The Modern American

Volume 9 | Issue 2 Article 1

2014

Planned Parenthood v. Rounds & Informed Consent

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PLANNED PARENTHOOD v. ROUNDS & INFORMED CONSENT

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I. Introduction

In 2005, South Dakota enacted some of the most stringent anti-abortion legislation in the country.[2] Among other restrictions, the regulations included an informed consent provision that requires the abortion provider to give the pregnant person, "[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]ncreased risk of suicide ideation and suicide" (the "suicide advisory").[3] In July 2012, in the matter of *Planned Parenthood v. Rounds*, the Eighth Circuit held that the suicide advisory was, "truthful, non-misleading information relevant to a patient's decision to have an abortion," and therefore was constitutional under the "undue burden" standard put forward in *Casey*.[4]

This paper will argue that the Eighth Circuit's decision subverts commonly accepted informed consent standards by endangering a patient's ability to make intelligent and autonomous decisions regarding their treatment options. The paper will further explain how the misleading information that South Dakota physicians are now required to give will damage the concept of informed consent at the expense of accurate advice, specifically tailored medical advice. This paper will also explain how the Eighth Circuit arrived at the opposite conclusion by exploring how the Eighth Circuit's decision endorses the promulgation of highly ideological laws that promote the state's preference for childbirth at the expense of actual informed consent. The paper will further argue that the decision creates a problematic precedent for doctors and patients – in both the context of abortion and the doctor-patient relationship generally.

First, the suicide advisory damages informed consent in South Dakota by requiring the physician to give the patient information that is misleading. Second, the Eighth Circuit's decision endorses the promulgation of highly ideological laws that promote the state's preference for childbirth at the expense of actual informed consent. Informed consent standards are intended to allow a patient, in evaluating her medical choices, to make an intelligent, autonomous decision. Thus, informed consent becomes illusory, because the consent given is predicated on information that may be misleading, confusing or otherwise irrelevant to the specific patient.

II. The Suicide Advisory is Damaging to Informed Consent in South Dakota

The suicide advisory hinders informed consent because it is misleading, and is likely irrelevant in most cases. The purpose of informed consent rules is to ensure that patients are aware of all information material to their healthcare, are fully able to evaluate their medical choices, and allow them to make intelligent choices while protecting their individual interests.[5] *Salgo v. Leland Stanford Jr. University*, the first American case to employ the term, concluded that physicians must provide the information necessary for a patient to make an "intelligent decision" about treatment.[6] The information required by informed consent standards is typically factual in nature and directly relevant to the patient's medical circumstances.[7] A provision of such information gives the patient the ability to weigh her own interests, values and preferences against the risks and benefits she would likely face via different treatment options.[8] In doing so, the informed consent standard promotes a patient's autonomy and right to

self-determination.[9] The Eighth Circuit's decision, requiring physicians to provide the suicide advisory, is damaging to the standard of informed consent because it unreasonably violates a patient's ability to make well-informed, intelligent choices about their treatment and compromises the decision-making autonomy of patients.

First, the informed consent statute is misleading. In contrast to the information provided in informed consent statements, the suicide advisory is misleading because it implies causation between abortion and suicide despite the fact that proof of such a relationship does not exist.[10] The advisory and the opinion are premised on research demonstrating a correlation between abortion and relative risk of suicide. A correlation is different from causation. Correlation describes a relationship where two variables are related such that if the value of one changes, the other changes at the same rate.[11] Causation, on the other hand, indicates that one event is the result of the occurrence of the other event.[12] A correlation *can* be created by causation, but the two variables are not necessarily related in that way.[13] For example, smoking is correlated with alcoholism: people who smoke are also likely to be alcoholics.[14] However, smoking does not cause alcoholism.[15] The term "relative risk" is another way to describe a correlation. Thus, while some research (which is heavily disputed, as I will discuss below) shows a correlation between abortion and relative risk of suicide (i.e. that women who obtain abortion care are more likely to commit suicide than other women), or a relative risk of suicide among women who obtained an abortion, the presence of that correlation does not necessarily mean that the two variables—abortion and suicide—are causally related. Moreover, in addition to obfuscating the difference between correlation and causation, the advisory is further misleading because physicians are required to provide it even in cases where it may be inapplicable.[16]

