abortion, other courts and legislatures have refused to recognize that cause of action.²⁸⁴ In 1999, the Michigan Court of Appeals repudiated its prior recognition of such a cause of action, stating that such a decision was best made by the legislature rather than the courts.²⁸⁵ Thus, a wrongful birth claim premised on the individual’s injury in giving birth to a child when the person would have preferred to have exercised the option of terminating the pregnancy is disfavored and limited to the situation in which the physician failed to disclose a significant birth defect.²⁸⁶ The injury is understood to be the injury of raising a disabled child, not the injury of giving birth at all.²⁸⁷

In understanding that pregnant people should be able to sue for wrongful birth, it is crucial that we not limit those claims to situations in which individuals allege that they were uninformed about potential birth defects. Giving birth to *any* child is wrongful if a person, after receiving proper informed consent, would have chosen to abort the fetus. The injury is not limited by whether the child is

²⁸² *Id.*

²⁸³ *Id.*

²⁸⁴ See Philip G. Peters, Jr., *Rethinking Wrongful Life: Bridging the Boundary Between Tort and Family Law*, 67 TUL. L. REV. 397, 415 (1992) (citing states that bar all types of wrongful birth claims). Twenty-three states recognize the claim by judicial decision. Maine allows wrongful birth claims by statute. Three state supreme courts have refused to allow wrongful birth claims, and twelve states have enacted legislation refusing to allow such claims. In three of those states, the state legislature overruled the court’s decisions. See, e.g., *Plowman v. Fort Madison Cmty. Hosp.*, 896 N.W.2d 393, 400 n.4-6 (Iowa 2017) (listing states in each category).

²⁸⁵ *Taylor ex rel. Taylor v. Kurapati*, 600 N.W.2d 670, 691 (Mich. Ct. App. 1999).

²⁸⁶ See, e.g., *Nanke v. Napier*, 346 N.W.2d 520, 522-23 (Iowa 1984) (stating that Iowa public policy is that “a parent cannot be said to have been damaged or injured by the birth and rearing of a normal, healthy child because the invaluable benefits of parenthood outweigh the mere monetary burdens as a matter of law”).

²⁸⁷ See *Smith v. Cote*, 513 A.2d 341, 350 (N.H. 1986); *Plowman*, 896 N.W.2d at 399. *But see* *Wilson v. Kuenzi*, 751 S.W.2d 741, 745-46 (Mo. 1988) (en banc) (finding no cause of action for doctor who failed to let woman know of availability of amniocentesis to detect Down syndrome).

disabled. It misconceives the nature of the injury to say the individual is injured by giving birth to a disabled child rather than by giving birth at all. The policy underlying the wrongful birth line of cases is that people should never feel regret for having given birth: that birth is always a joyous moment that tort law should value and that it would devalue human life to make relief available in those contexts.

Courts sometimes articulate this value principle by citing the offsetting-benefit tort principle. This principle, as explained in the *Restatement (Second) of Torts*, provides that

[w]hen the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred a special benefit to the interest of the plaintiff that was harmed, the value of the benefit conferred is considered in mitigation of damages, to the extent that this is equitable.²⁸⁸

This principle should have no application in the context where a state's coercive practices caused an individual not to terminate a pregnancy and, instead, to give birth to a child. The interest in terminating a pregnancy has nothing to do with the purported benefit in raising a child. The two events are not inherently connected and, certainly, there is no way to know if an individual who gives birth to a child under coercion will even receive any emotional benefit from raising the child. As Kathryn Vikingstad has argued, "The benefits parents receive from having the child are all emotional in nature: fun, joy, companionship, pride, affection, and comfort. Allowing these emotional benefits to offset, whether partially or completely, the financial injury of having to raise a child is a patent violation of the same interest limitation."²⁸⁹

