

Winter 2016

Abortion, Informed Consent, and Regulatory Spillover


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Recommended Citation

Shaw, Katherine A. and Stein, Alex (2016) "Abortion, Informed Consent, and Regulatory Spillover," *Indiana Law Journal*: Vol. 92 : Iss. 1 , Article 1.

Available at: <https://www.repository.law.indiana.edu/ilj/vol92/iss1/1>

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Abortion, Informed Consent, and Regulatory Spillover

KATHERINE SHAW* AND ALEX STEIN†

The constitutional law of abortion stands on the untenable assumption that any state's abortion regulations impact citizens of that state alone. On this understanding, the state's boundaries demarcate the terrain on which women's right to abortion clashes with state power to regulate that right.

This Article uncovers a previously unnoticed horizontal dimension of abortion regulation: the medical-malpractice penalties imposed upon doctors for failing to inform patients about abortion risks; the states' power to define those risks, along with doctors' informed-consent obligations and penalties; and, critically, the possibility that such standards might cross state lines. Planned Parenthood v. Casey and other decisions that have approved abortion-specific informed-consent requirements have failed to account for this interstate dynamic.

In recent years, fourteen states, led by South Dakota, have enacted statutes that direct doctors to warn patients, as part of an informed-consent dialogue, that abortion might cause depression and even suicide ideation and actual suicide. Although there is broad medical consensus that such warnings are unnecessary, courts have nonetheless concluded that the Supreme Court's Casey decision shields them from constitutional challenge. This may have implications not just in the states that mandate such warnings, but nationwide. Because doctors' informed-consent obligations incorporate medical information and practices from other jurisdictions, a doctor's failure to warn a patient about postabortion depression may expose her to liability for medical malpractice—even where her own state does not mandate such a warning statutorily. Eliminating this risk by warning a patient that abortion might lead to depression costs the doctor much less than the penalties she might incur for withholding that information.

This dynamic—which we term the “South Dakota effect”—threatens to transform informed-consent practices across the country, with profound consequences for

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† Visiting Professor of Law, Harvard Law School. Professor of Law, Brooklyn Law School. We thank Michelle Adams, Akhil Amar, Kate Andrias, Brian Bix, Vince Blasi, Anu Bradford, Bill Brewbaker, Jessica Bulman-Pozen, June Carbone, Ann Carlson, Jenny Carroll, Joe Colquitt, Liz Emens, Brian Fitzpatrick, Dov Fox, Heather Gerken, Suzanne Goldberg, Jeff Gordon, Zohar Goshen, Jamal Greene, Bernard Harcourt, Claire Hill, Julie Hill, Rob Jackson, Adam Kolber, Herbert Kritzer, Rebecca Kysar, Alexi Lahav, Ben Liebman, Peter Markowitz, Brett McDonnell, Steve Meili, Tom Merrill, Gillian Metzger, Jon Michaels, Henry Monaghan, Doug NeJaime, Gideon Parchomovsky, Michael Pardo, Sharon Paulsen, Anthea Roberts, Chris Roberts, Carol Sanger, Buffie Scott, Dan Schwarcz, Gil Siegal, Reva Siegel, Peter Siegelman, Adam Steinman, Stephanie Toti, Aaron Twerski, and participants in workshops at the Alabama University School of Law, Bar Ilan University School of Law, Benjamin N. Cardozo School of Law, Brooklyn Law School, Columbia Law School, UCLA Law School, University of Minnesota School of Law, and Vanderbilt Law School for insightful comments and suggestions. We also thank Kate Giessel, Jessica Marshall, and Elise Michael for outstanding research assistance, and the editors of the Indiana Law Journal for excellent editorial work.

women's willingness to elect abortion and for the experiences of women who choose to go forward with abortion procedures. More broadly, it highlights the need to re-think the abortion-federalism nexus.

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INTRODUCTION

Profound state variation has long characterized our law of abortion. In 1973, the year *Roe v. Wade*¹ was decided, thirty-one states prohibited abortion except where necessary to save a woman's life.² In a number of states, criminal prosecutions of doctors who performed abortions were common;³ in some of those states, not just doctors but also patients could in theory face criminal penalties.⁴ On the other end of the spectrum, by 1973, four states⁵ broadly permitted "abortion without restriction 'early' in pregnancy,"⁶ and a number of other states had liberalized their abortion laws to varying degrees.⁷

Roe, of course, dramatically changed the constitutional landscape, holding that the Constitution protects—at least to some degree—a woman's right to decide for

1. 410 U.S. 113 (1973).

2. Richard H. Fallon, Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS U. L.J. 611, 614 (2007).

3. Reva B. Siegel, *Roe's Roots: The Women's Rights Claims That Engendered Roe*, 90 B.U.L. REV. 1875, 1879 (2010).

4. HEATHER D. BOONSTRA, RACHEL BENSON GOLD, CORY L. RICHARDS & LAWRENCE B. FINER, GUTTMACHER INST., *ABORTION IN WOMEN'S LIVES* 11 (2006).

5. Those states were New York, Washington, Hawaii, and Alaska. Rachel Benson Gold, *Lessons From Before Roe: Will Past Be Prologue?*, GUTTMACHER REP. ON PUB. POL'Y, Mar. 2003, at 8.

6. Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions About Backlash*, 120 YALE L.J. 2028, 2047 (2011).

7. BOONSTRA ET AL., *supra* note 4, at 12; *see also* LINDA GREENHOUSE & REVA SIEGEL, *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING* 120–22 (Linda Greenhouse & Reva Siegel eds., 2010).

herself whether to terminate a pregnancy.⁸ Accordingly, *Roe* invalidated state laws that wholesale prohibited abortion. But the *Roe* Court continued to credit a strong state interest in regulating abortion, including in order to promote potential life.⁹ Crafting a trimester framework to balance these competing interests, *Roe* held that during the first trimester of pregnancy, when abortion is relatively uncomplicated and the fetus cannot live outside the womb, a woman's privacy and autonomy interests trump any state interest in regulation. As the pregnancy progresses, the state's interest in regulation becomes stronger, so that by the beginning of the third trimester, the state can prohibit abortion outright, except where necessary to preserve a woman's life or health.¹⁰

Roe's preservation of state regulatory prerogatives meant that state law continued to vary dramatically in the post-*Roe* era. And the most significant post-*Roe* case, *Planned Parenthood of Southeastern Pennsylvania v. Casey*,¹¹ only increased states' regulatory power in the context of abortion. Dispensing altogether with *Roe*'s trimester framework, *Casey* held that the state has a legitimate interest in regulating to protect women's health and safety, and to promote potential life, for the duration of a pregnancy.¹² Under *Casey*'s framework, abortion regulations will be sustained so long as they do not impose an "undue burden" on a woman's ability to choose to terminate a pregnancy prior to viability.¹³ Application of the undue burden standard—which permits regulations that do not have the "purpose or effect" of "plac[ing] a substantial obstacle in the path of a woman seeking an abortion"¹⁴—has vindicated state regulation of abortion facilities, procedures, and decisions. Among other things, it has allowed states to prescribe special rules for informed consent to abortion,¹⁵

8. See Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 GEO. L.J. 625, 640–41 (2008) ("Although the formal doctrine remains largely the same since *Roe*, the underlying right has evolved dramatically from a relational right protective of physician and patient autonomy to an individualistic right held by the woman alone.").

9. *Roe v. Wade*, 410 U.S. 113, 163 (1973) (recognizing "the State's important and legitimate interest in potential life").

10. *Id.* at 164–66.

11. 505 U.S. 833 (1992).

12. *Id.* at 846.

13. *Id.* at 878. Following viability, the balance of interests tilts sharply in favor of the state, which may regulate to the point of prohibition so long as the law contains an exception to preserve the life or health of the woman. *Id.* at 879. For powerful contemporary analysis of *Casey*'s "undue burden" doctrine, see Reva Siegel & Linda Greenhouse, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 YALE L.J. 1428 (2016).

14. *Casey*, 505 U.S. at 878.

15. In *Casey* itself, the Court upheld provisions of Pennsylvania law that required physicians to "inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the 'probable gestational age of the unborn child,'" in addition to advising the woman of "the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion." *Id.* at 881; see also *Karlin v. Foust*, 188 F.3d 446, 471–72 (7th Cir. 1999) (upholding Wisconsin statute requiring doctors to inform women seeking abortions of "the 'medical risks' associated with abortion including the risk of 'psychological trauma,'" but allowing doctors to exercise "best medical judgment" in determining exact contents of

exposing the rules' violators to a range of sanctions, including liability for medical malpractice.¹⁶ States defend these rules as informing, rather than hindering, women's choice.¹⁷ And courts have for the most part credited such justifications.¹⁸

Consider the South Dakota statute that requires abortion providers to tell patients seeking abortions that "the abortion will terminate the life of a whole, separate, unique, living human being"; that abortion might lead to "[d]epression and related psychological distress" or "[i]ncreased risk of suicide ideation and suicide"; and that pregnant women are eligible for childbirth and neonatal support.¹⁹ As a matter of state law, failure to provide such warnings will violate the patient's right to informed consent and expose violators to liability for malpractice and other penalties.²⁰ The statute essentially compels doctors to urge women to reconsider abortion decisions. To that end, it introduces a mandatory warning that amalgamates controversial and contested information, gives that information official recognition, and uses doctors to make the information appear credible.²¹

warnings); *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 531 (8th Cir. 1994) (upholding North Dakota law similar to Pennsylvania informed consent provision at issue in *Casey*).

16. In every state, violation of a patient's right to informed consent is actionable in tort. See RICHARD A. EPSTEIN, TORTS § 6.3 (1999). In addition, the statutes we address here designate women seeking abortions as their beneficiaries, which makes their breaches actionable. See *id.* § 6.4, at 146–50 (victims of health and safety statutes' violations can generally sue violators in tort); see also Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1724 (2008) (observing that, after *Roe v. Wade*, the antiabortion movement mobilized medical malpractice and informed-consent laws to block women's access to abortion).

17. See, e.g., *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 906 (8th Cir. 2012) (en banc) (finding "no unconstitutional hindrance of the woman's choice" in state-mandated advisory linking abortion and suicide).

18. See, e.g., *id.*; *Karlin*, 188 F.3d at 471; *Fargo Women's Health*, 18 F.3d at 531. We should note that the Supreme Court's recent decision in *Whole Woman's Health v. Hellerstedt*, No. 15-274 (U.S. June 27, 2016), https://www.supremecourt.gov/opinions/15pdf/15-274_p8k0.pdf [<https://perma.cc/28S6-EZSW>], which struck down a law requiring Texas clinics to conform to the requirements of ambulatory surgical centers and doctors who perform abortions to have admitting privileges at nearby hospitals—demonstrated that the "undue burden" standard does not authorize any abortion regulation a state might devise. To date, the decision has not had any impact on abortion-specific informed-consent requirements of the sort we discuss here. But the opinion does suggest an active judicial role in carefully scrutinizing the medical claims upon which abortion regulations are predicated. See *id.* at 20 (describing "[t]he statement that legislatures, and not courts, must resolve questions of medical uncertainty" as "inconsistent with this Court's case law"). So it may well be deployed in renewed attacks on the constitutionality of such laws.

19. S.D. CODIFIED LAWS §§ 34-23A-1.7, -10.1(1), (2) (2011). For a discussion of laws like South Dakota's as a form of "abortion exceptionalism"—that is, the singling out of abortion "for more restrictive government regulation as compared to other, similar procedures"—see generally Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 3, 6 (2012).

20. S.D. CODIFIED LAWS § 34-23A-1.7 (2011); see also *supra* note 16 (discussing tort liability). Other penalties extend to the criminal. S.D. CODIFIED LAWS § 34-23A-10.2 (2011) ("Statement of informed consent—Misdemeanor . . .").

21. See *infra* notes 69–74 and accompanying text. Similarly motivated statutes in other

Animating this statute is an antiabortion policy of the sort the Supreme Court credited as legitimate in both *Roe* and *Casey*.²² The majority of South Dakotans appear to support this policy.²³ Residents who favor unrestricted abortion rights have no real voice in South Dakota. Under conventional theories of federalism, their only remedy is exit: all they can do is move to a state whose abortion laws are less restrictive.²⁴ Whatever the minority-view holders choose to do, the statute will remain the law of South Dakota; its effects will be felt within the state's borders, and, so long as the statute does not contravene constitutional limits—as the Eighth Circuit has

states require doctors to provide empirically unsupported warnings that tie abortion to breast cancer. *See, e.g.*, KAN. STAT. ANN. §§ 65-6709(a)(3), -6710(a)(2)–(3) (Supp. 2014) (mandating that doctors tell patients that abortion may cause breast cancer when this risk is objectively present); MINN. STAT. ANN. § 145.4242(a)(1)(i) (West 2011) (same, but with a proviso that information must be provided “when medically accurate”); MISS. CODE ANN. § 41-41-33(1)(a)(ii) (West 2007) (same as Minnesota); MONT. CODE ANN. § 50-20-104(5)(a)(i) (2015) (same); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(iii) (West Supp. 2015) (same); *see also* Div. of Pub. Health, *Possible Medical Risks or Complications of Abortion*, ALASKA DEP’T HEALTH & SOC. SERVS. (2015), <http://dhss.alaska.gov/dph/wcfh/Pages/informedconsent/abortion/risks.aspx> [<https://perma.cc/EX67-B7MJ>] (mentioning that “the American Association of Pro-Life Obstetricians and Gynecologists . . . supports the view that there is a causal relationship between breast cancer and the termination of pregnancy”). *See generally infra* note 69 (listing studies repudiating the cancer-abortion link).

22. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 872 (1992) (“[T]he State may enact rules and regulations designed to encourage [a woman] to know that there are philosophical and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term [T]he Constitution does not forbid a State or city, pursuant to democratic processes, from expressing a preference for normal childbirth.” (quoting *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 511 (1989))).

23. *See* REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 4 (2005), <http://www.dakotavoices.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf> [<https://perma.cc/H3PD-B2CC>] (noting that the Task Force was created by a vote of 63-4 in the House and 28-6 in the Senate); Steven Ertelt, *South Dakota Polls Show Conflicting Result on Abortion Ban's Future*, LIFE NEWS.COM (Nov. 15, 2007), <http://archive.lifenews.com/state2607.html> [<https://perma.cc/3PZU-UKF9>] (reporting that polls show a majority of South Dakotans support a ban on abortions except for life-saving purposes and in cases of rape and incest).

24. *See* RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 893 (8th ed. 2011) (“[P]eople can sort themselves between states in accordance with their preferences. The right to move to a different state supplements voting power in controlling the action of government officials.”); Richard A. Epstein, *Exit Rights Under Federalism*, 55 *LAW & CONTEMP. PROBS.* 147, 150 (1992) (“Federalism works best where it is possible to vote with your feet.”); Seth F. Kreimer, Response, *Lines in the Sand: The Importance of Borders in American Federalism*, 150 *U. PA. L. REV.* 973, 982 (2002) (“[A] citizen of Texas who finds that state’s prohibitions on same sex relations too onerous can move to Vermont, while a citizen of New York whose desire to own assault weapons is unrealizable can move to Montana.” (footnote omitted)); *cf.* Fergus Ryan, *The Geography of Abortion* (Dec. 11, 2015) (unpublished manuscript), <http://ssrn.com/abstract=2702506> [<https://perma.cc/RUE6-R5NN>] (tying Ireland’s restrictive abortion rights to the freedom to travel and wide accessibility of abortion in the nearby Great Britain). *See generally* ALBERT O. HIRSCHMAN, *EXIT, VOICE, AND LOYALTY: RESPONSES TO DECLINE IN FIRMS, ORGANIZATIONS, AND STATES* 3–5 (1970).

concluded²⁵—neither Congress nor the Supreme Court has any say in this intrastate business.

But what if the impact of South Dakota’s regulation is not limited to South Dakota?²⁶ In this Article, we argue that the critical assumption that laws like South Dakota’s have no interstate effects misses a key aspect of the doctrine of informed consent and its impact on doctors’ behavior. Specifically, this assumption ignores the effect of the emergence and official ratification of new medical information and practices—including information and practices with contestable credentials—on doctors’ disclosure obligations. Attending to the operation of the law of informed consent reveals that state medical malpractice laws pose a hitherto unrecognized threat both to women’s exercise of abortion rights nationwide and to the basic principle that each state may decide for itself how to balance the competing interests at stake in abortion.