In order to argue that the suicide advisory disclosure is not misleading, South Dakota submitted various studies that demonstrated a correlation between abortion and suicide.[17] Although experts have criticized the results of most of the studies for flaws in methodology,[18] according to the Eighth Circuit, the presence of a correlation is sufficient to conclude that the suicide advisory is truthful.[19] Judge Gruender, writing for the majority, concluded that when the statute requires physicians to discuss an "increased risk," that term refers only to "a relatively higher probability of an adverse outcome in one group compared to other groups—that is, to 'relative risk.'"[20] His interpretation of the term "increased risk" relied on the use of the term in the technical, scientific literature submitted into evidence by proponents of the law.[21] He then concluded that the contextual definition of "relative risk" does not require proof of causation, at least as it pertained to the materials provided by supporters of the suicide advisory.[22]

Judge Gruender's analysis of relative risk is problematic for several reasons. First, by imputing into the suicide advisory a technical definition of "increased risk" which does not imply causation, the Eighth Circuit disregarded the importance of lay understanding in evaluating whether the advisory is misleading. The majority opinion read "increased risk" to mean "risk in a medical context."[23] The medical definition the majority decided upon was relative risk, which, as noted above, merely implies correlation, not causation.[24] However, the language of the statute does not require the physician to refer to "relative risk" or "risk in the medical context;" to inform the patient that "risk" refers only to a correlation or association, or to otherwise advise patients on the meaning of "increased risk." The suicide advisory simply requires that physicians specifically inform all women seeking abortion that the procedure carries with it an "increased risk of suicide and suicide ideation."[25]

The precise meaning of "risk" is left up to the individual physician to clarify (or not) and thus leaves wide open the possibility that a patient will misinterpret the suicide advisory to imply causation between abortion and suicide.[26] The Eighth Circuit's decision assumes that, either the patient will understand "increased risk" to indicate the mere presence of a correlation or the physician will explain the difference between correlation and causation. It also assumes that, if presented with the distinction between correlation and causation, the patient will understand the distinction and make her decision accordingly. It is common, however, to confuse correlation/relative risk and causation, as evidenced by the American Psychological Association (APA) report cited by the majority,[27] which suggested that research on the connection between abortion and mental health problems demonstrated a negative "tendency to confuse a risk and a cause."[28] If such

misunderstanding is common among professionals, it stands to reason that the confusion is even more common among average people. For a patient who is unaware of or does not understand that important distinction between risk-as-causation and risk-as-correlation, the advisory is misleading. Yet neither the legislature nor the majority in *Rounds* appeared concerned with the possibility that a woman might infer an erroneous causal connection after being told that a "risk factor" of abortion is "increased risk" of suicide. If actual informed consent were truly the objective of the legislature, it should have safeguarded against such a potentially important misunderstanding. Because the legislature failed to do so, however, the Eighth Circuit should not have upheld the statute because of its misleading effect.

Judge Gruender's next step in evaluating whether the suicide advisory was misleading was to characterize the evidence presented by both parties as to whether abortion lead to an increased relative risk of suicide. He characterized the available evidence as showing "some degree of medical and scientific uncertainty . . . as to whether abortion places a causal role in the observed correlation between abortion and suicide."[29] However, there is "no proof in the medical literature that abortion causes suicide," and unfortunately for the women of South Dakota, the Judge failed to consider the significant problems with much of the research that indicated existence of a correlation.[30] Researchers at the University of California found that the study upon which Judge Gruender relied "ha[d] fundamental analytical errors that render its conclusions invalid."[31] One researcher even characterized the study as "an abuse of the scientific process to reach conclusions that are not supported by the data."[32]