Typical of courts that have denied relief for the expenses of raising a healthy child is the Illinois Supreme Court decision in *Cockrum v. Baumgartner*.²⁹⁰ This case involved the consolidated consideration of two cases that involved a "wrongful pregnancy" or "wrongful birth" cause of action.²⁹¹ In the case brought by Donna and Leon Cockrum, they alleged that the doctor negligently performed a vasectomy; Donna Cockrum would not have chosen to become pregnant and give birth to a child but for the physician's negligence.²⁹² In the other case, Edna Raja alleged that Dr. Tulsky negligently performed a tubal cauterization, which was designed to make her sterile.²⁹³ Further, she alleged that she was negligently examined at Michael Reese Hospital, where she was not told that she was pregnant until after the time period during which she could have safely had an

²⁸⁸ RESTATEMENT (SECOND) OF TORTS § 920 (AM. L. INST. 1979).

²⁸⁹ Kathryn C. Vikingstad, *The Use and Abuse of the Tort Benefit Rule in Wrongful Parentage Cases*, 82 CHI.-KENT L. REV. 1063, 1098-99 (2007) (footnotes omitted).

²⁹⁰ 447 N.E.2d 385 (Ill. 1983).

²⁹¹ *Id.* at 386.

²⁹² *Id.*

²⁹³ *Id.* at 387.

abortion.²⁹⁴ Because of her hypertensive cardiac disease and the consequent medical dangers of childbirth, she would have elected to terminate the pregnancy if given a timely opportunity to do so.²⁹⁵ In both cases, the plaintiffs gave birth to a healthy child and sought damages that included the financial cost of raising a child.²⁹⁶

The Illinois Supreme Court concluded that it would harm the parent-child relationship for that kind of recovery to be possible.²⁹⁷ Further, the court observed that the doctrine of avoidable consequences counsels against recovery “where the parents had an opportunity to avoid parenthood through abortion or adoption.”²⁹⁸ But that argument disregarded the facts of these cases. These plaintiffs took steps to avoid all the consequences of pregnancy (which certainly include childbirth), and, in this case, Raja did not even have the opportunity to choose to terminate her pregnancy.

The dissent did an excellent job of reframing how a court should analyze the cause of action in cases where people were coerced into bearing a child due to the negligence of others.

A couple privileged to be bringing home the combined income of a dual professional household may well be able to sustain and cherish an unexpected child. But I am not sure the child’s smile would be the most memorable characteristic to an indigent couple, where the husband underwent a vasectomy or the wife underwent a sterilization procedure, not because they did not desire a child, but rather because they faced the stark realization that they could not afford to feed an additional person, much less clothe, educate and support a child when that couple had trouble supporting one another. The choice is not always giving up personal amenities in order to buy a gift for the baby; the choice may only be to stretch necessities beyond the breaking point to provide for a child that the couple had purposely set out to avoid having. The court today expresses concern about putting a negative imprimatur on a child’s life and yet, in denying damages for child rearing, the court may well be accomplishing the very result it seems so intent on avoiding—making a child of an unwanted birth a victim of a very real continuing financial struggle and thus a painful reminder of the obligations of parenthood to a couple who had no appetite for a parental lifestyle. Does that child then become more wanted because this court has seen fit to deny foreseeable expenses in a case where a physician’s negligence is undisputed?²⁹⁹

²⁹⁴ *Id.*

²⁹⁵ *Id.*

²⁹⁶ *Id.*

²⁹⁷ *Id.* at 390 (“We would observe, too, that it is clear that public policy commands the development and the preservation of family relations.”).

²⁹⁸ *Id.* at 390-91.

²⁹⁹ *Id.* at 394 (Clark, J., dissenting).

Justice Clark is correct to emphasize the class-based assumptions underlying the majority's reasoning. But the majority also essentially ignores the choices that are supposed to be available to a pregnant person—to choose whether to continue the pregnancy and give birth. By not holding the doctor or state responsible for the full implications of their negligence, the pregnant person is not made whole for the doctor's or state's negligent conduct. In the context of a state's coercive informed consent statutes, a state can afford to continue with its deceptive tactics if it is not held responsible for those tactics. It is often pointedly said that a state that claims to be "pro-life" cares about an "unborn child" only until the child is born; once she gives birth, the state will do little to help her with the financial burdens of motherhood. By broadly conceptualizing the damages an individual who goes to term can incur because of the state's coercive practices, a state could be found fully responsible for its supposed pro-life practices.