The mechanism by which state regulations like South Dakota’s might impose spillover effects on other states—including states whose laws provide for relatively broad access to abortion²⁷—is straightforward. Two distinct paradigms govern information disclosure in the context of informed consent. Thirty states follow the “doctors’ custom” standard, which requires doctors to inform patients about the nature, risks, and benefits of a treatment, along with the medically approved alternatives, to the extent that such disclosure is customary within the medical profession.²⁸ The remaining twenty states and the District of Columbia use the “patient expectation” standard, under which doctors must tell patients everything that a reasonable patient would wish to know about the treatment and its alternatives.²⁹ Critically for purposes of the present discussion, the “patient expectation” standard generally requires doctors to inform patients about a risk of death or serious harm even when that risk is extremely low.³⁰ The “doctors’ custom” standard, on the other hand, does not recognize this disclosure obligation.³¹ Under both standards, a doctor’s failure to provide requisite information to her patient constitutes an actionable tort.³² Under this framework, state regulation that requires doctors to advise pregnant women that abortion

25. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 905–06 (8th Cir. 2012) (en banc) (upholding South Dakota’s suicide proviso against constitutional challenge); see also *Planned Parenthood Minn. v. Rounds*, 653 F.3d 662, 673 (8th Cir. 2011) (upholding general risk advisory), *vacated in part on rehearing en banc*, 662 F.3d 1072 (2011).

26. *But see* Neal Devins, *How Planned Parenthood v. Casey (Pretty Much) Settled the Abortion Wars*, 118 *YALE L.J.* 1318, 1338 (2009) (observing that states like South Dakota that “push the boundaries of *Casey* are few in number and limited in influence”).

27. See generally GUTTMACHER INST., *STATE POLICIES IN BRIEF: AN OVERVIEW OF STATE ABORTION LAW* (2016).

28. See *infra* notes 148–50 and Table 1.

29. See *infra* notes 148–50 and Table 1.

30. See *infra* notes 90–94 and accompanying text.

31. See *infra* note 89 and sources cited therein.

32. See, e.g., S.D. CODIFIED LAWS § 34-23A-1.7 (2011) (“The South Dakota common law cause of action for medical malpractice informed consent claims based upon the reasonable patient standard is reaffirmed and is hereby expressly declared to apply to all abortion procedures.”); S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(i)–(ii) (2011) (specifying South Dakota’s special informed consent requirements for abortion, which include providing “[a] description of all known medical risks of the procedure and statistically significant risk factors to which

might lead to serious depression or suicide will gradually spread to other states, whose doctors will begin providing similar warnings as part of their informed-consent dialogues with patients. This dynamic will first unfold in the states that follow the “patient expectation” standard. Under this standard, depression and suicide squarely fall into the “death or serious harm” category. For that reason, information about even a low probability of postabortion depression or suicide, ratified by another state in the form of mandatory warnings, may fall within the scope of disclosure that a reasonable patient would expect from her doctor.³³ This reasonable expectation will gradually compel doctors to begin warning patients about postabortion depression and suicide. Failure to give this warning may expose doctors to liability for malpractice and possible blacklisting in the National Practitioner Data Bank.³⁴ The “depression and suicide” warning will thus spread across all states that follow the “patient expectation” standard.

Because those states are numerous, their adoption of the “depression and suicide” warning will gradually change doctors’ practices nationwide. We expect this change to occur due to two factors. The first factor is the negligible cost of the warning: it costs doctors very little³⁵ to provide the “depression and suicide” warning in their conversations with patients or in the office paperwork that patients must read and sign. The second factor is doctors’ aversion to the risk of malpractice liability. To reduce this risk, doctors develop special protocols known as defensive medicine.³⁶ Overinforming patients about remote risks is one of those protocols.³⁷ We call this regulatory spillover the “South Dakota effect.” This spillover is analogous to the famous California effect in environmental regulation.³⁸ California’s hydrocarbon and

the pregnant woman would be subjected,” including “[d]epression and related psychological distress” as well as “increased risk of suicide ideation and suicide”). In South Dakota, any such violation is also punishable criminally as a Class 2 misdemeanor. S.D. CODIFIED LAWS § 34-23A-10.2 (2011).

33. See *infra* notes 89–94, 120–22 and accompanying text.

34. See *infra* note 129 and accompanying text.

35. We ignore ideological costs here.

36. See Gideon Parchomovsky & Alex Stein, Essay, *The Distortionary Effect of Evidence on Primary Behavior*, 124 HARV. L. REV. 518, 537–38, 545–46 (2010) (showing that self-interested doctors use defensive medicine to create evidence that fends off malpractice suits); see also Patricia M. Danzon, *Liability for Medical Malpractice*, in 1B HANDBOOK OF HEALTH ECONOMICS 1339, 1368–69 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (discussing defensive medicine); Abigail R. Moncrieff, Essay, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 852–54 (2009) (same). Arguably, a doctor’s warning about postabortion depression might drive away patients, which might result in a loss of income. We estimate that the loss-of-income scenario is unlikely, since a patient opting out of the procedure frees up time for another patient. Furthermore, an economically minded doctor would rather lose a patient than expose herself to the risk of malpractice liability.

37. Parchomovsky & Stein, *supra* note 36, at 545–46; cf. James Gibson, *Doctrinal Feedback and (Un)Reasonable Care*, 94 VA. L. REV. 1641, 1644–45, 1653–61 (2008) (arguing that risk-averse doctors tend to prefer excessive treatment options that fend off malpractice suits and that such practices gradually transform into legally binding customs). Our argument applies to all doctors, regardless of their attitude toward risk.

38. We present here a simplified version of the California effect. For further details and

nitrogen oxide emission standards for cars are more stringent than the federal Environmental Protection Agency requirements. Compliance with California's demanding standards increases car production costs, but manufacturers must incur this additional expense in order to sell their cars to Californians. California's market for cars is simply too big to pass up. Furthermore, making cars with different emission systems that satisfy different regulatory requirements is far too complicated. Manufacturers consequently prefer to use California's emission standards for all cars.³⁹

A similar cost-benefit calculation may motivate doctors across the United States to add South Dakota-style "depression and suicide" warnings to their disclosure dialogues. South Dakota is not a large enough state to give global effect to its informed-consent requirements for abortion. Yet, together with a few like-minded states, it has managed to create a liability threat for all doctors and an option to remove that threat at very low cost.⁴⁰ Although our account of the South Dakota effect is largely theoretical, there is evidence that the threat has already begun to materialize.⁴¹

Because of the self-updating nature of informed consent, requirements like South Dakota's may have implications that cut across state lines. These implications include the interstate dissemination of potentially misleading information about the risks of abortion. The medical community holds that abortion is not causally connected to suicide, depression, breast cancer, infertility, or other ailments.⁴² This view is well grounded in empirical research.⁴³ Because abortion can be a stressful event, it may have undesirable psychological effects; but research suggests that for an average woman with no psychiatric history, postpartum depression is *at least* as likely as postabortion depression.⁴⁴

For these reasons, we believe legislative intervention is required to eliminate the South Dakota effect. This intervention could follow two distinct paths. First, Congress could act to eliminate the South Dakota effect. A number of scholars have

insightful analysis, see Ann E. Carlson, *Iterative Federalism and Climate Change*, 103 NW. U. L. REV. 1097, 1107–12 (2009).

39. For other influential analyses of the California effect, see DAVID VOGEL, *TRADING UP: CONSUMER AND ENVIRONMENTAL REGULATION IN A GLOBAL ECONOMY* 259–60 (1995) (describing and analyzing the California effect); Anu Bradford, *The Brussels Effect*, 107 NW. U. L. REV. 1, 19–35 (2012) (arguing that the European Union unilaterally globalizes its regulations and identifying this "Brussels effect" as a global variant of the "California effect").

40. See *infra* Part II.A.

41. See *infra* Part II.B.

42. See *infra* notes 69–74 and accompanying text.

43. See *infra* notes 69–74 and accompanying text.

44. Trine Munk-Olsen, Thomas Munk Laursen, Carsten B. Pederson, Øjvind Lidgaard & Preben Bo Mortensen, *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 NEW ENG. J. MED. 332, 334–36 (2011) (finding, in population-based cohort study of Danish women, that incidence of psychiatric treatment increased after childbirth, but not abortion); Julia R. Steinberg, Davida Becker & Jillian T. Henderson, *Does the Outcome of a First Pregnancy Predict Depression, Suicidal Ideation, or Lower Self-Esteem? Data from the National Comorbidity Survey*, 81 AM. J. ORTHOPSYCHIATRY 193, 196 (2011) (finding "no differences between women who aborted versus delivered in postpregnancy depression when controlling for background and economic characteristics, prepregnancy violence experience, or prepregnancy mental health"). For a more detailed survey of the literature, see *infra* note 72 and accompanying text.

recently argued that Congress is best situated to mediate certain sorts of interstate spillovers,⁴⁵ and the dynamic we identify is ripe for such intervention. As we show, Congress has ample Commerce Clause power to enact a statute designed to prevent the South Dakota effect. The federal statute we envision would protect doctors not subject to state-mandated heightened warnings from the imposition of the South Dakota standard. Alternatively, states could block the South Dakota effect by enacting statutes similar to the federal statute described above.

We should note before proceeding further that a number of scholars have raised serious constitutional objections to laws like South Dakota's. Among other things, they argue that these laws violate *Casey*'s requirement that state-mandated warnings be "truthful and not misleading"⁴⁶ and thus constitute an undue burden;⁴⁷ that they reveal the "untenability" of the compromise struck in *Casey*;⁴⁸ and that they compel physician speech in violation of the First Amendment.⁴⁹ These laws have not been

45. See, e.g., Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115, 117 (2010) ("[T]he federal government is more likely than the states to solve the problem of interstate spillovers."); Heather K. Gerken & Ari Holtzblatt, *The Political Safeguards of Horizontal Federalism*, 113 MICH. L. REV. 57, 108 (2014) ("Congress's lawmaking power makes it a natural choice for those aggrieved by an interstate spillover and seeking a referee."); Gillian E. Metzger, *Congress, Article IV, and Interstate Relations*, 120 HARV. L. REV. 1468, 1479, 1531 (2007) ("[T]he Constitution assigns the primary role of interstate umpire to Congress. . . . Assigning Congress [this] role . . . not only reflects constitutional text and structure, but also furthers federalism values and has some historical support.").

46. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882 (1992) (plurality opinion).

47. Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 26 (2008) ("[I]n light of what we now know about the effect of fear appeals and persuasion under the influence of anxiety, there is a legitimate case for closer scrutiny under *Casey* of the effect such State-provided information has on the decision-making of women seeking abortion . . ."); Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1621 (2008) ("*Casey*'s standard calls into question state mandates to warn women considering abortion about unfounded hazards, such as . . . serious psychological problems."); Siegel, *supra* note 16, at 1758 (arguing that much of *Casey* aligns with "ordinary informed consent practice . . . designed to facilitate a patient's consideration of risks and benefits of the treatment decision and its alternatives, presented in a balanced and even-handed way" and suggesting that regulation inconsistent with such principles may constitute an "undue burden"); see also, e.g., Aziza Ahmed, *Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent, and the First Amendment*, 43 J.L. MED. & ETHICS 51, 56 (2015) ("For poor women . . . the mandatory counseling and waiting period laws increase the personal and financial costs of obtaining an abortion and prevent women from accessing abortion services."); Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1054–56 (2014) (criticizing courts for allowing compliance with *Casey* standards to preempt every constitutional challenge to abortion regulation).

48. Caitlin E. Borgmann, *Abortion, the Undue Burden Standard, and the Evisceration of Women's Privacy*, 16 WM. & MARY J. WOMEN & L. 291, 324 (2010) ("The 'compromise' that *Casey* struck is an untenable one. . . . [It has] encouraged legislatures to pass abortion restrictions in fact based on moral norms but couched as grounded in scientific evidence.").

49. Caroline Mala Corbin, *Compelled Disclosures*, 65 ALA. L. REV. 1277, 1290–91

comprehensively tested in courts, and arguments against their constitutionality may yet carry the day. Rather than enter that constitutional debate, however, our project aims to shift the focus to another important aspect of these laws—from their standalone (un)constitutionality to a consideration of their interstate effects.⁵⁰

This Article proceeds in three parts. In Part I, we survey and criticize the informed-consent statutes of South Dakota and like-minded states. In Part II, we identify and examine the South Dakota effect. In Part III, we develop our law-reform proposals and explain their advantages and shortcomings. A short Conclusion follows.

I. SPECIAL INFORMED-CONSENT REQUIREMENTS FOR ABORTION

A. The “Right To Know”

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁵¹ the Supreme Court held that states have a legitimate and substantial interest in apprising women of “the health risks of abortion,”⁵² including harm to a woman’s “psychological well-being.”⁵³ Accordingly, it held that states may require doctors to give women

(2014) (arguing that abortion-related disclosure mandates are “out of step with prevailing free speech jurisprudence”); Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238 (2016) (theorizing First Amendment protection of professional speech as a freedom of medical and other professional communities to generate and disseminate knowledge); David Orentlicher, *Abortion and Compelled Physician Speech*, 43 J.L. MED. & ETHICS 9, 9 (2015) (arguing that ideology-driven disclosure mandates violate doctors’ free speech rights); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 989 (arguing that South Dakota’s depression and suicide warnings violate the First Amendment insofar as they force physicians “to express views that contradict and undermine the authority of medical knowledge”); cf. Sonia M. Suter, *The First Amendment and Physician Speech in Reproductive Decision Making*, 43 J.L. MED. & ETHICS 22, 25–28 (2015) (arguing that professional speech in informed-consent context has high value and that its regulation therefore requires heightened, and at times strict, First Amendment scrutiny); Timothy Zick, *Professional Rights Speech*, 47 ARIZ. ST. L.J. 1289, 1330 (2015) (“[W]hen [the state] engages in an ideological assault on the constitutional right to abortion . . . the state is no longer simply ensuring that women’s informed consent is obtained. . . . The First Amendment is not merely ‘implicated’ when states pass ideological abortion disclosure laws; it is threatened in unique ways.” (footnote omitted)).

50. We should note, in addition, the problematic nature of discussing informed-consent laws in the register of patient rights and autonomy. Rather than attempt to actually enhance patients’ autonomy, heightened informed-consent requirements aim—in many cases, overtly—to guide patients toward continuing with their pregnancies. See Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 250 (2009). But given that this is the terrain on which battles over abortion are being fought, it is useful to think through the effects of these laws within that framework. And this Article’s close examination of such laws reveals their previously unnoticed horizontal threat to abortion rights.

51. 505 U.S. 833.

52. *Id.* at 882 (plurality opinion).

53. *Id.*

“truthful, nonmisleading information” about those risks,⁵⁴ even when motivated by a preference for childbirth over abortion.⁵⁵ This authorization is controversial because it allows the government to supersede doctors in producing and promulgating medical information.⁵⁶ Yet at present it is part and parcel of our constitutional law.⁵⁷

Thus far, fourteen states have read *Casey* to sanction heightened informed-consent requirements for abortion.⁵⁸ Those states are Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, North Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin.⁵⁹ Though the terms of the statutes to some extent vary, in each state doctors must inform women about the risk of post-abortion depression.⁶⁰ Failure to do so will vitiate the patient’s consent to the abortion procedure and expose the doctor to tort liability, as well as disciplinary and sometimes criminal penalties.⁶¹ The bellwether of this trend was South Dakota—a state

54. *Id.*

55. *Id.* at 883. In giving this authorization, the Court overruled parts of its decisions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983) (invalidating “abortion regulations designed to influence the woman’s informed choice between abortion or childbirth”), and *Thornburg v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 762 (1986) (rejecting “[Pennsylvania’s] outright attempt to wedge the Commonwealth’s message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician”). *Casey*, 505 U.S. at 883.

56. See Steven E. Weinberger, Hal C. Lawrence III, Douglas E. Henley, Errol R. Alden & David B. Hoyt, *Legislative Interference with the Patient-Physician Relationship*, 367 NEW ENG. J. MED. 1557, 1557 (2012).

57. See *Gonzalez v. Carhart*, 550 U.S. 124, 159–60 (2007) (“The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know . . .”). *But see supra* note 18 (suggesting that the Court’s recent opinion in *Whole Woman’s Health v. Hellerstedt*, No. 15-274 (U.S. June 27, 2016) may reopen the constitutional debate).