In fact, the APA has found that "the best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater" if they have an elective first-trimester abortion than if they give birth.[33] Other research supports that finding.[34] The vast majority of abortions in the United States occur during the first trimester[35] and are a response to an unplanned pregnancy[36]—so for most women, there is no such increased relative risk. For other women, it is true that the some women experience sadness, grief, and other feelings of loss following an abortion. In an extensive review, however, of all the literature on the relationship between mental health and abortion, the APA found "no evidence sufficient to support the claim" that where a person has both a history of abortion and a history of mental health issues, the mental health issues resulted from the abortion.[37]

Judge Gruender's analysis suggests that where some correlation exists, it is therefore "non-misleading" for a physician to imply to a patient that causation exists, simply because a conclusive determination on causation has not been made. Indeed, the opinion stated that Planned Parenthood would have to "show that any 'medical and scientific uncertainty' has been resolved into a certainty *against* a causal role for abortion" in order for the suicide advisory to be held unconstitutionally misleading.[38] This position is outrageous for two reasons. First, it would be impossible to prove or disprove causation in the abortion context, because it would be unethical to assign women with unwanted pregnancies to abortion versus delivery or adoption groups and perform a clinical trial.[39] Second, any number of negative factors could create a correlation like the one the court relied on. For example, the APA found that "prior mental health emerged as the strongest predictor of postabortion mental health",[40] meaning that the Eighth Circuit's decision allows the state to lend its weight to one side of a medical debate – despite the fact that the chosen claims are based on methodologically suspect data.[41] The decision, therefore, is manifestly unfair to patients.

The majority went on to argue that the statute is permissible under both *Casey* and *Carhart*, and Judge Loken, in his concurrence, stated that precedent required the statute to be upheld.[42] Under *Casey*, states have wide latitude to require "the giving of truthful, non-misleading information about the nature of the procedure, the attendant health risks and those of childbirth"[43] even if the disclosure might "cause the woman to choose childbirth over abortion."[44] However, the standard articulated in *Casey* does not require that courts uphold ambiguous statutes that confuse, rather than inform, decision-making. Moreover, it is true that in the wake of *Carhart*, state and federal legislatures enjoy "wide discretion to pass legislation in areas where there is medical and scientific uncertainty."[45] However, *Carhart* does not say that the legislature has the power to compel physicians to warn every patient of

a "known" risk, which may be understood to imply causation where only a correlation has been shown. Thus, the Eighth Circuit could have held the suicide disclosure unconstitutional while remaining within the boundaries of precedent.

As Judge Murphy's dissent recognized, "informed choice is hindered" when a woman is simply informed that suicide is a "known medical risk" of having an abortion, "when the weight of the medical research indicates the opposite and she is not informed of the debate."[46] The statute forces disclosure of a "risk which the medical record refutes"[47] and obfuscates correlation and causation without requiring clarification of the nature of the "risk" being disclosed. If Planned Parenthood is correct that "it is more plausible that certain underlying factors, such as pre-existing mental health problems, predispose some women both to have unwanted pregnancies and to have suicidal tendencies, resulting in a misleading correlation between abortion and suicide,"[48] the disclosure would be irrelevant in those cases where the underlying factors are not present.

A further problem with mandated provision of the suicide advisory is that physicians are no longer able to provide their patients with information specifically tailored to the patient's individual needs, which could distort the decision-making process.[49] After *Rounds*, South Dakota physicians can no longer tailor their discussion of the risks and harms of abortion (and childbirth) to the unique situation of each patient; instead, they must convey standardized information that is likely to alter the patient's understanding of her choices in favor of the state-sponsored pro-childbirth position.[50] By mandating use of the suicide advisory, the Court allowed the state to inject its interpretation of the relevant medical literature into the doctor-patient relationship and the patient's decision-making process.[51] Unfortunately, misleading information of the sort provided by the suicide advisory does not assist in intelligent decision-making; rather, it results in a violation of patient autonomy known as "informational manipulation."[52] Informational manipulation occurs when an agent manages information in order to alter a person's understanding of a situation and induce them to do what the agent wants. Thus, it does not facilitate autonomous decision-making on the part of women seeking abortion in South Dakota, but rather hinders the decision-making process. In this manner, the decision subverts the ability of women in South Dakota to provide truly informed consent.