Nonetheless, it may not be realistic to expect state court judges, acting as common-law judges, to create causes of action against a state's coercive practices. Further, it is always possible that a state legislature could override a judge's common-law determination. Thus, we need to consider, as will be discussed below, whether these coercive practices violate the Fourteenth Amendment's liberty and equality protections.

IV. LACK OF INFORMED CONSENT AS A CONSTITUTIONAL VIOLATION: CHOICE CANNOT INCLUDE COERCION

Even if tort law³⁰⁰ is not an effective vehicle to remedy these problems of informed consent, constitutional law could be, especially now that we better understand the consequences of the states' deliberate misinformation in the name of informed consent. These state laws that are disguised as promoting "informed consent" must be unconstitutional because they deliberately try to *take away* informed consent. The problem is not merely that they provide biologically incorrect and irrelevant information to pregnant people but that they *fail* to tell them what they really need to know—what it is like to stay pregnant for nine months and give birth, including the risk of postpartum depression and a Cesarean birth.

It is clear that these requirements are imposed on pregnant people—and only pregnant people—because they are conceived of as mere vessels to carry fetuses to term rather than as independent adults who are entitled to make their own decisions. States act in calculated and coercive ways to try to "persuade" them to carry a fetus to term. As Justice Stevens said in his *Casey* dissent, quoting an earlier case that invalidated a nearly identical Pennsylvania statute, "That the Commonwealth does not, and surely would not, compel similar disclosure of

³⁰⁰ As a common-law legal regime, it also seems unlikely that state court judges would conclude that the state legislature had violated basic principles of informed consent under tort law. The federal courts would, in theory, be a more fruitful path because they would be less hesitant to criticize state law.

every possible peril of necessary surgery or of simple vaccination, reveals the anti-abortion character of the statute and its real purpose.”³⁰¹

A. *Reconceptualizing Pregnancy-Related Constitutional Law*

These coercive attempts to influence pregnant people’s decisions whether to terminate their pregnancies should be subject to the highest scrutiny because they implicate *both* equality and liberty principles, as found in the Court’s equal protection and abortion jurisprudence. Constitutional law regarding reproductive freedom has failed to recognize the need for the highest level of scrutiny in this context. Rather than *lowering* the level of scrutiny because a case involves an individual’s pregnancy, the Court should *raise* the level of scrutiny.

The Court’s mistaken path with respect to state imposition of unconstitutional coercion on pregnant people’s lives begins with the 1974 decision in *Geduldig v. Aiello*.³⁰² California’s disability insurance program paid benefits to persons temporarily disabled from work but excluded pregnancy-related disabilities from coverage.³⁰³ In a 6-3 decision, the Court upheld the program as consistent with the Court’s recent recognition of heightened scrutiny in cases challenging gender discrimination, finding that it was alright for the state to lower the expenses associated with its insurance program by excluding a sex-specific condition from coverage.³⁰⁴ It explained,

[T]his case is thus a far cry from cases like *Reed v. Reed* and *Frontiero v. Richardson*, involving discrimination based upon gender as such. The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities. . . . Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis, just as with respect to any other physical condition.³⁰⁵

Thus, rather than asking whether the state could justify its singling out of pregnant people to bear the expense of financially stabilizing the state’s disability insurance program, the Court lowered the level of scrutiny and required virtually no justification at all.³⁰⁶ Justice Brennan, joined by Justices

³⁰¹ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 936 (1992) (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part) (quoting *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 764 (1986)).

³⁰² 417 U.S. 484, 497 (1974).

³⁰³ *Id.* at 486.