58. See *infra* note 148 and accompanying text and Table 1.

59. KAN. STAT. ANN. §§ 65-6709(a)(3), -6710(a) (Supp. 2014); LA. REV. STAT. ANN. § 40:1061.15 (2016); MICH. COMP. LAWS ANN. § 333.17015(11)(b)(iii) (West Supp. 2015); MINN. STAT. ANN. §§ 145.4242, .4243(a)(2) (West 2011); MO. ANN. STAT. § 188.039(2), (3) (West Supp. 2015); MONT. CODE ANN. §§ 50-20-104(5), -304 (2015); NEB. REV. STAT. ANN. §§ 44-2816, 28-327.01(1)(b) (LexisNexis 2015); N.C. GEN. STAT. ANN. § 90-21.13, .82(1)(b) (West Supp. 2014); S.D. CODIFIED LAWS §§ 34-23A-10.1(1)(e), -1.7 (2011 & Supp. 2015); TEX. HEALTH & SAFETY CODE ANN. §§ 171.012(a)(1)(B), 171.014 (Supp. 2015); UTAH CODE ANN. § 76-7-305.5(2)(a), (o) (LexisNexis Supp. 2015); VA. CODE ANN. § 18.2-76(F)(3) (2014); W. VA. CODE ANN. § 16-2I-3(a)(2) (LexisNexis 2011); WIS. STAT. ANN. § 253.10(1)(b)3, (3)(c)1.f (West Supp. 2015); see also, e.g., TEX. DEP’T OF HEALTH, A WOMAN’S RIGHT TO KNOW 16 (2003); *Abortion Risks*, LA. DEPARTMENT HEALTH & HOSPS., <http://new.dhh.louisiana.gov/index.cfm/page/1063/n/275> [<https://perma.cc/7ACL-UXCA>] (informing women that abortion might cause “depression, grief, anxiety, lowered self-esteem, regret, attachment, flashbacks, and substance abuse”).

60. See *infra* note 148 and accompanying text and Table 1.

61. See, e.g., S.D. CODIFIED LAWS § 34-23A-1.7 (2011) (reaffirming the South Dakota common-law cause of action for medical malpractice informed-consent claims available against doctors who fail to warn patients about postabortion depression); S.D. CODIFIED LAWS.

that since 2005 has statutorily required doctors to warn women not only about the general risk of postabortion depression, but also about the fact that abortion may lead to ideation of suicide and to actual suicide.⁶²

In the pages ahead, we focus on statutes mandating that doctors warn patients about the risk of postabortion depression. With one exception,⁶³ these mandates are not expressly qualified by *Casey*'s "medically accurate" proviso. Doctors consequently appear to have no choice but to tell every patient that she may develop depression following an abortion. Under the statutory mandates of South Dakota,⁶⁴ Louisiana,⁶⁵ Michigan,⁶⁶ and Wisconsin,⁶⁷ doctors must also warn patients that post-abortion depression may have serious consequences that may include feelings of guilt, sleep disturbance, loss of interest in work or sex, anger, psychological trauma, and suicidal thoughts.⁶⁸

Unlike the breast-cancer warnings mandated in some states,⁶⁹ warnings about

§ 34-23A-10.2 (2011) (categorizing violation of South Dakota's disclosure obligations for doctors as a Class 2 misdemeanor reportable to the Board of Medical Examiners).

62. S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (2011). A number of states also require women seeking abortions to undergo an ultrasound examination that displays the fetus's image and heartbeat. See Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 351, 393-96 (2008) (arguing that such laws are morally reprehensible in that they coercively use a woman's body as a source of information); see also *Stuart v. Camnitz*, 774 F.3d 238, 242 (4th Cir. 2014) (invalidating North Carolina's mandatory ultrasound law as going well beyond the means "states have customarily employed to effectuate their undeniable interests in ensuring informed consent and in protecting the sanctity of life"), *cert. denied*, 135 S. Ct. 2838 (2015). In addition, the states of Alaska, Kansas, Minnesota, Mississippi, Montana, and Texas require doctors to highlight the connection between abortion and breast cancer and notify women about that connection when it is "medically accurate." See *supra* note 21.

63. North Carolina is the exception. N.C. GEN. STAT. ANN. § 90-21.82(1)(b) (West Supp. 2014) (requiring a doctor to inform a woman seeking an abortion, "when medically accurate," about "any adverse psychological effects").

64. S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (2011).

65. LA. REV. STAT. ANN. §§ 40:1061.16, :1061.17, :1157.1, :1157.2 (2016).

66. MICH. COMP. LAWS ANN. § 333.17015(1)(b)(iii) (West Supp. 2015).

67. WIS. STAT. ANN. § 253.10(1)(b)3, (3)(c)1(f) (West Supp. 2015).

68. Texas's administrative materials (the information booklet distributed by the Department of Health pursuant to section 171.014 of the Texas Health and Safety Code) also inform women that "[s]ome women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks, and substance abuse." TEX. DEP'T HEALTH, *supra* note 59, at 16.

69. See *supra* notes 21, 62. For literature disclaiming any link between abortion and breast cancer, see COMM. ON GYNECOLOGIC PRACTICE, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION NO. 434, INDUCED ABORTION AND BREAST CANCER RISK (2009) (refuting unequivocally the connection between abortion and breast cancer risk and asserting there is "no causal relationship between induced abortion and a subsequent increase in breast cancer risk"); Katherine DeLellis Henderson, Jane Sullivan-Halley, Peggy Reynolds, Pamela L. Horn-Ross, Christina A. Clarke, Ellen T. Chang, Susan Neuhausen, Giske Ursin & Leslie Bernstein, *Incomplete Pregnancy Is Not Associated with Breast Cancer*

postabortion depression are not empirically preposterous. Abortion can be an emotionally taxing event,⁷⁰ though it often brings about feelings of relief in the end.⁷¹ Although the experience does not independently drive women into full-blown depression,⁷² it may still contribute to depression by aggravating preexisting mental or

Risk: The California Teachers Study, 77 *CONTRACEPTION* 391, 396 (2008) (“[O]ur results provide . . . strong evidence that neither induced abortion nor miscarriage is associated with breast cancer risk and may help to resolve any remaining uncertainty as to whether such a relationship exists.”); Gillian K. Reeves, et al., *Breast Cancer Risk in Relation to Abortion: Results from the EPIC Study*, 119 *INT’L J. CANCER* 1741, 1744 (2006) (“[T]he findings presented here provide further unbiased evidence for the lack of an adverse effect of induced abortion on breast cancer risk.”).

70. Nancy E. Adler, Henry P. David, Brenda N. Major, Susan H. Roth, Nancy Felipe Russo & Gail E. Wyatt, *Psychological Factors in Abortion: A Review*, 47 *AM. PSYCHOLOGIST* 1194, 1197 (1992) (“[A]n unwanted pregnancy is . . . an event that can be challenging or stressful. . . . Termination of an unwanted pregnancy may reduce the stress At the same time, the abortion itself may be experienced as stressful.”).

71. *Id.* at 1198 (“When women are asked to indicate which emotions they experience following first-trimester abortion, the most frequent response is to report feelings of relief and happiness”); David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140 *ANNALS INTERNAL MED.* 620, 624 (2004) (“Induced abortion does not harm women’s emotional health; for most women, it allows an overall improvement in quality of life. Indeed, the most common reaction to abortion is a profound sense of relief.” (endnotes omitted)).

72. Rather, well-designed studies and meta-analyses of the extensive research in the area refute the claim that abortion causes psychological harm. APA TASK FORCE ON MENTAL HEALTH AND ABORTION, REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION, 5–6 (2008), <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> [<https://perma.cc/QYG8-NFTH>] (“The best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy.” (emphasis in original)); NAT’L COLLABORATING CTR. FOR MENTAL HEALTH, ACAD. OF MED. ROYAL COLLS., *INDUCED ABORTION AND MENTAL HEALTH: A SYSTEMATIC REVIEW OF THE MENTAL HEALTH OUTCOMES OF INDUCED ABORTION, INCLUDING THEIR PREVALENCE AND ASSOCIATED FACTORS* 8 (2011), www.aomrc.org.uk/doc_view/9432-induced-abortion-and-mental-health [<https://perma.cc/L528-956Z>] (finding, based on extensive review of existing studies, that “rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth”); Adler et al., *supra* note 70, at 1198 (“[T]he weight of the evidence is that legal abortion as a resolution to an unwanted pregnancy, particularly in the first trimester, does not create psychological hazards for most women undergoing the procedure.”); Vignetta E. Charles, Chelsea B. Polis, Srinivas K. Sridhara & Robert W. Blum, *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 *CONTRACEPTION* 436, 448–49 (2008) (finding that the best studies—well designed and well executed—“suggest[ed] few, if any, differences between aborters and their respective comparison groups in terms of mental health sequelae”); Brenda Major, Caroline Richards, M. Lynne Cooper, Catherine Cozzarelli & Josephine Zubek, *Personal Resilience, Cognitive Appraisals, and Coping: An Integrative Model of Adjustment to Abortion*, 74 *J. PERSONALITY & SOC. PSYCHOL.* 735, 741 (1998) (“Overall, our sample of women did not report high levels of psychological distress 1 month following their abortions”); Brenda Major, *Commentary, Psychological Implications of Abortion—Highly Charged and Rife with Misleading Research*, 168 *CANADIAN MED. ASS’N J.* 1257, 1258 (2003) (“[Well-designed

emotional conditions.⁷³ The probability of this scenario is not high, but it is not negligible either.⁷⁴ This probability therefore cannot be written off completely.

studies establish] that the emotional well-being of women who abort an unplanned pregnancy does not differ from that of women who carry a pregnancy to term.”); Munk-Olsen et al., *supra* note 44, at 334–36 (reporting increase in psychiatric treatment after childbirth, but not abortion); Gail Erlick Robinson, Nada L. Stotland, Nancy Felipe Russo, Joan A. Lang & Mallay Occhiogrosso, *Is There an “Abortion Trauma Syndrome”? Critiquing the Evidence*, 17 HARV. REV. PSYCHIATRY 268, 276 (2009) (“[P]ublished studies concluding that abortion causes psychiatric illness have numerous methodological problems; since their conclusions are questionable, they should not be used as a basis for public policy.”); Steinberg et al., *supra* note 44, at 196 (finding no psychiatric differences between women who aborted versus delivered); Nada Stotland, *The Myth of Abortion Trauma Syndrome: Update, 2007*, 42 PSYCHIATRIC NEWS 28, 28 (2007) (“[A] growing body of empirical research has demonstrated that abortion does not cause psychiatric illness.”); Carolyn Westhoff, Lucy Picardo & Ellen Morrow, *Quality of Life Following Early Medical or Surgical Abortion*, 67 CONTRACEPTION 41, 41 (2003) (“[Results of original study] provide substantial reassurance that women undergoing abortion experience a marked improvement in their quality of life after the abortion.”); *see also* Siegel, *supra* note 16, at 1719 n.81 (canvassing empirical literature). Two important recent contributions analyze results from a longitudinal “turn-away study,” which compares women who presented at particular clinics and received abortions to women who presented at the same facilities but were denied abortions because they were just over the applicable state-law gestational limits. D.G. Foster, J.R. Steinberg, S.C.M. Roberts, J. Neuhaus & M.A. Biggs, *A Comparison of Depression and Anxiety Symptom Trajectories Between Women Who Had an Abortion and Women Denied One*, 45 PSYCHOL. MED. 2073, 2073 (2015) (“Women who received an abortion had similar or lower levels of depression and anxiety than women denied an abortion.”); Corinne H. Rocca, Katrina Kimport, Sarah C.M. Roberts, Heather Gould, John Neuhaus & Diana G. Foster, *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, PLOS ONE, July 8, 2015, at 1, 10, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832> [<https://perma.cc/2FBR-3YK4>] (assessing women’s emotional reactions to abortion and finding that “at all time points over three years, 95% of participants reported abortion was the right decision”).

73. *See* Robinson et al., *supra* note 72, at 268 (“The most consistent predictor of mental disorders after abortion remains preexisting disorders”); Lisa Rubin & Nancy Felipe Russo, *Abortion and Mental Health: What Therapists Need To Know*, in FROM MENARCHE TO MENOPAUSE: THE FEMALE BODY IN FEMINIST THERAPY 69, 74 (Joan C. Chrisler ed., 2004) (“Researchers have identified a number of predictors of women’s mental health after abortion. The most important is a woman’s *previous* mental health.” (emphasis in original)); *see also* Julia H. Littell & James C. Coyne, Correspondence, *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 BRIT. J. PSYCHIATRY 75, 75–76 (2012) (identifying eleven methodological flaws in a statistical study that claimed to have found significant correlation between abortion and mental health problems).

74. *See, e.g.*, David M. Fergusson, L. John Horwood & Elizabeth M. Ridder, *Abortion in Young Women and Subsequent Mental Health*, 47 J. CHILD PSYCHOL. & PSYCHIATRY 16, 23 (2006) (study identifying depression and suicidal tendencies in young women who underwent abortion, while acknowledging inability to control for wantedness of the pregnancy and concluding that “the issue of whether or not abortion has harmful effects on mental health remains to be fully resolved”); Brenda Major, Catherine Cozzarelli, M. Lynne Cooper, Josephine Zubek, Caroline Richards, Michael Wilhite & Richard H. Gramzow, *Psychological Responses of Women After First-Trimester Abortion*, 57 ARCHIVES GEN. PSYCHIATRY 777, 777 (2000) (reporting that a small percentage of women, especially those with prior history of depression,

Whether the prospect of postabortion depression is significant enough to be included in doctors' disclosure obligations to patients, however, is an altogether separate question. Every medical procedure involves risks. The multitude and variety of those risks make it impossible for doctors to give their patients complete information about every risk of harm. Moreover, even if doctors were to give patients full information, the information's complexity would make it impossible for the patients to properly evaluate its significance.⁷⁵ Some risks associated with a patient's treatment must therefore remain undisclosed.

Separating those remote risks from the information that doctors must disclose to their patients is not easy. This choice depends on how the policy maker values individual autonomy relative to efficiency.⁷⁶ Policy makers who place more value on autonomy demand that doctors disclose to patients as much information as possible. Such disclosure, so goes the argument, makes a patient better informed about available treatments, which enables her to choose the treatment she really wants. Policy makers who prefer efficiency over autonomy allow the medical profession to select the information that patients should receive. Arguably, this selective disclosure streamlines the provision of medical care while still allowing the patient to choose the treatment that fits her needs.

These conflicting viewpoints are reflected in the split between states that base their informed-consent requirements on doctors' customs and jurisdictions that extract those requirements from patients' expectations. Thirty states base doctors' informed-consent obligations—in general or specifically with respect to abortion—on customs and practices of the medical profession.⁷⁷ This approach standardizes informed-consent obligations and makes them easy to comply with, which gives doctors more time to actually treat patients. By adopting the “doctors' custom” standard, states therefore value efficiency in the provision of medical care over patients' autonomy. The other twenty states and the District of Columbia require doctors'

experience post-traumatic stress disorder and psychological problems postabortion); *see also* Priscilla K. Coleman, Catherine T. Coyle, Martha Shuping & Vincent M. Rue, *Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey*, 43 J. PSYCHIATRIC RES. 770 (2009); Willy Pedersen, *Abortion and Depression: A Population-Based Longitudinal Study of Young Women*, 36 SCANDINAVIAN J. PUB. HEALTH 424, 424 (2008) (finding increased rates of depression for Norwegian women in their twenties who undergo abortions). *But see* Robinson et al., *supra* note 72, at 275 (“[I]n order to get an abortion in New Zealand, one must prove to two specialist consultants that the pregnancy would seriously harm the life, physical, or mental health of the woman, that the woman is severely mentally handicapped, or that the pregnancy was the result of rape or incest. These conditions suggest an inclusion bias [in Fergusson's work] toward vulnerable, high-risk women in the abortion group.”); *infra* note 108 (noting extensive criticism of Coleman).

75. *See generally* OMRI BEN-SHAHAR & CARL E. SCHNEIDER, *MORE THAN YOU WANTED TO KNOW: THE FAILURE OF MANDATED DISCLOSURE* 107–18 (2014) (explaining how overflow of information distorts decisions).