III. *Rounds* Creates Worrisome Precedent for Informed Consent Laws Everywhere

Second, in upholding the suicide advisory, the Eighth Circuit gave legitimacy and support to a specific class of anti-abortion laws that are designed to "unduly influence a woman's choice, in violation of the ethical boundaries of medical informed consent."[53] These laws, known as "woman-protective" anti-abortion laws, are designed to outlaw abortion on the premise that abortion presents various harms to women. Woman-protective anti-abortion laws are frequently justified using suspect social science claims, religious mores, and anecdote rather than empirical studies of abortion's effects on public health.[54] The suicide advisory is no exception; in enacting the 2005 anti-abortion law, the South Dakota legislature relied heavily on a Report prepared by the South Dakota Task Force to Study Abortion.[55] Significantly, that report was later renounced by the Task Force's chair, an obstetrician and anti-abortion activist, for being "biased and opinionated" and "less than completely objective and factual."[56]

The precise type of woman-protective law that *Rounds* upholds is the abortion-specific informed consent law. All states already require informed consent before a medical procedure (including before an abortion), it is a process that has traditionally been self-regulated by the medical profession.[57] However, many states have enacted additional informed consent laws specific to abortion, mandating disclosures that, like South Dakota's suicide advisory, "not only go beyond what is required for other medical procedures, but also include information that is inaccurate, incomplete, or irrelevant to the particular abortion procedure to be performed."[58] As discussed above, informed consent standards are intended to facilitate autonomous decision-making in the medical context, on the basis of relevant, factual information.[59] Yet, woman-protective anti-abortion laws, and anti-abortion informed consent requirements specifically, are not always designed to provide patients with factual information.[60] Rather, the laws create "informational manipulation," which, in this context, means that the state manages the information provided to patients

regarding abortions in a manner that may alter the patient's understanding of their medical situation. Furthermore, the information provided could affect the patient's course of medical care in a manner that may actually be inconsistent with the patient's self-interest.[61]

The functioning of the suicide advisory provides an example. Without the suicide advisory, a South Dakota physician is still required, under normal informed consent standards, to provide the patient with the information necessary to make an informed decision about whether to procure an abortion.[62] If the physician, in his or her medical judgment, finds that the patient will be at risk for suicide or suicide ideation following the procedure, she has a duty to inform the patient of that risk.[63] On the other hand, if the patient is not deemed to be at risk, the doctor has no duty to inform the patient of the correlation between suicide and abortion.[64] Under the suicide advisory, however, the doctor must inform the patient of the risk factor regardless of whether the patient is actually at risk. When the information is no longer tailored to the patient's needs, but instead reflects the state's interests, the result is informational manipulation. The information may lead the patient to conclude that she will necessarily be at increased risk of suicide if she chooses abortion (even if this is not the case), and instead choose to move forward with the unwanted pregnancy.[65] The state, of course, hopes to encourage the pregnant woman to choose childbirth.[66] But her choice to do so is not truly autonomous if made in the face of misleading information deliberately intended to influence her choice.

Abortion-specific informed consent laws have sprung up all over the United States.[67] By upholding the suicide advisory, the Eighth Circuit gave cover to other required disclosures that might actually be harmful to informed consent. When presented with the opportunity to preserve the integrity of informed consent and the doctor-patient relationship, the Eighth Circuit took the side of state legislatures across the country who wish to decide for doctors and patients what medical information is material to every decision related to abortion.

Of particular concern is the "no causal relationship" standard articulated by Judge Gruender.[68] This new evidentiary requirement suggests that any informed consent legislation could be constitutional as long as there is some demonstrated correlation between the disfavored procedure and a risk factor. Since the Eighth Circuit gave credence to the notion that correlation necessarily shows the possibility of causation,[69] it may actually be impossible for a plaintiff to claim that such a statute is unconstitutional. In the context of abortion-specific informed consent laws, this could mean that states can now require disclosures of other alleged "risks," including fear of vacuums and other pseudo-scientific risk factors that some studies purport to correlate with abortion.[70] As long as proponents of the law could demonstrate some "medical uncertainty," defined in *Rounds* as the possibility of causation shown by the presence of a correlation, the required disclosure would not be unconstitutional.