³⁰⁴ *Id.* at 497.

³⁰⁵ *Id.* at 496 n.20 (citations omitted).

³⁰⁶ *Id.* at 497.

Douglas and Marshall, dissented, arguing that the Court's analysis was inconsistent with heightened scrutiny for gender-based discrimination.³⁰⁷

Even worse, it is hard to see how the majority opinion even engaged in the "pretext" analysis that it said could be invoked. The California legislature likely concluded that it was alright to exclude pregnant people from coverage because it assumed that pregnant people would be married women who were financially dependent on their husbands. Unlike men who were disproportionately affected by covered conditions such as prostatectomies, circumcision, hemophilia, or gout, women were expected to be able to bear the financial hardships of pregnancy and childbirth.³⁰⁸ Women were also probably not considered "real workers" who needed financial compensation while they took temporary disability leave. Pregnant workers were likely viewed as mothers who should leave work to care for the child who was born. Thus, the EEOC had taken the position that protection against pregnancy discrimination was crucial for female workers because "systematic and pervasive discrimination against women was frequently found in employers' denial of employment opportunity and benefits to women on the basis of the childbearing role, performed solely by women."³⁰⁹

The purpose of heightened scrutiny is for the Court to more carefully examine the kinds of arguments made by the state of California to justify its exclusion of pregnancy-related conditions from coverage. As an expert in the field of employment discrimination, the EEOC took that position. But the Court, disregarding its recent case law applying heightened scrutiny, flipped the inquiry. Because it presumed that the use of pregnancy as a category is presumptively *not* pretextual, it put the burden of proof on the plaintiff to demonstrate pretext in order to invoke heightened scrutiny.

If one thinks that *Geduldig* is outdated and does not reflect continued stereotypical thinking about pregnancy, one can look at a handful of post-*Geduldig* cases. In *Michael M. v. Superior Court of Sonoma County*,³¹⁰ the Court again affirmed the state of California's stereotypical thinking about pregnancy.³¹¹ This time, the state of California made men alone potentially liable for statutory rape.³¹² In a plurality opinion, authored by Justice Rehnquist, the Court upheld the state statute in an ambiguous opinion.

The California Supreme Court had subjected the state statute to strict scrutiny and found that the classification could be "supported not by mere social convention but by the immutable physiological fact that it is the female exclusively who can become pregnant" and that the State has "a compelling and demonstrable . . . interest in minimizing both the number of such pregnancies

³⁰⁷ *Id.* at 497-505 (Brennan, J., dissenting).

³⁰⁸ *Id.* at 501.

³⁰⁹ *Id.* at 502 n.6 (quoting Brief of the United States Equal Employment Opportunity Commission as Amicus Curiae at 10, *Geduldig*, 417 U.S. 484 (No. 73-640)).

³¹⁰ 450 U.S. 464 (1981) (plurality opinion).

³¹¹ *Id.* at 476.

³¹² *Id.* at 466.

and their disastrous consequences.”³¹³ The U.S. Supreme Court found that strict scrutiny does not apply to sex discrimination cases; instead, a different form of heightened scrutiny applies.³¹⁴ Further, the Court found that “this Court has consistently upheld statutes where the gender classification is not invidious, but rather realistically reflects the fact that the sexes are not similarly situated in certain circumstances.”³¹⁵ This case fit into that noninvidious category.

The Court’s analysis in this case is strong evidence of why heightened scrutiny is needed in cases where a state legislates with regard to a woman’s capacity to become pregnant. The history of California’s statutory rape law

demonstrates that the law was initially enacted on the premise that young women, in contrast to young men, were to be deemed legally incapable of consenting to an act of sexual intercourse. Because their chastity was considered particularly precious, those young women were felt to be uniquely in need of the State’s protection.³¹⁶

The law was based on “outmoded sexual stereotypes” and did not aim to reduce the incidence of teenage pregnancy.³¹⁷ Assuming that the criminal law has a deterrent effect, the obvious way to reduce the incidence of teenage pregnancy is to make *all* teenagers potentially subject to criminal liability for sexual intercourse.³¹⁸ Thus, although the Court purported to use a type of heightened scrutiny, it seems that the scrutiny became quite minimal as soon as the state argued a pregnancy-related rationale for its statute. In other words, the Supreme Court has twice allowed the state of California to use obviously pretextual pregnancy arguments to justify its use of sexual stereotypes to advance its state policies.