76. *See generally* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994) (describing informed-consent doctrine as a tension between patients' autonomy right and doctors' interest in self-regulation).

77. *See infra* notes 148–50 and Table 1.

provision of information to patients to satisfy a “reasonable patient’s” expectation.⁷⁸ This requirement expands doctors’ disclosure obligations beyond the information that the medical profession deems material.

The two standards overlap along two important dimensions. First, doctors’ customs integrate the legal requirement that it is the patient who must ultimately decide whether to undergo a particular procedure, with the doctor helping the patient choose wisely.⁷⁹ Second, and equally important, because the “patient expectation” standard honors only reasonable expectations, doctors have no obligation to reveal information that their profession considers wholly irrelevant or, worse, detrimental to the patient’s treatment.⁸⁰ Doctors’ customs thus shape patients’ expectations and are affected by them at the same time.⁸¹

This dialectic brings the “doctors’ custom” and “patient expectation” standards close to each other. Both standards require doctors to inform patients about the nature, risks, and benefits of the recommended procedure and its medically approved alternatives.⁸² The differences between the two standards relate to peripheral information, including doctors’ performance records, medically inferior procedures, and remote risks. Under the “patient expectation” standard, physicians may be obligated to inform patients about their past performance and rate of success in carrying out the procedure in question.⁸³ The “doctors’ custom” standard, on the other hand, does not recognize this far-reaching disclosure obligation.⁸⁴ The “patient expectation” standard also sometimes requires doctors to tell patients about procedures doctors

78. See *infra* notes 148–50 and Table 1.

79. Schuck, *supra* note 76, at 924 (“The most fundamental normative argument in favor of requiring health care providers to obtain patients’ informed consent to medical treatments proceeds from the principle of autonomy—the notion that each mature individual has a right to make the basic choices that affect her life prospects.”); *id.* at 916 (“Physicians may not deal with their patients at arm’s length; they owe their patients a fiduciary duty, which includes an obligation to act exclusively in the patient’s interests and to disclose all information material to those interests.”).

80. But the patient can ask questions that must be answered truthfully. See, e.g., IOWA CODE ANN. § 147.137(2) (West 2014) (entitling patients to ask doctors questions and receive satisfactory answers); 25 TEX. ADMIN. CODE § 601.4 (2015) (same).

81. For that reason, we separate the two approaches by their three functional differences as specified below.

82. See Alex Stein, *Toward a Theory of Medical Malpractice*, 97 IOWA L. REV. 1201, 1232 & n.166 (2012) (summarizing the informed-consent requirement and citing relevant authorities).

83. *Goldberg v. Boone*, 912 A.2d 698, 717 (Md. 2006) (holding that a surgeon’s inexperience presents a jury issue of whether informed consent was given); *Johnson ex rel Adler v. Kokemoor*, 545 N.W.2d 495, 505–06 (Wis. 1996) (requiring doctors to reveal their past records). For analysis of this rule, see Aaron D. Twerski & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 NW. U. L. REV. 1 (1999).

84. See, e.g., *Wlosinski v. Cohn*, 713 N.W.2d 16, 21 (Mich. Ct. App. 2005) (“[D]efendants, as a matter of law, did not have a duty to disclose Dr. Cohn’s statistical history of transplant failures to obtain the decedent’s informed consent.”); *cf. Duffy v. Flagg*, 905 A.2d 15, 20–22 (Conn. 2006) (holding that Connecticut’s so-called “patient expectation” standard does not require doctors to disclose prior experience with procedures).

consider inferior or of which they disapprove.⁸⁵ Examples of such procedures include vaginal breech delivery as a substitute for a broadly recommended C-section⁸⁶ and a risky bone surgery instead of bed rest.⁸⁷ The “doctors’ custom” standard exempts doctors from the duty to notify patients about such inferior treatment options.⁸⁸

The “doctors’ custom” standard also relieves doctors of the obligation to inform patients about remote risks of harm.⁸⁹ For example, an orthopedic surgeon does not have to tell a patient contemplating spinal cord surgery that one in one thousand patients undergoing a similar surgery becomes paralyzed after falling on the floor from his bed.⁹⁰ Courts applying the “patient expectation” standard see things differently. In the oft-cited “patient expectation” precedent *Canterbury v. Spence*,⁹¹ the court ruled that doctors must inform patients about small chances of death or severe incapacitation.⁹² The gravity of the potential harm makes such disclosure mandatory even where the chances are quite remote.⁹³ Based on this understanding of the law,

85. See, e.g., *Matthies v. Mastromonaco*, 733 A.2d 456, 460–64 (N.J. 1999) (holding that “patient expectation” standard authorizes jurors to hold doctors liable for failure to disclose nonrecommended medical alternatives).

86. See, e.g., William M. Gilbert, Shauna M. Hicks, Nina M. Boe & Beate Danielsen, *Vaginal Versus Cesarean Delivery for Breech Presentation in California: A Population-Based Study*, 102 *OBSTETRICS & GYNECOLOGY* 911, 911 (2003) (demonstrating empirically that normal-term breech fetuses have significantly increased neonatal mortality and morbidity when delivered vaginally relative to a C-section).

87. *Matthies*, 733 A.2d at 458–60.

88. See, e.g., *Welch v. United States*, 737 F. Supp. 2d 18, 34 (D. Me. 2010) (“Because modern medicine no longer recognizes as reasonable the surgical resection of a colon tumor for someone in [the patient’s] condition, explaining this alternative [to the patient was not required under Maine’s “doctors’ custom” standard].”); *Taylor v. County of Cook*, 957 N.E.2d 413, 433 (Ill. App. Ct. 2011) (holding under Illinois’s “doctors’ custom” standard that the court below “did not err in stating what [the patient] would or would not have done had she received information about alternative treatments was irrelevant since the standard to base the treatment decision upon is an objective and not a subjective standard”).

89. See, e.g., *Bronneke v. Rutherford*, 89 P.3d 40, 46 (Nev. 2004) (holding under “doctors’ custom” standard that reasonable chiropractor need not inform patient about risk of stroke that amounts to one in 5,850,000); see also BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 217–18 (7th ed. 2013) (attesting that doctors’ custom standard does not obligate doctors to tell patients about remote risks).

90. This example draws on *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), a case decided under the “patient expectation” standard.

91. 464 F.2d 772 (D.C. Cir. 1972).

92. *Id.* at 788 (“A very small chance of death or serious disablement may well be significant”); see also, e.g., *Martin ex rel Sceptur v. Richards*, 531 N.W.2d 70, 75 (Wis. 1995) (attesting that “courts have . . . been quick to recognize that although the risk of a complication may be small, such risk may be significant to a patient’s decision in light of the potentially severe consequences” (citing *Canterbury*, 464 F.2d at 788)).

93. See, e.g., *Henderson v. Milobsky*, 595 F.2d 654, 659 (D.C. Cir. 1978) (affirming *Canterbury*’s requirement that a patient be informed about “a one percent chance of very serious consequential harm”); *McKinney v. Nash*, 174 Cal. Rptr. 642 (Cal. Ct. App. 1981) (holding that, prima facie, doctors must inform patients about a one in 1000 risk of testicular atrophy due to vascular damage caused by hernia repair operation); *Hondroulis v. Schuhmacher*,

the *Canterbury* court concluded that the surgeon in our above-mentioned example had violated the patient's right to informed consent.⁹⁴

Doctors' duty to inform patients about improbable but serious harms marks the baseline for assessing the effects of mandatory warnings about postabortion depression. Depression resulting from abortion is a low-probability event in and of itself. Cases in which abortion renders a woman deeply depressed or suicidal have an even lower probability. But proponents of postabortion depression warnings do not see this as a problem. They believe that these warnings are socially desirable as a means of dissuading women from choosing abortion. This justification, however, has a constitutional limit: information that doctors communicate to patients cannot be misleading. *Misinforming* a woman about the abortion's consequences in order to convince her to keep an unwanted pregnancy is quite clearly unconstitutional under *Casey*.⁹⁵

For that reason, many proponents of postabortion depression warnings have abandoned arguments that are transparently motivated by antiabortion paternalism and instead have begun appealing to women's individual autonomy. These proponents argue that warnings are warnings: all they do is give women more information about abortion as part of their "right to know."⁹⁶ This information enhances a woman's choice and control over her destiny. After receiving this information, some women may feel uncomfortable about the depression prospect, even when its probability is low. They may want to eliminate this prospect completely by calling the abortion off. Other women may decide not to worry about serious but low-probability scenarios and go ahead with the abortion procedure. Arguably, therefore, warnings about postabortion depression have only an upside and no downside. By giving women more information, they enhance women's autonomy without restricting access to abortion.

This argument has some intuitive appeal. Part of its appeal lies in the fact that

553 So. 2d 398, 403 (La. 1988) ("*Canterbury* notes that there is no bright line separating a significant from an insignificant risk. Disclosure has been required when there was a three percent chance of death, paralysis or other injury, and when there was a one percent chance of loss of hearing. Nondisclosure has been justified when there was a 1.5% chance of loss of an eye and a one in 100,000 chance of death." (citing, respectively, *Bowers v. Talmage*, 159 So. 2d 888 (Fla. Dist. Ct. App. 1963); *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967); *Yeates v. Harms*, 393 P.2d 982 (Kan. 1964); and *Pauscher v. Iowa Methodist Med. Ctr.*, 408 N.W.2d 355 (Iowa 1987)) (footnotes omitted)); *Long v. Jaszczak*, 688 N.W.2d 173, 179–80 (N.D. 2004) (holding that an undisclosed one in 40,000 to one in 150,000 risk of allergic reaction and death from intravenous pyelogram makes a triable issue of informed-consent violation); *see also Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 496 n.41 (Cal. 1990) ("One cannot know with certainty whether a consent is valid until a lawsuit has been filed and resolved."); Jon F. Merz, *An Empirical Analysis of the Medical Informed Consent Doctrine: Search for a "Standard" of Disclosure*, 2 RISK 27, 42 (1991) ("[N]o physician can absolutely avoid liability under the informed consent laws unless he or she discloses every known risk . . .").

94. *See Canterbury*, 464 F.2d at 786–88.

95. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992).

96. *See Siegel*, *supra* note 16, at 1706 (observing that "advocates of incremental and absolute abortion restrictions have increasingly come to justify such regulation in the frames of their opponents, and now often portray abortion restrictions as promoting women's informed consent, women's health, women's welfare, and women's freedom").

mandatory warnings about postabortion depression conform with the “patient expectation” standard, which in many states applies to all patients, whatever the procedure, and not just to women considering abortion. Accordingly, it might appear that the depression warnings do not single out pregnant women as requiring special paternalistic protection.⁹⁷ Indeed, the emergence of the “patient expectation” standard itself represented courts’ rejection of the paternalism with which doctors treated patients under the “doctors’ custom” standard for informed consent.⁹⁸

This argument is predicated on the assumption that a person’s autonomy increases with the addition of all new information. In the next section, we show that this assumption is not necessarily true and argue against its introduction into our rules of informed consent.

B. The Right Not To Know

A person is best positioned to make an important decision when she has full information concerning that decision. From this simple truth people often derive a related, and yet altogether different—as well as fundamentally flawed—proposition about the value of information. They tend to believe that accumulation of information related to a person’s decision invariably makes the person better informed and brings her closer to the truth.⁹⁹ This belief is flawed for a simple reason: not all information is trustworthy. Some information might lead a person astray.

An individual with full knowledge of the facts need not filter information for quality. For a person with no such omniscience, however, identifying information as reliable and unreliable is an absolute must in order to determine what information to heed and what to ignore. Scarcity of time and resources and limits of cognition make this informational strategy rational and, indeed, necessary for any person.¹⁰⁰ As a general matter, a rational person will do well to ignore risks that are abstract and remote.¹⁰¹

Mandatory warnings about postabortion depression are a case in point. When a doctor informs a woman that abortion might cause depression in some cases, the woman might reasonably want to know about the circumstances of those cases in order to compare those cases with hers. Acquiring that information, however, may not provide much assistance. Consider a doctor who tells the woman that those rare cases involved women with prior psychological or psychiatric problems. This piece of information obscures more than it illuminates. First, psychological and psychiatric problems are not created equal and do not affect people in the same way. Second,

97. *But see id.* at 1773–80 (unveiling gender paternalism in antiabortion movement’s allusions to women’s autonomy).

98. *See Canterbury*, 464 F.2d at 790 (associating “patient’s expectation” standard with patient’s freedom to decide for herself).

99. Remarkably, Jeremy Bentham relied on this belief in his proposal to abolish all technical rules of evidence. *See* ALEX STEIN, FOUNDATIONS OF EVIDENCE LAW 122–33 (2005) (discussing Bentham’s evidence theory and exposing its flaws).

100. *See* Alex Stein, *Inefficient Evidence*, 66 ALA. L. REV. 423, 429–34 (2014) (explaining how evidence law eliminates inefficient information).

101. *See id.* at 435–39 (developing signal-to-noise criterion for selecting evidence for trials).

some of these problems may have been serious enough to cause the depression by themselves, thus rendering the abortion causally immaterial. Third and equally importantly, psychological and psychiatric problems may also trigger postpartum depression in a woman who delivers a completely healthy baby.¹⁰² These scenarios are remote, unspecified, and unforeseeable. Factoring them into a specific decision about abortion can only create an impasse.

We therefore believe that the informed-consent doctrine should exempt doctors from the obligation to inform all patients about remote risks of harm associated with the recommended treatment—and in particular, the remote risk of depression without reference to a woman’s individual circumstances. Notifying a patient about such risks does not enhance her autonomy. In fact, it makes the patient less informed and, consequently, less autonomous. This is because the information she receives is selective and misleading: it only reveals the remote risks faced by patients who undergo the recommended treatment. It does not tell the patient about other remote risks, including those she would face if she *did not* receive the treatment.

Consider again the seminal case *Canterbury v. Spence*.¹⁰³ Assume, counterfactually, that the doctor does tell the patient that in approximately one case out of one thousand a person undergoing an identical spinal cord surgery becomes paralyzed after falling from his bed.¹⁰⁴ Would that information help the patient make the right decision? We do not think so. Consider the risks faced by a person who requires surgery to fix his back problems but avoids doing it. First, the person’s problems may aggravate over time into a condition that might severely impair his functioning and perhaps lead to paralysis.¹⁰⁵ Second, the person might get involved in a car accident, a fight, or a fall that will inflict critical trauma on his untreated back. The combined probability of these scenarios may well be greater than one in one thousand.

If so, the court in *Canterbury* should not have stopped at asking doctors to inform patients about the “surgery, fall, and paralysis” scenario. The court should have also required that doctors tell patients about equally morbid and equally improbable scenarios that involve people with *untreated* back problems. If a patient should know about one improbable possibility in order to make an autonomous choice of treatment, then she should also be apprised of all other potential outcomes that fall within the same realm of possibility. The informed-consent doctrine cannot rationally require doctors to notify patients about just one specific low-probability risk among many.

A much better alternative would be to exclude all remote scenarios (regardless of the magnitude of the harm) and focus solely on those scenarios that are likely enough to materialize in the patient’s case. These causally significant scenarios can only be identified by the medical profession, which analyzes and utilizes the collective experience of doctors.

That said, the Supreme Court’s decision in *Casey* gave states the power to select

102. Stacey A. Tovino, *Scientific Understandings of Postpartum Illness: Improving Health Law and Policy?*, 33 HARV. J.L. & GENDER 99, 121–22 (2010) (summarizing current multifactorial explanations for postpartum depression).

103. 464 F.2d 772 (D.C. Cir. 1972).

104. *Id.* at 776 (describing patient’s falling accident).

105. See John W. McDonald & Cristina Sadowsky, *Spinal-Cord Injury*, 359 LANCET 417, 417 (2002) (listing morbid consequences of untreated spinal cord injuries).

the risks about which doctors should notify patients within their borders.¹⁰⁶ The Court also held that in exercising that power, states are entitled to implement their preference for childbirth over abortion.¹⁰⁷ For that reason, supporters of mandatory warnings about postabortion depression can claim that our critique of these warnings is beside the point. Specifically, they can argue that postabortion and postpartum depression, while both unfortunate, are not equal in the eyes of South Dakota and like-minded states. For these states, postpartum depression accompanies the birth of a living human being—and is therefore a much happier end. These states therefore can require doctors to tell women about postabortion depression, while leaving the discussion of the postpartum depression risk to doctors' discretion. There is nothing inconsistent, illogical, or probabilistically irrational in that choice.