Yet, the holding of *Rounds* need not be restricted to abortion. Indeed, the majority stated that informed consent standards should not be different just because abortion is concerned.[71] Thus, *Rounds* may also hold serious implications for informed consent and the practice of medicine more generally. When the state decides that it can arbitrarily choose which risk factors are important and which are not, it violates the physician's autonomy as an expert and provider of healthcare.[72] When the burden is on the plaintiff to completely disprove causation between the disfavored procedure and the chosen risk factor, the task of removing politics from the examining room becomes nearly insurmountable. This decision leaves open the opportunity for any state-based information manipulation in an informed consent setting. For many, abortion may seem a unique enough procedure to justify the state's influence on patient choices, but the standard articulated by the Eighth Circuit could easily extend to other more "mainstream" procedures. This possibility should be of concern to doctors and patients throughout the country who seek to evaluate the risks and benefits of medical procedures, including abortion, free from the interference of politicians. It suggests that a state can inject itself into the fiduciary relationship between doctor and patient with the blessing of the federal judiciary.[73] It gives state legislatures permission to use any correlative risk factor to influence medical choices, thereby undermining the autonomous decision-making of patients.

IV. Conclusion

The Eighth Circuit had the opportunity to protect informed consent while remaining within the bounds of *Casey* and *Carhart*. Instead, the majority opinion subordinated informed consent in favor of an ideological law based on questionable science. The decision is problematic for the women of South Dakota, who will now be confronted with politicians' determination that all women are at an increased risk of suicide following abortion. It is also problematic as a matter of precedent, because it gave federal appellate approval to a type of informed consent law that has very little to do with informed consent. Perhaps most dangerous is Judge Gruender's requirement that a plaintiff would have to prove *no causation whatsoever* in order to make an informed consent statute unconstitutionally misleading. This requirement could potentially extend beyond abortion such that any required disclosure could be permissible, as long as there is some correlation between a risk factor and a disfavored procedure. *Rounds* is a very problematic decision for the women of the Eighth Circuit, but also for any person who values a doctor-patient relationship free from the interference and manipulation of government preferences.

(Endnotes)

[1] Harvard Law School, J.D. Class of 2014. Many thanks to the staff of *The Modern American* for their thoughtful edits and helpful feedback.

[2] *See* 2005 S.D. Sess. Laws 356. *See also* Evelyn Nieves, *S.D. Makes Abortion Rare Through Laws and Stigma*, WASH. POST (December 27, 2005), http://www.washingtonpost.com/wp-dyn/content/article/2005/12/26/AR2005122600747.html.

[3] S.D. Codified Laws § 34–23A–10.1(1)(e) (2012). In addition to the "suicide advisory," the physician must also list "depression and related psychological distress" and the rate of deaths due to abortion as risk factors to which the woman would be subjected, as well as all other known risks to her physical health and the probable gestational age of the fetus. *Id.* The physician is also required to inform the woman that the "abortion will terminate the life of a whole, separate, unique, living human being," S.D. Codified Laws § 34–23A–10.1(1)(b), that she "has an existing relationship with that unborn human being" which enjoys protection under Federal and State law, S.D. Codified Laws § 34–23A–10.1(1)(c), and that obtaining the abortion will terminate that relationship. S.D. Codified Laws § 34–23A–10.1(1)(d).

[4] *See* Planned Parenthood Minn. v. Rounds, 686 F.3d 889, 892–893 (8th Cir. 2012) (quoting Planned Parenthood Minn. v. Rounds, 653 F.3d 662 (8th Cir. 2011)). Following the enactment of the 2005 legislation, Planned Parenthood Minnesota, North Dakota, South Dakota filed suit seeking an injunction against enforcement of the law. *See* Planned Parenthood Minn. v. Rounds, 530 F.3d 724 (8th Cir. 2008). The District Court had held the suicide advisory to be unconstitutionally vague and an undue burden, and a divided Eighth Circuit panel affirmed. *See Rounds*, 686 F.3d at 892–93. However, the Eighth Circuit granted a rehearing en banc solely on that issue, and reversed the panel's decision. *See Rounds*, 686 F.3d at 892.