The Court’s refusal to invoke genuine heightened scrutiny in cases related to women’s capacity to become pregnant was also reflected in the more recent case of *Nguyen*, the immigration case discussed in Part I. The Court purported to invoke heightened scrutiny but then seemingly became deferential because “[f]athers and mothers are not similarly situated with regard to the proof of biological parenthood. The imposition of a different set of rules for making that legal determination with respect to fathers and mothers is neither surprising nor troublesome from a constitutional perspective.”³¹⁹ The Court then concluded: “The differential treatment is inherent in a sensible statutory scheme, given the unique relationship of the mother to the event of birth.”³²⁰

³¹³ *Michael M. v. Superior Ct. of Sonoma Cnty.*, 601 P.2d 572, 574 (Cal. 1979) (in bank).

³¹⁴ *Michael M.*, 450 U.S. at 468-69 (plurality opinion).

³¹⁵ *Id.* at 469.

³¹⁶ *Id.* at 494-95 (Brennan, J., dissenting) (footnote omitted).

³¹⁷ *Id.* at 496.

³¹⁸ Of course, free and ready availability of contraception, along with state-funded abortions, could be even more effective at achieving those ends.

³¹⁹ *Nguyen v. INS*, 553 U.S. 53, 63 (2001).

³²⁰ *Id.* at 64.

In a sharply worded dissent, Justice O'Connor emphasized the strict nature of heightened scrutiny. She insisted that heightened scrutiny requires an inquiry into a statute's *actual* purpose.³²¹ She argued that the Court justified the statute with interests that were not even offered by INS.³²² The actual history of the statute, when it was enacted in 1940, demonstrated that it was "paradigmatic of a historic regime that left women with responsibility, and freed men from responsibility, for nonmarital children."³²³ This history reflects why heightened scrutiny is *most* needed when states or Congress seek to legislate on the basis of women's capacity to become pregnant.

B. *Applying Heightened Scrutiny to Abortion*

The abortion case law, of course, also reflects the special need for heightened scrutiny when state legislatures enact laws related to women's capacity to become pregnant. These statutes ban abortion entirely³²⁴ and make women face coercive practices in order to procure an abortion.³²⁵ They try to make the lives of pregnant women even more difficult by raising the costs and difficulties of procuring an abortion while doing nothing to provide women the resources to raise the children they may bear. Women are expected to be mothers as their inherent destiny without even being offered state support to facilitate their role as (working) mothers.

While it is not helpful to determine what is the *primary* cause of women's subjugation in society, it is certainly helpful to remember that women's capacity to become pregnant must be put on that list. When state statutes or rules are designed to treat women coercively during their pregnancies, then we must understand those statutes and rules as contributing to the subordination of women.

Hence, *Casey* was wrong when it overturned *Akron* and *Thornburgh* for their invalidation of so-called informed consent laws that were designed to coerce women to remain pregnant rather than secure an abortion. But *Casey* was not merely wrong because *Akron* and *Thornburgh* correctly reflected the core

³²¹ *Id.* at 76-78 (O'Connor, J., dissenting).

³²² *Id.* at 79.

³²³ *Id.* at 92.

³²⁴ See K.K. Rebecca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 29, 2019), <https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html> (listing state bans on abortion).