Even with the Supreme Court's approval of this general approach, some of the states' laws sit uneasily with¹⁰⁸ the Court's admonition that such information be "truthful and not misleading."¹⁰⁹ But rather than assess the constitutionality of these laws under *Casey*'s proviso, we focus on a different strain of the Supreme Court's abortion jurisprudence: the premise that the regulation of informed consent is an intrastate affair. We submit that this premise is mistaken in that it ignores the South Dakota effect, to which we now turn.

II. THE SOUTH DAKOTA EFFECT

In this part of the Article, we demonstrate that the postabortion depression warnings mandated by South Dakota and like-minded states threaten to spread to other

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

107. *Id.*

108. This transgression is particularly blatant in the state at the center of this piece, South Dakota, whose statute, S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (2011), requires doctors to warn patients that the abortion might lead to suicide ideation and suicide. *But see* *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 894–95 (8th Cir. 2012) (en banc) (upholding the constitutionality of South Dakota's suicide warning as truthful and not misleading). The Eighth Circuit based its conclusion upon studies carried out by Mika Gissler et al., David Fergusson et al., and the state's expert witness, Dr. Priscilla Coleman. Coleman et al., *supra* note 74; Fergusson et al., *supra* note 74; Mika Gissler, Elina Hemminki & Jouko Lonnqvist, *Suicides After Pregnancy in Finland, 1987–94: Register Linkage Study*, 313 BRIT. MED. J. 1431, 1432 (1996). The *Rounds* decision, however, paid no attention (1) to the fierce and widespread critique of Coleman's studies, *see, e.g.*, Robinson et al., *supra* note 73; (2) to Fergusson's caveat about his research group's inability to control for wantedness of the aborted pregnancies and his own unwillingness to draw firm conclusions from the study; and (3) to the failure of Gissler et al. to distinguish between wanted and unwanted pregnancies in a Scandinavian country where use of contraception is a norm, *see* AM. PSYCHIATRIC ASS'N, ABORTION AND WOMEN'S REPRODUCTIVE HEALTH CARE RIGHTS 2 (2009). Furthermore, Gissler's study expressly connected women's suicides to preexisting conditions that included "low social class, low social support, and previous life events." Gissler et al., *supra*, at 1434; *see also* VA. CODE ANN. § 18.2-76(F)(3) (2014); *cf. Haupt*, *supra* note 49, at 1297 (developing theory extending constitutional free-speech protection to professions as "knowledge commun[ities]" and criticizing *Rounds* for failure to protect doctors against state-imposed duty to tell patients that abortion might lead to suicide).

109. *Casey*, 505 U.S. at 882 (plurality opinion); *see infra* notes 46–49 and accompanying text.

states. This regulatory spillover challenges the conventional assumption that state laws of informed consent have no effect on other states. As we will show, although *statutes* requiring doctors to warn women about postabortion depression are confined to the borders of the states that enacted them, the change they effect within their states could infiltrate the informed-consent requirements of other states.

A. Regulatory Spillover

Regulatory spillovers come in a variety of different forms and raise a number of distinct concerns. An important recent contribution to the literature, by Professor Heather Gerken and Ari Holtzblatt, describes (though it does not endorse) the conventional wisdom regarding interstate spillovers this way: “[S]tate-generated spillovers cause interstate friction, generate inefficiencies, undermine the national marketplace, violate the autonomy of other states, and threaten democracy by preventing citizens of the affected state from choosing their own destinies.”¹¹⁰ This description captures many of the harms—economic and political—that a single state’s activity can inflict upon other states. Professors Samuel Issacharoff and Catherine Sharkey offer another definition, one that focuses on cost-shifting and the protection of in-state economic interests: “By ‘spillover effects’ we simply mean state law that, by its operation, shifts costs and favors its own citizens while disproportionately affecting out-of-state interests, or, as the economists would have it, imposes externalities on others.”¹¹¹ Professor Gillian Metzger emphasizes constitutionally grounded notions of state sovereignty and autonomy in identifying the concerns raised by spillovers, observing that “state autonomy . . . embod[ies] the idea that each state is free to pursue the policies it believes best, . . . free from unwanted interference by its sister states.”¹¹²

These and other scholarly works¹¹³ tend to emphasize intentionality and self-interest, analogizing state actions to those of self-seeking individuals. Specifically, they posit that state policies are often deliberately designed to shift economic and political costs across state lines while retaining benefits in-state.¹¹⁴

110. Gerken & Holtzblatt, *supra* note 45, at 62.

111. Samuel Issacharoff & Catherine M. Sharkey, *Backdoor Federalization*, 53 UCLA L. REV. 1353, 1371 (2006); *see also* Cameron O’Brien Flynn & Robin Fretwell Wilson, *When States Regulate Emergency Contraceptives Like Abortion, What Should Guide Disclosure?*, 43 J.L. MED. & ETHICS 72, 77, 82 (2015) (identifying expansion of abortion regulation to emergency contraceptives as “regulatory spillover”). *But see* Erin O’Hara O’Connor & Larry E. Ribstein, *Preemption and Choice-of-Law Coordination*, 111 MICH. L. REV. 647, 660 (2013) (acknowledging that “[s]pillover problems from extraterritorial regulation can take several forms”).

112. Metzger, *supra* note 45, at 1513.

113. *See, e.g.*, Scott Fruehwald, *The Rehnquist Court and Horizontal Federalism: An Evaluation and a Proposal for Moderate Constitutional Constraints on Horizontal Federalism*, 81 DENV. U. L. REV. 289, 329 (2003) (“[S]tates should not be able to externalize costs and internalize benefits, giving benefits to itself or its citizens, but placing part of the cost on other states or their citizens.”); Bruce L. Hay, *Conflicts of Law and State Competition in the Product Liability System*, 80 GEO. L.J. 617, 617 (1992) (“When states can pass laws whose costs are borne by outsiders, self-interested behavior by each makes all worse off.”).

114. *See* Gerken & Holtzblatt, *supra* note 45, at 70.

We use the concept of “spillover” more expansively. On our account, regulatory spillovers encompass any extraterritorial effects of state laws, whether intentional or unintentional, without reference to purpose or (necessarily) to economic effects. Moreover, spillovers, as we describe them here, need not provide any benefit to—or even have any impact upon—the citizens of the state whose regulation migrates to another state.¹¹⁵ And our focus on the impact of such migrations is less on states *qua* states than on *citizens* of states (primarily, in this instance, on women seeking abortions and physicians who perform abortions).

Our account also differs from the existing writings on regulatory spillovers in terms of both the spillover’s domain and the mechanism through which the spillover occurs. The South Dakota effect does not operate by affecting manufacturers and products in a national market, like the California effect.¹¹⁶ Nor does it trigger an increase in the movement of particular items—marijuana,¹¹⁷ say, or firearms¹¹⁸—from states with laxer regulations to states with more stringent regulations. Rather, its impact is primarily on doctrine and practice.¹¹⁹

115. See, e.g., ROBERT A. SCHAPIRO, *POLYPHONIC FEDERALISM: TOWARD THE PROTECTION OF FUNDAMENTAL RIGHTS* 115 (2009) (“The social and moral policies of one state may have an impact on people all over the United States. . . . [Among other things,] [t]he abortion policies . . . of neighboring states may have an impact on the social fabric of a particular state.”); Robert P. Inman & Daniel L. Rubinfeld, *Making Sense of the Antitrust State-Action Doctrine: Balancing Political Participation and Economic Efficiency in Regulatory Federalism*, 75 *TEX. L. REV.* 1203, 1281 (1997) (proposing refinement to antitrust state-action doctrine “to ensure that state regulations that adversely affect the economic interests of citizens living outside the regulating state will be curtailed”); Jason Marisam, *The Internationalization of Agency Actions*, 83 *FORDHAM L. REV.* 1909, 1917 (2015) (arguing that, in the international context, “[r]egulatory spillover effects exist whenever one nation’s regulations substantially affect the well-being of another nation’s population”).

116. For another illustration of a spillover that results from a single state’s dominance on the relevant market, consider the profound influence of Texas’s Board of Education decisions on the contents of schoolbooks nationwide. As a market for schoolbooks, Texas is “so big and influential that national publishers tended to gear their books toward whatever it wanted,” including controversial and scientifically unfounded views about evolution. Gail Collins, *How Texas Inflicts Bad Textbooks on Us*, *N.Y. REV. BOOKS* (June 21, 2012), <http://www.nybooks.com/articles/archives/2012/jun/21/how-texas-inflicts-bad-textbooks-on-us/> [<https://perma.cc/KY6F-VNWU>]. According to schoolbook publishers, “Given the high cost of developing a single book, the risk of messing with Texas was high.” *Id.*; see also Gerken & Holtzblatt, *supra* note 45, at 79.

117. See Jack Healy, *Nebraska and Oklahoma Sue Colorado Over Marijuana Law*, *N.Y. TIMES* (Dec. 18, 2014), <http://www.nytimes.com/2014/12/19/us/politics/nebraska-and-oklahoma-sue-colorado-over-marijuana-law.html> [<https://perma.cc/ZJ87-KAMB>]; see also *Nebraska v. Colorado*, 136 S. Ct. 1034 (2016) (mem.) (denying Nebraska and Colorado leave to file complaint), http://www.supremecourt.gov/orders/courtorders/032116zor_h3ci.pdf [<https://perma.cc/AF3M-BUSE>].

118. See Heather Gerken & James T. Dawson, *Living Under Someone Else’s Laws*, *DEMOCRACY*, Spring 2015, at 42, 44 (“When Virginia and Georgia maintain lax gun rules, firearms flood into New York . . .”).

119. The closest analogue to this type of spillover is a hypothetical spread of mandatory consumer warnings that link cellphones to cancer. Such warnings presently exist only in Berkeley, California. Carol Pogash, *Cellphone Ordinance Puts Berkeley at Forefront of*

B. Interstate Migration of Postabortion Depression Warnings

Against this backdrop, the regulatory spillover we identify results from the interplay between new information pertaining to medical risk and the states' rules of informed consent. In this context, "new information" includes any medical information, whatever its source, which has not yet been endorsed or definitively rejected by the medical community. As we have explained, rules of informed consent vary from one state to another: some states base disclosure requirements on doctors' customs, while others align those requirements with a reasonable patient's expectations.¹²⁰ The introduction of new information relating to risks affects these standards differently.

The "patient expectation" standard requires doctors to inform patients about every factor that might influence a reasonable patient's selection of treatment, including remote risks of serious harm.¹²¹ This broad disclosure requirement extends to all medical information that might help a patient choose the right treatment, including information that comes from out of state.¹²² Failure to satisfy this requirement

Radiation Debate, N.Y. TIMES (July 21, 2015), <http://www.nytimes.com/2015/07/22/us/cellphone-ordinance-puts-berkeley-at-forefront-of-radiation-debate.html> [https://perma.cc/5KQQ-KEF2] (reporting that the City of Berkeley "passed a measure—not actually backed by science—requiring cellphone stores to warn customers that the products could be hazardous to their health, presumably by emitting dangerous levels of cancer-causing radiation").

120. See *Canterbury v. Spence*, 464 F.2d 772, 787–88 (D.C. Cir. 1972).

121. See sources cited *supra* note 93.

122. For a salient example, see *Harbeson v. Parke Davis, Inc.*, 746 F.2d 517 (9th Cir. 1984), a case decided under Washington's "patient expectation" standard. In that case, the Ninth Circuit found an informed-consent violation in a doctor's failure to notify a pregnant patient that an anticonvulsant drug, Dilantin, which he prescribed for the patient's epilepsy, had been found to correlate with birth defects by a study that appeared in a reputable medical journal in Great Britain, *The Lancet*. *Id.* at 519. The court ruled that "the district court did not err in finding as a fact that a reasonable patient would have considered these risks in deciding on treatment," *id.* at 524, and it ended its decision with the following statement of doctrine and policy:

The [British] article pointed out what are at least potentially material risks. It may be that those risks had not yet been documented or accepted as a fact in the medical profession. Nonetheless, under the doctrine of informed consent, those risks should have been disclosed. Medical knowledge should not be limited to what is generally accepted as a fact by the profession. To hold otherwise would defeat the purpose of the doctrine, give little weight to exploratory medical research, and invite impossible line drawing.

Id. at 525; see also *Hall v. Hilbun*, 466 So.2d 856, 870–71 (Miss. 1985) (observing that medical education and training undergo "nationalization" and that information affecting doctors' standards and practices crosses state boundaries); Kenneth S. Abraham, *Stable Divisions of Authority*, 44 WAKE FOREST L. REV. 963, 973 (2009) ("[W]hen the reasonable patient standard applies to the informed-consent issue, testimony regarding the breach issue under the malpractice and informed-consent counts is likely to come from different sources . . ."); George P. Smith, II, *The Vagaries of Informed Consent*, 1 IND. HEALTH L. REV. 109, 116 (2004) ("Other states choose to apply the . . . prudent patient standard of informed consent, thereby requiring a physician to inform his patient of *all sources and degrees of information* which an

exposes the doctor to liability for medical malpractice.¹²³ As a result, new medical information, whatever its source,¹²⁴ updates doctors' disclosure obligations upon introduction.¹²⁵

average, ordinary, and reasonable patient should and would require in order to make an informed decision regarding the need to submit to a proposed treatment therapy." (emphasis added)); Twerski & Cohen, *supra* note 83, at 38 ("[A] provider or MCO [managed care organization] that has risk information in a form from which comparative inferences can be drawn—whether the MCO developed that information itself or obtained it from another source, such as the government—has the same duty to disclose this information [to the patient] as it does to disclose information about risks associated with the procedure."); *cf.* *Weekly v. Solomon*, 510 N.E.2d 152, 156 (Ill. Ct. App. 1987) (holding that, under Illinois's "doctors' custom" standard, "the locality rule does not apply to the issue of informed consent" and allowing a physician from Ohio to testify about informed-consent violation by a doctor from Illinois).

123. See David M. Studdert, Michelle M. Mello, Marin K. Levy, Russell L. Gruen, Edward J. Dunn, E. John Orav & Troyen A. Brennan, *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. EMPIRICAL LEGAL STUD. 103, 117, 120 (2007) (finding that doctors practicing in "patient expectation" jurisdictions are more than twice as likely to be held liable for informed-consent violations as physicians working in the states that follow the "doctors' custom" standard).

124. But compare *Spencer v. Seikel*, a case in which the Oklahoma Supreme Court dismissed the patient's argument that her doctors "had a duty to inform her that abortion, although prohibited in Oklahoma at her stage of pregnancy, was available in other states." 742 P.2d 1126, 1129 (Okla. 1987). The court distinguished between the national medical standards Oklahoma doctors must use in treating patients, and the abortion laws of states other than Oklahoma. *Id.* In the court's words, "searching for legal alternatives is a job more suitable for lawyers." *Id.*; see also Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 335 (1999) ("By characterizing abortion as *legally* rather than *geographically* unavailable, the [*Spencer*] court absolved the physician of the duty to disclose." (emphasis in original)). The *Spencer* decision guided the court in a California appellate case, *Schiff v. Prados*, which involved a doctor's failure to inform the patient about a cancer treatment not approved by the FDA and consequently unlawful in California, but available in Texas. 112 Cal. Rptr. 2d 171, 184 (Ct. App. 2001). The court ruled in connection with this failure that "even if Texas had allowed [the] treatment . . . , [it] was, for legitimate policy reasons, outlawed in California. It would be contrary to the public policies reflected in our cancer treatment statutes to require a physician to discuss treatments those statutes proscribe." *Id.* As a general matter, held the court, under California's "patient expectation" standard laid down in *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972), "a treatment that cannot legally be administered in this state is not 'available' within the meaning of this rule, and thus . . . a physician cannot be held liable for failing to disclose the existence of such a treatment." *Schiff*, 112 Cal. Rptr. 2d at 173. This formulation left open the possibility, however, that California doctors could be obligated to inform patients about out-of-state treatment alternatives *not* outlawed in California.