[5] *See* Canterbury v. Spence, 464 F.2d 772, 782–783 (D.C. Cir. 1972) ("It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment . . . [I]t is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification."). *See also* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 121, 121 (Oxford University Press 1986); Janet L. Dolgin, *The Legal Development of the Informed Consent Doctrine: Past and Present*, 19 CAMBRIDGE Q. OF HEALTHCARE ETHICS 97 100, 102, 104 (2010). For an illuminating discussion on the similarities of informed consent in medical examination and its similarities to abortion law, *see* Jennifer Yeo, *Raising the Standard of Abortion Informed Consent: Lessons to be Learned from the Ethical and Legal Requirements for Consent to Medical Experimentation*, 21 Colum. J. Gender & L. 357, 359, 380 (2011).

[6] *See* Salgo v. Leland Stanford Jr. Univ. Bd. of Tr., 317 P.2d 170, 181 (Cal. Ct. App. 1957).

[7] *See, e.g.*, *Canterbury*, 464 F.2d at 781 ("The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it."); Wilkinson v. Vesey, 295 A.2d 676, 686 (R.I. 1972) ("[A] physician has an obligation to make a reasonable explanation and disclosure to his patient of the risks and hazards involved in a proposed course of treatment to the end that whatever consent given by the patient to the prescribed treatment may be an informed and intelligent consent."); Cooper v. Roberts, 286 A.2d 647, 650 (Pa. Super. Ct. 1971) ("[T]he primary interest of Pennsylvania jurisprudence in regard to informed consent is that of having the patient informed of all the material facts from which he can make an intelligent choice as to his course of treatment . . ."); *Salgo*, 317 P.2d at 181 ("[E]ach patient presents a separate problem . . . [I]n discussing the element of a risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.").

[8] *See Canterbury*, 464 F.2d at 783 ("The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken . . . [I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."); *Wilkinson*, 295 A.2d at 689 ("It is not necessary to tell the patient any and all of the possible risks and dangers of a proposed procedure . . [M]ateriality is to be the guide."); *Cooper*, 286 A.2d at 650 (noting that while the patient must be the "arbiter of

the medical treatment he will undergo," the physician need not "disclose Every [sic] risk"); *Salgo*, 317 P.2d at 181.

[9] *See* FADEN, *supra* note 5; Dolgin, *supra* note 5.

[10] *See Rounds*, 686 F.3d at 907 (Murphy, J., dissenting) ("The most reliable evidence in the record shows that abortion does not have a *causal* relationship to the risk of suicide and that South Dakota's mandated advisory is not truthful, but actually misleading.").

[11] *See, e.g.*, AUSTRALIAN BUREAU OF STATISTICS, *Correlation and Causation*, (July 3, 2013), http://www.abs.gov.au/websitedbs/a3121120.nsf/home/statistical+language+-+correlation+and+causation.

[12] *Id.*

[13] *Id.*

[14] *See, e.g.*, AUSTRALIAN BUREAU OF STATISTICS, *Correlation and Causation*, (July 3, 2013), http://www.abs.gov.au/websitedbs/a3121120.nsf/home/statistical+language+-+correlation+and+causation.

[15] *Id.*

[16] *See* Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL. REV. 4 (2007), *available at* http://www.guttmacher.org/pubs/gpr/10/4/gpr100406 (stating that the written materials that several states require doctors to provide to women are nongermane to the women receiving them).

[17] *See* Planned Parenthood Minn. v. Rounds, 686 F.3d 889, 898 (8th Cir. 2012) (majority opinion).