³²⁵ This list is long: waiting periods, unnecessary sonograms, so-called informed consent, hospital requirements, hospital admitting privileges, among others. See generally Elizabeth Nash, Rachel Benson Gold, Lizamarie Mohammed, Zohra Ansari-Thomas & Olivia Cappello, *Laws Affecting Reproductive Health and Rights: State Policy Trends at Midyear, 2018*, GUTTMACHER INST.: POL'Y ANALYSIS (July 31, 2018), <https://www.guttmacher.org/article/2018/07/laws-affecting-reproductive-health-and-rights-state-policy-trends-midyear-2018> [<https://perma.cc/5ZYM-8BBQ>].

holding of *Roe*; instead it was wrong because such coercive rules should also be understood to be inconsistent with the Court's equality jurisprudence.

The Court's equality jurisprudence shows why heightened scrutiny should attach to that category of cases. It is time for a majority of the Court (rather than merely a sharp dissent authored by Justices O'Connor or Ginsburg) to reveal that sexism is a reason to invoke heightened scrutiny in all pregnancy-related cases, including abortion cases. That is how constitutional law often makes progress. For the Court to move from *Bowers v. Hardwick*³²⁶ to *Lawrence v. Texas*,³²⁷ it had to recognize that *Bowers* was wrongly decided as an initial matter.³²⁸ In the present moment, in which many state legislatures perceive the Court as growing more conservative, state legislatures are grabbing what they perceive as newfound power to substantially restrict women's ability to procure abortions. They are seizing every available opportunity to coerce women into carrying their pregnancies to term while also fighting health care coverage for those same women and their children.³²⁹

This is the classic playbook to keep women in their place—as mothers. Make it difficult for them to obtain contraception,³³⁰ fail to protect them from sexual assault,³³¹ make abortions very difficult to obtain,³³² make them bear the economic consequences of childbirth,³³³ and then argue that childcare leave should be unfunded because women made the “choice” to bear children.³³⁴ By recognizing the deep-seated sexism underlying these efforts, we can strengthen the Court's existing abortion jurisprudence to include protections against this type of sex-role stereotyping. Because tort law is not able to resist and remedy this kind of state coercion in the name of informed consent, constitutional law needs to protect women's equality and liberty interests.

³²⁶ 478 U.S. 186 (1986).

³²⁷ 539 U.S. 558 (2003).

³²⁸ *See id.* at 578-79.

³²⁹ For example, twenty-six states challenged the constitutionality of the Affordable Care Act, which required free access to contraception as part of covered health care policies. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588-89 (2012).

³³⁰ *See Zubik v. Burwell*, 136 S. Ct. 1557, 1561 (2016) (challenging contraception mandate under Affordable Care Act).

³³¹ *See United States v. Morrison*, 529 U.S. 598, 627 (2000) (finding that Congress exceeded its authority by enacting certain provisions of Violence Against Women Act).

³³² *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2320 (2016) (considering impact of Texas law on the number of abortion clinics in the state).

³³³ *See Family and Medical Leave Act*, 29 U.S.C. § 2615 (requiring employers to provide some leave following birth of child but not requiring employers to pay employees who take this leave).

³³⁴ *See generally* Sunny Frothingham & Sarah Jane Glynn, *Rhetoric vs. Reality: 4 Myths About Paid Parental Leave*, CTR. FOR AM. PROGRESS (Aug. 14, 2017, 9:02 AM), <https://www.americanprogress.org/issues/women/reports/2017/08/14/437285/rhetoric-vs-reality-4-myths-paid-parental-leave/> [<https://perma.cc/W3GG-NYRU>] (documenting the unavailability of paid parental leave for most workers).