125. See *Ray v. Kapiolani Med. Specialists*, 259 P.3d 569, 583–84 (Haw. 2011) (ruling under "patient expectation" standard that doctors must disclose to patients "recognized serious possible risks [and] complications . . . involved in the treatment" (quoting *Barcai v. Betwee*, 50 P.3d 946, 959 (Haw. 2002))); *Parker v. Ortiz*, No. L-0280-08, 2014 WL 4064801, at *7 (N.J. Super. Ct. App. Div. 2014) ("Concerning the risks that must be disclosed by a physician [under 'patient expectation' standard], [t]he case law is clear. A plaintiff alleging lack of informed consent has the burden of producing expert testimony to establish that the risk cited

When the source of such information is published studies, and those studies are contradicted by other studies, this updating may proceed at a slower pace, because doctors will have conflicting sources of information. Under such circumstances, instead of informing patients about the controversy, doctors will normally wait for further studies that will resolve the conflict. Because they are contradicted by other studies, controversial studies that link abortion to depression would ordinarily be excluded from routine informed-consent conversations between doctors and patients.

However, the legislative endorsements those studies have received from South Dakota and thirteen other states alter the landscape. Those studies have now acquired an official seal of approval. This ratification turns the abortion-depression nexus into information that reasonable patients might expect to receive. The “reasonable expectation” standard for informed consent consequently may require doctors to give patients this information.

Under the “doctors’ custom” standard, by contrast, new medical information does not automatically update doctors’ disclosure obligations. Such updating only occurs when a substantial number of doctors coalesce around a common practice of providing particular information to patients. Formation of this professional custom is a slow and incremental process.¹²⁶

Doctors, however, have independent incentives to expedite that process and incorporate new information into their disclosure practices without thorough scrutiny. This incentive is twofold. First, doctors’ marginal cost of delivering medical information to patients is low. Adding information to a standard informed-consent form and briefly explaining it to patients costs doctors very little, yet it practically eliminates their prospect of being sued for informed-consent violations.¹²⁷ Doctors

was one that the defendant should have been aware of because it was known to the medical community at the time.” (quoting *Tyndall v. Zaboski*, 703 A.2d 980, 982 (N.J. Super. Ct. 1997)); *Fitzpatrick v. Natter*, 961 A.2d 1229, 1246 (Pa. 2008) (ruling under “patient expectation” standard that doctors must inform patients about “recognized” risks).

126. See generally Gideon Parchomovsky & Alex Stein, *Torts and Innovation*, 107 MICH. L. REV. 285 (2008) (showing how slow formation of medical and technological customs serving as benchmarks of tort liability discourages innovation).

127. In *Karlin v. Foust*, the Seventh Circuit interpreted Wisconsin’s informed-consent mandate, WIS. STAT. ANN. § 253.10(3)(c)1.f (West Supp. 2015), as allowing doctors to accompany the statutory warning that abortion might cause psychological trauma with their own assessment of the patient’s situation, which might rule out the prospect of postabortion depression. 188 F.3d 446, 473 (7th Cir. 1999); see also Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, HASTINGS CTR. REP., Sept.–Oct. 2009, at 21, 23 (encouraging South Dakota doctors to “contextualize the script, separating medical fact from legislative conjecture. . . . In essence, it is the physician’s burden to rehabilitate a counseling process that has been debauched by the South Dakota legislature”). Any such communication, however, could expose the doctor to a malpractice suit that would accuse him of downplaying the risk of depression. Doctors consequently have a strong incentive not to downplay the warning. See Parchomovsky & Stein, *supra* note 36, at 545 (attesting that doctors have strong incentive to “generate evidence that will help them fend off liability should a malpractice suit be filed against them”); cf. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 737 (8th Cir. 2008) (en banc) (holding that First Amendment does not require that physicians be given an option to disassociate themselves from postabortion depression warnings when these are truthful and nonmisleading).

therefore would tend to notify patients about new information even when their exposure to liability for not doing so is minimal.¹²⁸

As importantly, doctors wish to avoid suit for malpractice and informed-consent violations not only for financial reasons but also because of the reputational consequences of an unfavorable disposition of the suit in a verdict or a settlement. Under federal law, such verdicts and settlements must be reported to the National Practitioner Data Bank—a clearinghouse that collects negative information about doctors and makes it accessible to hospitals and other healthcare organizations.¹²⁹ For a risk-averse doctor, eliminating the risk of being sued for malpractice consequently becomes a high priority even when the risk is small. Driven by this incentive, doctors may relay new information to patients even when there is doubt about the information's credibility and relevance to the treatment.¹³⁰

As the number of such doctors grows, their protocols will begin affecting other doctors. These other doctors might not fear the prospect of suit as intensely as their risk-averse colleagues. They might even conclude that the new information is worthless and misleading. Yet, despite their initial disinclination to share the information with patients, they might nonetheless decide to do so. This strategy would be entirely rational because the disclosure protocols of risk-averse doctors might be interpreted by courts as a custom, even if they had not actually become one.¹³¹ Furthermore, companies that insure doctors against malpractice liability have incentives to condition their coverage on doctors' disclosure of all risks associated with a particular treatment.¹³² This may further motivate doctors to include every possible risk in their patient-information packets and dialogues.

In the case of mandatory warnings about postabortion depression, we anticipate that this dynamic will unfold in two stages. Initially, the warnings will be adopted by doctors who provide abortion services in jurisdictions following the "patient expectation" standard. To date, those warnings have received the seal of approval from fourteen states. As we have noted, this state-sponsored information links abortion to serious harms that include depression, suicidal thoughts, and, as per South Dakota

128. See Parchomovsky & Stein, *supra* note 36, at 519–20, 545 (explaining relevant cost-benefit tradeoff and applying it to doctors' decisions).

129. Health Care Quality Improvement Act of 1986 § 421, 42 U.S.C. § 11131 (2012) (requiring reports on medical malpractice payments); see 42 U.S.C. § 11135(b) (2012) ("With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) of this section is presumed to have knowledge of any information reported under this subchapter to the Secretary with respect to the physician or practitioner."). "A hospital disregarding negative information about a physician to whom it grants attending privileges exposes itself to suit for negligent credentialing." Astein, Comment to *NPDB and Due Process*, BILL OF HEALTH (Aug. 12, 2013), <http://blogs.law.harvard.edu/billofhealth/2013/08/12/npdb-and-due-process/> [<https://perma.cc/CR47-F22G>].

130. See Gibson, *supra* note 37, at 1653–61 (arguing that risk aversion motivates doctors to take extreme precautions against malpractice liability).

131. See *id.* (identifying a similar dynamic in treatments doctors choose to deliver).

132. We attempted to verify this assessment empirically, but insurance companies we contacted declined to reveal their policies.

law, actual suicide.¹³³ The probability of those harms is very low, if not negligible.¹³⁴ Yet, because this probability is not zero and the harms are serious, doctors in “patient expectation” jurisdictions may choose to provide patients with these warnings in order to avoid the risk of suit for informed-consent violations. This risk is real, given the presence of numerous organizations willing to subsidize suits against abortion providers.¹³⁵ And there is evidence that these organizations are actively looking for opportunities to sue doctors for violating a woman’s “right to know” about post-abortion depression.¹³⁶

Once all “patient expectation” states incorporate the postabortion depression warning in their doctors’ disclosure obligations, the number of jurisdictions in which doctors give women this warning will rise from fourteen to thirty-one. Among the fourteen states that mandate this warning expressly, four states (Minnesota, South Dakota, West Virginia, and Wisconsin) follow the “patient expectation” standard for all medical treatments and procedures.¹³⁷ The update of the doctors’ disclosure obligations will consequently occur in seventeen “patient expectation” jurisdictions out of twenty-one. These jurisdictions include Alabama, Alaska, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Iowa, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, Pennsylvania, and Washington.¹³⁸

This update will mark the beginning of the second and final phase of the South Dakota effect. Once doctors in thirty-one jurisdictions begin warning women about the risk of postabortion depression, physicians practicing in the “doctors’ custom” states will gradually follow suit. These physicians will sense the incipient, if not actual, change in the general custom of disclosing information to abortion patients.¹³⁹ This will also cause physicians to heed the risk of suit, which they can eliminate at a very low cost. Importantly, this second update needs to unfold in only twenty out of the thirty states that follow the “doctors’ custom” standard.¹⁴⁰ Ten out of those thirty states have already aligned themselves with South Dakota by enacting statutes directing doctors to warn women about postabortion depression.¹⁴¹

133. S.D. CODIFIED LAWS. § 34-23A-10.1(1)(e)(ii) (2011).

134. *See supra* note 108.

135. *See* Kathryn A. Eidmann, *Acuna and the Abortion Right: Constraints on Informed Consent Litigation*, 20 COLUM. J. GENDER & L. 262, 262–63 (2011).

136. *Id.*

137. *See infra* Table 1.

138. *See infra* Table 1.

139. There is evidence that physicians are beginning to sense this risk. *See* Zita Lazzarini, *South Dakota’s Abortion Script—Threatening the Physician–Patient Relationship*, 359 NEW ENG. J. MED. 2189, 2191 (2008) (“Although some may view South Dakota’s restrictive abortion provisions as affecting only the 700 or so women who seek an abortion in that state each year, such complacency may be misplaced. These provisions mark a substantial inroad into the physician-patient relationship that ought to worry any practicing physician.”).

140. *See infra* Table 1.

141. We estimate that these ten states should include Louisiana as well because it has adopted a mixed informed-consent standard for procedures other than abortion. *See* Hondroulis v. Schuhmacher, 553 So. 2d 398, 404 (La. 1988) (extending doctors’ general informed-consent obligation to information “material in a reasonable patient’s decision to undergo treatment,” but limiting it to risks that are “medically known” and “significant” rather than “rare or remote”).

The global notification about postabortion depression issued by the Planned Parenthood Federation of America¹⁴² is probably the best real-world illustration of this dynamic. Planned Parenthood is one of the nation's largest providers of reproductive health and abortion services.¹⁴³ It led the constitutional challenge to South Dakota's informed consent statute—ultimately, without success.¹⁴⁴ Yet even Planned Parenthood warns women about the possibility of postabortion depression.¹⁴⁵ As we discuss in Part II.C, the organization links this notification to all of its regional websites, including those that serve branches domiciled in the states following the “doctors’ custom” standard for informed consent (and where legislatures have not mandated any abortion-specific warnings). Planned Parenthood thus acts similarly to car manufacturers who make all of their cars conform to California's emission requirements instead of satisfying the general—and less stringent—EPA standards.¹⁴⁶ The size and stature of that organization make it reasonable to anticipate that its current informed-consent practice will affect other doctors as well. To avoid malpractice suits, those doctors might adopt Planned Parenthood's notification.¹⁴⁷

We summarize this dynamic in Table 1 and the Figures below:

Table 1. Standards by state

State	Doctors’ Custom	Mandatory Warning About Postabortion Depression	Patient Expectation
Alabama			✓
Alaska			✓
Arizona			✓
Arkansas			✓
California			✓
Colorado	✓		
Connecticut			✓
Delaware	✓		
District of Columbia			✓

142. *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures> [<https://perma.cc/SN4X-G9MY>].

143. *Who We Are*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/about-us/who-we-are> [<https://perma.cc/UE27-CW7B>].

144. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 375 F. Supp. 2d 881, 889 (D.S.D. 2005) (issuing preliminary injunction against South Dakota informed-consent statute), *vacated en banc*, 530 F.3d 724 (8th Cir. 2008), *remanded to* 650 F. Supp. 2d 972, 983 (D.S.D. 2009) (striking down as unconstitutional suicide proviso in South Dakota informed-consent statute), *aff’d*, 653 F.3d 662 (8th Cir. 2011), *rev’d en banc*, 686 F.3d 889, 906 (8th Cir. 2012) (finding “no unconstitutional hindrance of the woman’s choice” in state-mandated advisory linking abortion to suicide ideation and suicide).

145. *In-Clinic Abortion Procedures*, *supra* note 142.

146. *See supra* notes 38–39 and accompanying text.

147. We thank Tom Merrill for drawing our attention to this scenario.

State	Doctors' Custom	Mandatory Warning About Postabortion Depression	Patient Expectation
Florida			✓
Georgia	✓		
Hawaii			✓
Idaho	✓		
Illinois	✓		
Indiana	✓		
Iowa			✓
Kansas	✓	✓	
Kentucky			✓
Louisiana	✓	✓	
Maine	✓		
Maryland			✓
Massachusetts			✓
Michigan	✓	✓	
Minnesota		✓	✓
Mississippi	✓		
Missouri	✓	✓	
Montana	✓	✓	
Nebraska	✓	✓	
Nevada	✓		
New Hampshire	✓		
New Jersey			✓
New Mexico			✓
New York	✓		
North Carolina	✓	✓	
North Dakota	✓		
Ohio	✓		
Oklahoma	✓		
Oregon	✓		
Pennsylvania			✓
Rhode Island	✓		
South Carolina	✓		
South Dakota		✓	✓
Tennessee	✓		
Texas	✓	✓	
Utah	✓	✓	

State	Doctors' Custom	Mandatory Warning About Postabortion Depression	Patient Expectation
Vermont	✓		
Virginia	✓	✓	
Washington			✓
West Virginia		✓	✓
Wisconsin		✓	✓
Wyoming	✓		

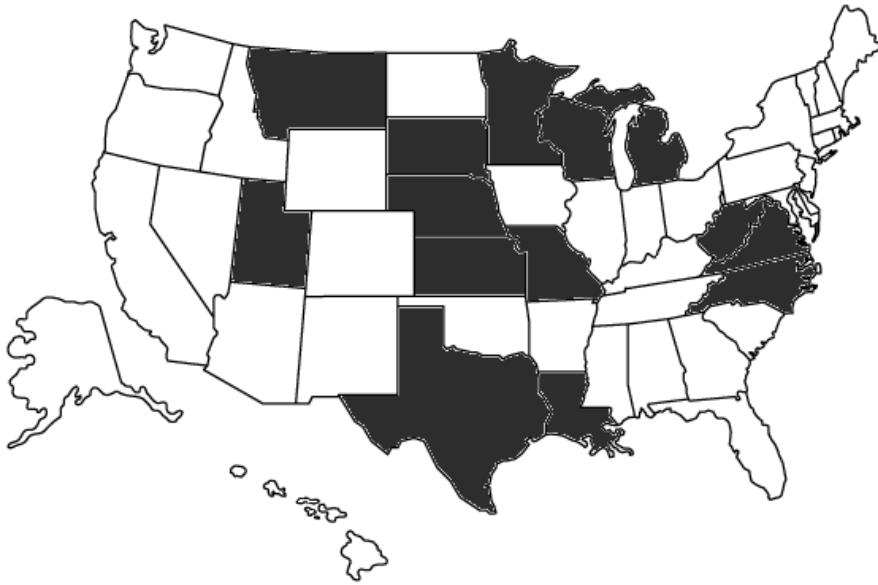


Figure 1. Starting point: Mandatory-warning states

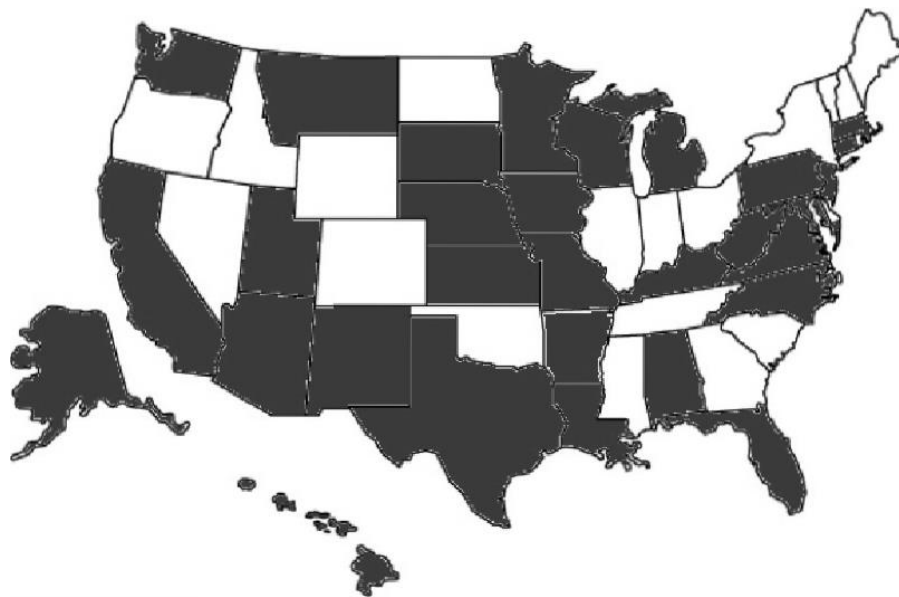


Figure 2. Stage 1: Mandatory warnings spread to patient-expectation states

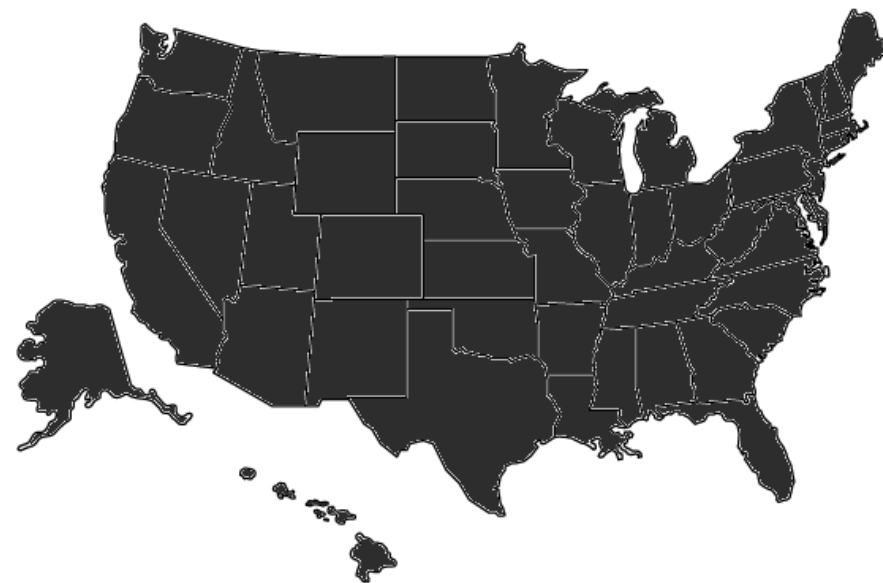


Figure 3. Stage 2: Mandatory warnings take hold nationwide

In compiling the table and figures, we relied on the states' statutory provisions and case law.¹⁴⁸ In line with our Article's goal, Table 1 juxtaposes the special