[18] *Id.* at 908–10 (Murphy, J., dissenting). *See also* APA Task Force on Mental Health and Abortion, REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 3 (2008) (stating that a majority of studies on the relationship between abortion and mental health problems "suffered from methodological problems, often severe in nature") [hereinafter "APA REPORT"]; Vignetta E. Charles et. al., *Abortion and long-term mental health outcomes: a systematic review of the evidence*, 78 CONTRACEPTION 436, 448–49 (2008) (finding that the "highest quality studies" showed "few, if any" differences between women who obtained abortions and their respective comparison groups, while "studies with the most flawed methodology consistently found negative mental health" outcomes).

[19] *See Rounds*, 686 F.3d at 898 (majority opinion).

[20] *Id.* at 894.

[21] *Id.*

[22] *Id.* at 900.

[23] *Id.* at 894.

[24] *Id.* at 894–95.

[25] S.D. Codified Laws § 34–23A–10.1(1)(e) (2012).

[26] *See, e.g.*, Michael C. Dorf, *Can the Government Require Doctors to Provide Misleading Information to Patients Seeking Abortions?*, VERDICT (Aug. 20, 2012), http://verdict.justia.com/2012/08/20/can-the-government-require-doctors-to-provide-misleading-information-to-patients-seeking-abortions ("[M]ost women seeking abortions are not scientists and they will therefore assume—incorrectly—that the are hearing about a link between abortion and suicide because abortion causes suicide. Otherwise, the warning will make no sense."). *Cf.* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L. J. 899, 945 (1994) (discussing the failure of most physicians to convey medical risk to patients in a comprehensible way).

[27] *See Rounds*, 686 F.3d at 895.

[28] *Id.* (citing BRENDA MAJOR ET. AL, AMERICAN PSYCHOLOGICAL ASSOCIATION, REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 20 (2008)).

[29] *Id.* at 900 (citations omitted).

[30] *Id.* at 908–911 (Murphy, J., dissenting).

[31] Joerg Dreweke, *Study Purporting to Show Link Between Abortion and Mental Health Outcomes Decisively Debunked*, GUTTMACHER INST. (March 5, 2012), http://www.guttmacher.org/media/nr/2012/03/05/index.html.

[32] *Id.*

[33] *See* APA REPORT 4.

[34] *See* Academy of Medical Royal Colleges, *Induced Abortion and Mental Health: A Systematic Review of the Mental Outcomes of Induced Abortion, Including their Prevalence and Associated Factors* 8 (December 2011), *available at* http://www.nccmh.org.uk/reports/ABORTION_REPORT_WEB%20FINAL.pdf (finding that "the rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth" and that "the factors associated with increased rates of mental health problems for women in the general population following birth and following abortion were similar") [hereinafter INDUCED ABORTION]. *See also* Charles, *supra* note 18, at 449.

[35] *See* Dreweke, *supra* note 31 (stating that 89% of abortions occur within the first twelve weeks).

[36] Lawrence B. Finer et. al, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 110, 110 (2005).

[37] *See supra* note 33.

[38] *See Rounds*, 686 F.3d. at 900 (majority opinion).

[39] *See* APA REPORT 8.

[40] *See supra* note 33. *See also* INDUCED ABORTION, *supra* note 34, at 8 ("The most reliable predictor of post-abortion mental health problems was a history of mental health problems before the abortion.").

[41] Charles, *supra* note 18, at 449 ("[M]aking policy recommendations such as the enforcement of so-called "informed consent" laws .(which often provide misinformation regarding mental health risks of abortion) is unwarranted based on the current state of the evidence. If the goal is to help women, we are obligated to base program and policy recommendations on the best science, rather than using science to advance political agenda.")

[42] *See Rounds*, 686 F.3d at 906 (Loken, J., concurring).

[43] *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992).

[44] *See id.* at 883.

[45] *See* Gonzales v. Carhart, 550 U.S. 124, 163 (2007).

[46] *See Rounds*, 686 F.3d at 911 (Murphy, J., dissenting).

[47] *See id.* at 912.

[48] *See id.* at 899.

[49] *See* State v. Presidential Women's Center, 707 So.2d 1145, 1150 (Fla. Dist. Ct. App. 1998) (striking down an informed consent statute because it "standardize[d] the information being

given to all women and remove[d] the discretion accorded to physicians in all circumstances other than abortion").