CONCLUSION: GENUINE INFORMED CONSENT

The current so-called informed consent approach is not about informed consent at all; it is about coercion, pure and simple. A recent example from Ohio reflects the deliberatively coercive nature of informed consent even when various communities are trying to improve informed consent.³³⁵ On a national level, a coalition of individuals and organizations have come together to enact what they describe as proinformation statutes to help improve the lives of children born with Down syndrome.³³⁶ One challenge for women who receive a prenatal diagnosis of Down syndrome is that they may have stereotypical understandings of what it means to raise a child with Down syndrome. For example, Heather Sachs testified before the Senate Finance Committee in Maryland that she only received a pamphlet entitled “So You’ve Had a Mongoloid: Now What?” when she gave birth to her daughter with Down syndrome.³³⁷ She worked in coalition with others to require physicians and health care providers to deliver accurate, up-to-date information to women who have received a prenatal diagnosis of Down syndrome.³³⁸ This accurate information “covers all pregnancy options, including termination, as was required by participating medical groups and understood by the Down syndrome groups.”³³⁹ Although the proinformation movement has only had legislative success in a handful of states, many interested individuals have tried to counter negative stereotypes about being the parent of a child with Down syndrome in all states.

But states such as Ohio have taken steps to stop this proinformation movement in its tracks. Senate Bill 164³⁴⁰ makes it a fourth-degree felony for a physician to induce an abortion on a pregnant woman who has had a prenatal diagnosis of Down syndrome. David Perry, the father of a child with Down

³³⁵ See S.B. 164, 132d Gen. Assemb., Reg. Sess. (Ohio 2017) (prohibiting abortion if “an unborn child has or may have Down Syndrome”).

³³⁶ See *Pro-Information Laws & Toolkit*, NAT’L DOWN SYNDROME SOC’Y, <https://www.ndss.org/programs/ndss-legislative-agenda/healthcare-research/pro-information-laws-toolkit/> [<https://perma.cc/5T96-Q5TU>] (last updated Jan. 2021).

³³⁷ Mark Leach, *Delaware and Maryland Join Massachusetts and Kentucky in Enacting Laws to Provide Information with a Down Syndrome Test Result*, DOWN SYNDROME PRENATAL TESTING (May 12, 2014), http://www.downsyndromeprenataltesting.com/delaware-and-maryland-join-massachusetts-and-kentucky-in-enacting-laws-to-provide-information-with-a-down-syndrome-test-result/?utm_content=bufferf7dd3&utm_medium=social&utm_source=facebook.com&utm_campaign=buffer [<https://perma.cc/WU9S-2286>].

³³⁸ See *id.*

³³⁹ Nancy McCrea Iannone, *GUEST POST - Keep Abortion Politics out of the Pro-Information Movement*, HOW DID WE GET INTO THIS MESS? (June 21, 2014), <http://www.thismess.net/2014/06/keep-abortion-politics-out-of-pro.html> [<https://perma.cc/NGW9-ELF3>].

³⁴⁰ Ohio S.B. 164.

syndrome, has explained the implications of the Ohio Down syndrome bill on this national proinformation movement, noting,

This coalition cannot survive when states like Ohio use Down syndrome as a weapon against reproductive rights. If legislatures make it criminal even to speak about decisions and motivations, how can we urge doctors to help women navigate life as a parent of a child with a genetic condition? If women and doctors have to avoid the conversation for fear of criminal liability, fear and myth will win over information.³⁴¹

Informed consent has an important role to play in reproductive health decisions and can even be an opportunity to disabuse women of myths that may surround pregnancy and childbirth. But, unfortunately, states often display little interest in treating pregnant women like adult patients who are entitled to make responsible decisions about their own lives. They prefer coercion over information. They are not genuinely interested in helping children born with Down syndrome; they are only interested in coercing pregnant women to give birth. They are even willing to make it difficult for pregnant women to have helpful conversations with health care professionals to guide their choices. These coercive practices violate basic principles of informed consent under tort law and interfere with women's constitutional right to decide whether to terminate a pregnancy.

Uninformed consent is not informed consent.

³⁴¹ David M. Perry, *How Ohio Is Using Down Syndrome to Criminalize Abortion*, PAC. STANDARD (Oct. 3, 2017), <https://psmag.com/social-justice/gop-using-down-syndrome-as-cynical-wedge> [<https://perma.cc/F48U-WCAX>].