148. ALA. CODE § 26-23A-4(b)(2) (LexisNexis Supp. 2009); ALASKA STAT. §§ 18.05.032(a)(7), .16.060(b)(2) (2014); ARIZ. REV. STAT. ANN. § 36-2153(A)(1)(c) (Supp. 2015); ARK. CODE ANN. § 20-16-1703(b)(1)(B) (Supp. 2015); *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (in bank) (holding that reasonable patient's expectation standard applies in California); *Garhart ex rel. Tinsman v. Columbia/HealthONE, L.L.C.*, 95 P.3d 571, 587 (Colo. 2004) (holding that "doctors' custom" standard applies in Colorado); *Logan v. Greenwich Hosp. Ass'n*, 465 A.2d 294, 299 (Conn. 1983) (holding that reasonable patient's expectation standard applies in Connecticut); DEL. CODE ANN. tit. 18, § 6852(a)(1)–(2) (2015); *Shapira v. Christiana Care Health Servs., Inc.*, 99 A.3d 217, 221–22 (Del. 2014) (explaining that "doctors' custom" standard applies in Delaware pursuant to title 18, section 6852(a)(2) of the Delaware Code); *Miller–McGee v. Wash. Hosp. Ctr.*, 920 A.2d 430, 439 (D.C. 2007) (citing *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972)) (holding that reasonable patient's expectation standard applies in the District of Columbia); FLA. STAT. ANN. § 390.0111(3)(a)(1)(a) (West Supp. 2016); GA. CODE ANN. §§ 31-9-6.1, -9A-3(1), (2012); HAW. REV. STAT. § 671-3(b) (West Supp. 2014); *Cuc Thi Ngo v. Queen's Med. Ctr.*, 358 P.3d 26, 37 (Haw. 2015) (reaffirming *Carr v. Strode* and "patient expectation" standard for Hawaii); *Carr v. Strode*, 904 P.2d 489, 500 (Haw. 1995) (holding that reasonable patient's expectation standard applies in Hawaii); IDAHO CODE ANN. §§ 18-604(7), 18-609(2)(c), 39-4506 (Supp. 2015); *Xeniotis v. Cynthia Satko, D.D.S., M.S., P.C.*, 14 N.E.3d 1207, 1213 (Ill. App. Ct. 2014) (explaining that in Illinois, "[a] doctor must disclose the risks that a reasonable medical professional would have disclosed under similar circumstances" and that "[t]he failure of the physician to conform to the professional standard of disclosure must be proven by expert medical evidence"); *Doe v. Planned Parenthood/Chi. Area*, 956 N.E.2d 564, 570 (Ill. App. Ct. 2011) (reaffirming in abortion case that "doctors' custom" standard applies in Illinois); IND. CODE § 16-34-2-1.1 (Supp. 2015); *Culbertson v. Mernitz*, 602 N.E.2d 98, 101–04 (Ind. 1992) (holding that reasonably prudent physician standard applies to informed consent cases in Indiana); *Kennis v. Mercy Hosp. Med. Ctr.*, 491 N.W.2d 161, 166 (Iowa 1992) (holding that reasonable patient's expectation standard applies in Iowa); *Pauscher v. Iowa Methodist Med. Ctr.*, 408 N.W.2d 355, 359 (Iowa 1987) (same); KAN. STAT. ANN. §§ 65-6709(a)(3), -6710(a)(3) (Supp. 2014); *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960) (holding that "doctors' custom" standard applies in Kansas); KY. REV. STAT. ANN. § 311.725(1)(a)(1) (LexisNexis 2011); LA. REV. STAT. ANN. § 40:1061.17 (Supp. 2016); *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 404–05 (La. 1988) (interpreting Louisiana statute as adopting "doctors' custom" standard); ME. REV. STAT. ANN. tit. 22, § 1599-A (2004); ME. REV. STAT. ANN. tit. 24, § 2905(1)(A)–(C), (2) (2015) (codifying "doctors' custom" standard for Maine); *Ouellette v. Mehalic*, 534 A.2d 1331, 1332 (Me. 1988) (holding that "doctors' custom" standard applies in Maine); *Woolley v. Henderson*, 418 A.2d 1123, 1129–30 (Me. 1980) (same); *Sard v. Hardy*, 379 A.2d 1014, 1020 (Md. 1977) (holding that reasonable patient's expectation standard applies in Maryland); MASS. ANN. LAWS ch. 112, § 12S (LexisNexis 2004) (indicating possible shift to "doctors' custom" standard with respect to abortion); *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240, 243 (Mass. 1982) (holding that reasonable patient's expectation standard applies in Massachusetts); MICH. COMP. LAWS ANN. § 333.17015(11)(b)(iii) (West Supp. 2015); *Wlosinski v. Cohn*, 713 N.W.2d 16, 20 (Mich. Ct. App. 2005) (holding that "doctors' custom" standard generally applies in Michigan); MINN. STAT. ANN. §§ 145.4242, .4243(a)(2) (West 2011); *Cornfeldt v. Tongen*, 295 N.W.2d 638, 640 (Minn. 1980) (holding that reasonable patient's expectation standard applies in Minnesota); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 701–02 (Minn. 1977) (same); MISS. CODE ANN. § 41-41-33(1)(a)(ii) (West 2007); *Whittington v. Mason*, 905 So. 2d 1261,

abortion-related warnings of South Dakota and similar states against the informed-consent requirements for abortion procedures in other states. These other

1266 (Miss. 2005) (realigning Mississippi informed-consent law with “doctors’ custom” standard); MO. ANN. STAT. § 188.039(2)–(3) (West Supp. 2015); *Aiken v. Clary*, 396 S.W.2d 668, 675 (Mo. 1965) (holding that “doctors’ custom” standard generally applies in Missouri); MONT. CODE ANN. §§ 50-20-104(5), -304 (2015); *Negaard v. Estate of Fedra*, 446 P.2d 436, 441 (Mont. 1968) (holding that “doctors’ custom” standard generally applies in Montana); NEB. REV. STAT. ANN. § 28-327.01(1)(b) (LexisNexis 2015); NEB. REV. STAT. ANN. § 44-2816 (LexisNexis 2010); NEV. REV. STAT. ANN. § 41A.110 (LexisNexis 2012); NEV. REV. STAT. ANN. § 442.253 (LexisNexis 2015); *Folger v. Corbett*, 394 A.2d 63, 64 (N.H. 1978) (holding that “doctors’ custom” standard generally applies in New Hampshire); *Matthies v. Mastromonaco*, 733 A.2d 456, 462 (N.J. 1999) (holding that reasonable patient’s expectation standard applies in New Jersey); *Largey v. Rothman*, 540 A.2d 504, 509 (N.J. 1988) (per curiam) (same); N.M. STAT. ANN. UJI § 13-1104B (2015); N.Y. PUBLIC HEALTH LAW § 2805-d(1) (McKinney 2012); N.C. GEN. STAT. ANN. §§ 90-21.13(a), -21.82(1)(b) (West Supp. 2014); N.D. CENT. CODE ANN. § 14-02.1-02(11) (Supp. 2015) (setting up “doctors’ custom” standard for informed consent to abortion); OHIO REV. CODE ANN. § 2317.56 (LexisNexis Supp. 2015); OKLA. STAT. ANN. tit. 63, §§ 1-738.2, .3 (West 2015) (setting forth informed-consent requirement for abortions in Oklahoma using medical profession’s standard); OR. REV. STAT. § 677.097 (2013); *Macy v. Blatchford*, 8 P.3d 204, 210 (Or. 2000) (en banc); 18 PA. STAT. AND CONS. STAT. ANN. § 3205(a)(1) (West 2015); 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (West 2014); R.I. GEN. LAWS § 23-4.7-3 (2008); S.C. CODE ANN. § 44-41-20 (2002); S.D. CODIFIED LAWS §§ 34-23A-1.7, -10.1(1)(e) (2011 & Supp. 2015); TENN. CODE ANN. § 29-26-118 (2012); TEX. CIV. PRAC. & REM. CODE ANN. § 74.103 (2011) (establishing “doctors’ custom” standard for Texas by authorizing panels of experts to determine and promulgate doctors’ disclosure obligations to patients); TEX. HEALTH & SAFETY CODE ANN. §§ 171.012(a)(1)(B), .014 (West Supp. 2015); UTAH CODE ANN. § 76-7-305.5(2)(a), (o) (LexisNexis Supp. 2015); UTAH CODE ANN. § 78B-3-406 (LexisNexis 2012) (limiting doctors’ disclosure obligations to “substantial and significant” risks, thus effectively aligning them with “doctors’ custom” standard); *Reiser v. Lohner*, 641 P.2d 93, 98 (Utah 1982) (reaffirming Utah’s “settled general rule” that “[t]he physician must inform the patient of all substantial and significant risks which might occur; yet he need not advise the patient of every conceivable risk”); VT. STAT. ANN. tit. 12, § 1909(a)(1) (Supp. 2015); VA. CODE ANN. § 18.2-76(F)(3) (2014) (Virginia’s special informed-consent requirements for abortion); *Rizzo v. Schiller*, 445 S.E.2d 153, 155 (Va. 1994) (holding that “doctors’ custom” standard generally applies in Virginia); *Bly v. Rhoads*, 222 S.E.2d 783, 787 (Va. 1976) (same); WASH. REV. CODE ANN. § 7.70.050(2) (West Supp. 2015); *Backlund v. Univ. of Wash.*, 975 P.2d 950, 956 n.3 (Wash. 1999) (holding that reasonable patient’s expectation standard applies in Washington); W. VA. CODE ANN. § 16-21-3(a)(2) (LexisNexis 2011); *Adams v. El-Bash*, 338 S.E.2d 381, 385–86 (W. Va. 1985) (holding that reasonable patient’s expectation standard generally applies in West Virginia); *Cross v. Trapp*, 294 S.E.2d 446, 455 (W. Va. 1982) (same); WIS. STAT. ANN. § 253.10(1)(b)3, (3)(c)1.f (West Supp. 2015); *Johnson ex rel. Adler v. Kokemoor*, 545 N.W.2d 495, 501 n.16 (Wis. 1996) (holding that reasonable patient’s expectation standard generally applies in Wisconsin); *Havens v. Hoffman*, 902 P.2d 219, 222 (Wyo. 1995) (holding that “doctors’ custom” standard generally applies in Wyoming); *Roybal v. Bell*, 778 P.2d 108, 112 (Wyo. 1989) (same). *But see* N.J. STAT. ANN. § 26:2H–12.8 (West Supp. 2015) (subjecting general hospitals in New Jersey to “doctors’ custom” standard); *Peterson v. Shields*, 652 S.W.2d. 929, 931 (Tex. 1983) (holding that disclosures not addressed by the state’s statutory Medical Disclosure Panel will be governed by the “patient expectation” standard).

states' requirements are predominantly the same for abortion and for other medical procedures. Nine states, however, have designed special informed-consent requirements for abortion that substitute the generally applicable "doctors' custom" standard with the "patient expectation" standard,¹⁴⁹ or vice versa.¹⁵⁰

Our figures summarize the two-stage proliferation of postabortion depression warnings. At stage one, as those warnings proliferate in the seventeen "patient expectation" jurisdictions that presently do not mandate them, the number of jurisdictions in which doctors warn patients about postabortion depression grows from fourteen to thirty-one. This increase makes postabortion depression warnings customary. At stage two, doctors practicing in the remaining twenty jurisdictions update their disclosure obligations in accordance with this emerging custom.

As we noted at the outset, the South Dakota effect is similar to the California effect in one important respect: both effects involve globalization of a local standard. This similarity, however, is the only thing that the two effects have in common. The activities and incentives that produce those effects differ critically, and policy makers should be aware of those differences as well. The California effect is brought about by actors' responses to two incentives: economic attractiveness of the local market and the high cost of dual regulatory compliance.¹⁵¹ These incentives lead to

149. ALA. CODE § 26-23A-4(b)(2) (LexisNexis 2009) (substituting general "doctors' custom" standard, adopted in *Fain v. Smith*, 479 So. 2d 1150, 1152 (Ala. 1985) (per curiam), with "patient expectation" standard for abortion procedures in Alabama); ARIZ. REV. STAT. ANN. § 36-2153(A)(1)(c) (2014) (substituting general "doctors' custom" standard, adopted in *Riedisser v. Nelson*, 534 P.2d 1052, 1054 (Ariz. 1975), with "patient expectation" standard for abortion procedures in Arizona); ARK. CODE ANN. § 20-16-1703 (b)(1)(B) (2015) (substituting general "doctors' custom" standard, previously codified in ARK. CODE ANN. § 16-114-206(b)(1) (2015), with "patient expectation" standard for abortion procedures in Arkansas); FLA. STAT. ANN. § 390.0111(3)(a)(1)(a) (West Supp. 2016) (substituting general "doctors' custom" standard, codified in FLA. STAT. ANN. § 766.103 (West 2011) and described in *In re Standard Jury Instructions in Civil Case—Report No. 12-01*, 30 So.3d 596, 606 (Fla. 2013) (per curiam), with "patient expectation" standard for abortion procedures in Florida); KY. REV. STAT. ANN. § 311.725(1)(a)(1) (LexisNexis 2011) (substituting general "doctors' custom" standard, adopted in *Keel v. St. Elizabeth Medical Center*, 842 S.W.2d 860, 861 (Ky. 1992), with "patient expectation" standard for abortion procedures in Kentucky); see also *Sargent v. Shaffer*, 467 S.W.3d 198 (Ky. 2015) (attesting that under Kentucky law, informed consent is generally determined by doctors' customary practice).

150. N.D. CENT. CODE ANN. § 14-02.1-02(11) (Supp. 2015) (substituting general "patient expectation" standard, adopted in *Jaskoviak v. Gruver*, 638 N.W.2d 1, 8-9 (N.D. 2002), with "doctors' custom" standard for abortion procedures in North Dakota); OHIO REV. CODE ANN. § 2317.56 (LexisNexis 2010 & Supp. 2015) (substituting general "patient expectation" standard, adopted in *Nickell v. Gonzalez*, 477 N.E.2d 1145, 1148 (Ohio 1985), with "doctors' custom" standard for abortion procedures in Ohio); OKLA. STAT. ANN. tit. 63, §§ 1-738.2, .3 (Supp. 2016) (laying down special informed-consent requirement for abortions in Oklahoma that uses medical profession's standards while overriding the general "actual patient's expectation" approach adopted by *Scott v. Bradford*, 606 P.2d 554, 557-59 (Okla. 1979)); R.I. GEN. LAWS § 23-4.7-3 (2008) (substituting general "patient expectation" standard, adopted in *Miller v. Rhode Island Hospital*, 625 A.2d 778, 783-85 (R.I. 1993), with "doctors' custom" standard for abortion procedures in Rhode Island).