50 *See, e.g.*, Note, *Eighth Circuit Applies Planned Parenthood of Southeastern Pennsylvania v. Casey to South Dakota "Suicide Advisory"*, 126 HARV. L. REV. 1438, 1446 (2013) ("In *Rounds*, by contrast, physicians were required to provide a specific piece of contested information to every patient, regardless of individual circumstances, as a part of their own personal disclosure obligations.").

51 *Id.*

52 *Id.*

53 *See* Yeo, *supra* note 5, at 358.

54 *See* Reva Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1642–1647, 1655–1664, 1674 (2008). Siegel also explores the conscious choice, influenced by market research, of anti-abortion activists to shift to a discourse of women's health—not as the result of a newfound interest in women's health, but in response to perceptions that the antiabortion movement cared only about fetuses and not enough about mothers. *See id.* at 1669–1673.

55 *Id.* at 1652.

56 Chet Brokaw, *Leader of State's Abortion Panel Unhappy with Final Report*, ABERDEEN AM. NEWS (December 14, 2005), at B6.

57 *See* Yeo, *supra* note 5, at 358. It is true that the government regulates informed consent to some degree, at least insofar as courts have stepped in to establish basic standards and allow lawsuits when the standards are not met. However, the courts have not told doctors exactly what information to disclose; rather, they have called for disclosure "when the exigencies of reasonable care call for it" and left the precise disclosures up to the medical judgment of the physician. Canterbury v. Spence, 464 F.2d 772, 779 (D.C. Cir. 1972). *See also* Wilkinson v. Vesey, 295 A.2d 676, 689 (R.I. 1972) (physicians must disclose what risks a "reasonable person, in what the physician knows or should know is his patient's position" would need to know to make an informed decision); Cooper v. Roberts, 286 A.2d 647, 650 (Pa. Super. Ct. 1971) (a physician must disclose "all those facts, risks and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment"); Salgo v. Leland Stanford Jr. Univ. Bd. of Tr., 317 P.2d 170, 181 (Cal. Ct. App. 1957) (physician must disclose facts necessary to form intelligent consent).

58 *See* Yeo, *supra* note 5, at 358.

59 *See, e.g.*, *Canterbury*, 464 F.2d at 782–783. *See also* FADEN, *supra* note 6, at 121; Dolgin, *supra* note 6, at 97, 100, 102, 104.

60 *See* Siegel, *supra* note 59, at 1663–64.

61 *Id.*

62 *See* Veith v. O'Brien, 739 N.W.2d 15, 32 (S.D. 2007) ("[W]e have consistently held that it is the physician's duty to make full disclosure to and obtain informed consent from the patient.").

63 *See id. See also* Wheeldon v. Madison, 347 N.W.2d 367, 374 (S.D. 1985).

64 *See Wheeldon*, 347 N.W.2d at 375 ("Materiality . . . is the cornerstone upon which the physician's duty to disclose is based.").

65 *Cf.* Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WISC. L. REV. 413, 416 (1979) (discussing the way disclosures can and often are made in such a way as to influence patient choice according to the doctor's wishes).

66 *See* Planned Parenthood Minn. v. Rounds, 686 F.3d 889, 906 (8th Cir. 2012).

67 *See* Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 GUTTMACHER POL'Y REV. 6, 6 (2006), *available at* http://www.guttmacher.org/pubs/gpr/09/4/gpr090406.pdf.

68 *See Rounds*, 686 F.3d at 900.

69 *See id.* at 899–900.

70 *See* Siegel, *supra* note 54, at 1655 (citing PAULA ERVIN, WOMEN EXPLOITED: THE OTHER VICTIMS OF ABORTION (1985)).

71 *See Rounds*, 686 F.3d at 900.

72 Many thanks to Matthew Aizpuru for his insights on this topic.

73 It is conceivable that another court could carry this holding past even the healthcare realm into the law of trusts, investment advising and beyond. Allowing the government to impose disclosures of specific, politically identified risks on fiduciary relationships has the potential to alter an archetypal legal concept, particularly if the plaintiff carries the burden of disproving the government's proposed advice.