151. These incentives are best explained in Anu Bradford's discussion of the Brussels effect, the European cousin of the California effect. Bradford, *supra* note 39, at 17 ("The

productive activities that benefit society (e.g., manufacture of cars that minimize damage to the environment).¹⁵² Activities that produce the South Dakota effect, on the other hand, are completely divorced from productivity. Far from being welfare enhancing, those activities instill in abortion patients unnecessary fear and anxiety that may undermine their ability to make informed choices.

C. Empirical Evidence

Thus far, our discussion of the South Dakota effect has been theoretical. We have not raised, let alone answered, the question of whether the antiabortion statutes of South Dakota and like-minded states have to date caused doctors from other jurisdictions to change their behavior.

This question is undeniably important, but we cannot provide a definite answer. The absence of information about doctors' confidential communications with abortion patients and the inaccessibility of informed-consent forms for abortion prevent us from doing so. We do, however, provide a tentative answer. First, we show that suits against doctors for failure to inform patients about possible postabortion depression have become a real threat in the post-*Casey* world. Second, we examine the information given to prospective patients by one of the nation's largest providers of reproductive health services and abortion: the Planned Parenthood Federation of America.¹⁵³

The *Casey* decision did not merely approve special informed-consent requirements for abortion.¹⁵⁴ It also appeared, at least to some, to credit the view that the risk of postabortion depression is real.¹⁵⁵ This prompted an experienced practitioner to publish an article warning abortion doctors about their potential liability for failure

exporter has an incentive to adopt a global standard whenever its production or conduct is nondivisible across different markets or when the benefits of a uniform standard due to scale economies exceed the costs of forgoing lower production costs in less regulated markets.”).

152. *Cf. id.* at 64 (observing that self-globalizing, but ill-designed, regulations erode social welfare).

153. PLANNED PARENTHOOD, <http://www.plannedparenthood.org> [<https://perma.cc/C68Y-X9H3>].

154. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 883 (1992).

155. *Id.* at 882 (crediting the possibility that “a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed”); *see also* *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. . . . Severe depression and loss of esteem can follow.” (citation omitted)). For a markedly different perspective, *see Roe v. Wade*, 410 U.S. 113, 153 (1973) (“Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.”). For scholarship raising concerns about this sort of Supreme Court factual claim, *see* Allison Orr Larsen, *Confronting Supreme Court Fact Finding*, 98 VA. L. REV. 1255, 1257 (2012) (critiquing Supreme Court’s “in-house” fact finding and citing, as an example, the Court’s factual claims in *Carhart* regarding “the emotional consequences of abortions generally”). *See also* Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193, 1200 (2010) (tracing roots of idea of “abortion trauma” in *Carhart*).

to inform patients about that risk.¹⁵⁶ The article argued that doctors must inform patients about possible postabortion depression under both “doctors’ custom” and “patient expectation” standards.¹⁵⁷

This idea came to occupy the agenda of organizations that use medical malpractice suits as an antiabortion weapon.¹⁵⁸ Unsurprisingly, this weapon became particularly popular after *Casey*.¹⁵⁹ Reporting suggests that a number of plaintiffs funded by antiabortion organizations sued doctors for failure to inform the plaintiffs about postabortion depression.¹⁶⁰ One of those organizations apparently developed and distributed a manual for attorneys that explained how to file such suits.¹⁶¹ There is, however, very limited public information about such suits. Our research has uncovered only three suits that have been litigated to judgment and ended in published decisions. One of those suits, *Acuna v. Turkish*,¹⁶² has been the subject of extensive public and scholarly attention.¹⁶³ The other two, *Perez v. Park Madison Professional Laboratories*¹⁶⁴ and *Doe v. Planned Parenthood/Chicago Area*,¹⁶⁵ are far less known.¹⁶⁶

In *Acuna*, the plaintiff tied her alleged emotional distress to the realization that she had killed an “existing human being” by having an abortion.¹⁶⁷ She claimed that

156. Thomas R. Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639 (1996).

157. Specifically, it claimed that

a physician’s withholding of important information on the risks of potential harmful psychological and emotional consequences arising from an abortion, absent significant justifying factors, will be viewed . . . as usurping the patient’s right to informed consent. . . . [W]e may expect a generally uniform response in both patient and professional rule jurisdictions to the problems of how and to what extent the patient should be informed of potential emotional and psychological problems.

Id. at 666.

158. See Eidmann, *supra* note 135, at 268; Kathy Seward Northern, *Procreative Torts: Enhancing the Common-Law Protection for Reproductive Autonomy*, 1998 U. ILL. L. REV. 489, 494 (“There are increasing indications that abortion malpractice litigation is on the rise. At least some of that litigation, moreover, may stem from pro-life advocates attempting to dissuade doctors from performing abortions.”).

159. Eidmann, *supra* note 135, at 268 (reporting that “[a]bortion malpractice strategies became increasingly popular in the mid-1990s” and providing examples).

160. *Id.* at 272–73.

161. *Id.*

162. 930 A.2d 416 (N.J. 2007); *Acuna v. Turkish*, 915 A.2d 1045 (N.J. 2007), *cert. denied*, 552 U.S. 825 (2007).

163. See, e.g., Dresser, *supra* note 47, at 1603–04 (discussing *Acuna* and its implications); Eidmann, *supra* note 135 (same); Manian, *supra* note 50, at 261 & n.261 (same); Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 CORNELL J.L. & PUB. POL’Y 1, 15 & n.52 (2011) (same).

164. 630 N.Y.S.2d 37 (N.Y. App. Div. 1995).

165. 956 N.E.2d 564 (Ill. App. Ct. 2011).

166. See also *Humes v. Clinton*, 792 P.2d 1032, 1035, 1038 (Kan. 1990) (affirming dismissal of patient’s suit for doctor’s failure to warn her about emotional distress originating from abortion carried out to eliminate life-threatening risks in continuing the pregnancy).

167. 930 A.2d at 418.

her physician ought to have informed her of this but failed to do so, thereby violating her informed-consent right.

The New Jersey Supreme Court ruled for the defendant. It reasoned that the plaintiff's view of the embryo as an "existing human being" was not a medical fact but rather a "moral, theological, or philosophical" proposition.¹⁶⁸ For that reason, the court held that a patient—even in a "patient expectation" state like New Jersey—could not reasonably expect doctors to tell her that an embryo is an existing human being.¹⁶⁹

The *Acuna* court acknowledged the existence of the South Dakota statute requiring doctors to inform patients that abortion terminates the life "of a whole, separate, unique, living human being."¹⁷⁰ The court declined, however, to import the South Dakota view of abortion into the New Jersey doctrine of informed consent. This decision was motivated by the court's unwillingness to include information it deemed "nonmedical" in doctors' disclosure obligations.¹⁷¹

Importantly, the court also noted that

[p]laintiff has not pointed out whether even a small minority of physicians currently give such instructions. Plaintiff has not directed us to any jurisdiction or any court that has found a common law duty requiring doctors to tell their pregnant patients that aborting an embryo is the killing of an existing human being—an instruction suggesting that both the doctor and patient would be complicit in committing the equivalent of murder.¹⁷²

This decision consequently leaves open the possibility that future plaintiffs might claim that they have been improperly denied *medical information* about the low probability of postabortion depression. Under New Jersey's "patient expectation" standard, reaffirmed by the *Acuna* court,¹⁷³ doctors must give patients medical information that covers low-probability scenarios and nonrecommended treatment options.¹⁷⁴ Such information may well originate from another state: all that matters is the information's medical nature. This understanding of *Acuna* may prompt cautious doctors to include the postabortion depression possibility in their patient-information packets.

Our projection that informed-consent laws might take this path is bolstered by the *Perez* case, in which a New York appellate court applied New York's "doctors'

168. *Id.* at 425–26 ("Clearly, there is no consensus in the medical community or society supporting plaintiff's position that a six- to eight-week-old embryo is, as a matter of biological fact—as opposed to a moral, theological, or philosophical judgment—'a complete, separate, unique and irreplaceable human being' or that terminating an early pregnancy involves 'actually killing an existing human being.'").

169. *Id.* at 426.

170. *Id.* at 427 (acknowledging S.D. CODIFIED LAWS § 34–23A–10.1(1)(b), (d) (2011)).

171. *Id.* at 425–26.

172. *Id.* at 427.

173. *Id.* at 425.

174. For example, in *Matthies v. Mastromonaco*, the court ruled that it might have been reasonable for an elderly osteoporotic patient to expect her doctor to inform her about an operation that required installation of bone screws and was contraindicated for patients in her condition. 733 A.2d 456, 459, 464 (N.J. 1999).

custom” standard.¹⁷⁵ This case involved a twenty-four-year-old woman who underwent a second-trimester abortion procedure.¹⁷⁶ Prior to that procedure, her doctor’s clinic gave her a patient-information packet that included a warning about postabortion depression.¹⁷⁷ The woman then signed an informed-consent form confirming that she had read about and fully understood the abortion risks specified in the packet.¹⁷⁸ However, in her subsequent suit against the doctor, the woman argued that the information she received was deficient. Specifically, she claimed that her “crisis pregnancy” situation required the doctor to talk her out of the abortion.¹⁷⁹

The court rejected this claim.¹⁸⁰ The court held that doctors practicing in New York have no obligation to talk patients out of abortions¹⁸¹ and concluded that the defendant’s postabortion depression warnings aligned with the state’s informed-consent requirements.¹⁸² This decision suggests that warning about postabortion depression was not beyond the defendant’s call of duty (perhaps because this was a second-trimester abortion).¹⁸³ Remarkably, the defendant’s standard form for informed consent included this warning, which indicates that at least some doctors were providing the warning even in the period immediately following *Casey*.¹⁸⁴

The plaintiff in a more recent case, *Doe v. Planned Parenthood*,¹⁸⁵ raised two independent claims based on her doctor’s failure to alert her to the postabortion depression possibility. She first alleged that the defendants—the Planned Parenthood doctors, nurses, and counsel—failed to inform her “that an abortion ‘procedure

175. *Perez v. Park Madison Prof'l Labs.*, 630 N.Y.S.2d 37, 40–41 (N.Y. App. Div. 1995).

176. *Id.* at 38–39.

177. *Id.* at 39.

178. *Id.*

179. *Id.* at 41. As the court described her claims, “[a]ccording to plaintiff, this harm [resulting from the abortion] includes mental anguish, neurosis, guilt, sleeplessness and depression from the awareness that, by reason of defendant’s negligence, she needlessly committed an act which is in violation of her deep-seated convictions.” *Id.* at 40.

180. *Id.* at 41.

181. *Id.*

182. *Id.* at 40–41 (“Having received accurate information concerning her medical condition at the time of her abortion, as well as of all the physical and emotional risks attendant upon the procedure, plaintiff was obviously the only person in a position to know whether an abortion under those circumstances was in violation of her personal convictions. She cannot seek to hold defendant liable because those convictions have apparently changed since she consented to and underwent the procedure.”).

183. *See id.* at 39 (describing the packet, which referred to the “possible problems related to second trimester abortions’ including the potential medical and emotional risks”).

184. *Id.*; *see also id.* at 40 (“[E]vidence in this case shows that plaintiff was specifically told of the risk of sadness and depression and the possibility of serious depression as a result of an abortion.”).

185. *Doe v. Planned Parenthood/Chi. Area*, 956 N.E.2d 564 (Ill. App. Ct. 2011). Note that plaintiff was represented by Harold Cassidy, the same attorney who brought the *Acuna* case and the chief architect of the South Dakota law. *See* Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1646 n.16 (2008) (detailing Cassidy’s involvement in South Dakota legislation); *see also* Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1027 & n.150 (same).

would terminate the life of a second patient, a living human being as a matter of biological fact.”¹⁸⁶ The second claim charged that the defendants failed to notify her that “there is a greater risk of . . . depression . . . in women who undergo an abortion than in those who give birth.”¹⁸⁷ The first of those complaints was identical to the plaintiff’s allegation in *Acuna*,¹⁸⁸ and the court relied heavily on *Acuna* in rejecting it.¹⁸⁹

Remarkably, the court dismissed the plaintiff’s action without addressing her second claim. In reaching that decision, the court assumed that this claim, too, relied on the already-rejected theory that ascribes “living human being” status to embryos.¹⁹⁰ Alas, this assumption was wrong. The plaintiff’s second claim alluded to the general incidence of postabortion depression as an empirical fact unassociated with any specific perception of embryos. The court therefore should have properly addressed this argument but failed to do so. Under current law, however, this argument would have been unlikely to prevail; this is because Illinois follows the “doctors’ custom” standard,¹⁹¹ under which doctors are not obligated to notify patients about remote scenarios that the medical profession deems immaterial.¹⁹²

The upshot of the preceding analysis is straightforward. Although the “doctors’ custom” standard does not presently obligate doctors to warn patients about post-abortion depression, under the “patient expectation” standard things might be different. As we have explained, the “patient expectation” standard requires doctors to inform patients about remote scenarios that involve substantial harm to the patient.¹⁹³ This standard therefore provides fertile ground for the South Dakota effect.¹⁹⁴

This understanding of the current legal situation is far from speculative. As we have noted, it guides the operations of the Planned Parenthood Federation of America, a major organization that provides reproductive health and abortion services to millions of women across the United States.¹⁹⁵ Planned Parenthood informs women contemplating an abortion that, although “[s]erious, long-term emotional problems after abortion are . . . uncommon,” they have been observed in some

186. *Doe*, 956 N.E.2d at 567.

187. *Id.*

188. *See Acuna v. Turkish*, 930 A.2d 416, 418 (N.J. 2007).

189. *Doe*, 956 N.E.2d at 572 (“We echo the observation of the New Jersey Supreme Court. No court, regardless of where it sits, has found a common law duty requiring doctors to tell their pregnant patients that aborting an embryo, or fetus, is the killing of an existing human being.” (emphasis omitted)).

190. *Id.* at 573–74.

191. *Id.* at 568–59.

192. *Id.*

193. *See supra* notes 92–93 and accompanying text.

194. Although none of these cases resulted in victories for the plaintiffs, they may nonetheless represent examples of what Douglas NeJaime has termed “winning through losing.” As NeJaime explains, “[l]itigation loss may, counterintuitively, produce winners. When savvy advocates lose in court, they may nonetheless configure the loss in ways that result in productive social movement effects and lead to more effective reform strategies.” Douglas NeJaime, *Winning Through Losing*, 96 IOWA L. REV. 941, 945 (2011); *see also* Ben Depoorter, Essay, *The Upside of Losing*, 113 COLUM. L. REV. 817 (2013) (analyzing strategic decisions of litigants who pursue hopeless litigation to highlight misfortunes and create public outcry).

195. *See Learn*, PLANNED PARENTHOOD (2014), <http://www.plannedparenthood.org/learn> [<https://perma.cc/MK52-LXFN>].

cases.¹⁹⁶ The organization then moves on to clarify that women “having a history of emotional problems,” “having important people in [their lives] who aren’t supportive of [their] decision to have an abortion,” or “having to terminate a wanted pregnancy [for health reasons]” are more likely to develop serious postabortion depression.¹⁹⁷ Consistent with our projection,¹⁹⁸ Planned Parenthood also apprises women of the fact that “[s]erious, long-term emotional problems after abortion are about as uncommon as they are after giving birth.”¹⁹⁹

All of this shows that the South Dakota effect is real rather than merely theoretical. To the extent that it forces doctors to instill medically unsubstantiated fears in their abortion patients, this effect is unfair to women in at least two ways. First, it may dissuade women from electing abortions they have determined are in their best interests.²⁰⁰ Second, it may actually make postabortion depression more likely, since the risk of being depressed after an abortion is not independent of the abortion experience itself. Remarkably, two studies have identified a positive correlation between the intensity of antiabortion activities outside of clinics—picketing, demonstrations, and related activities—and patients’ postabortion depression symptoms.²⁰¹ It is entirely possible that warnings about postabortion depression could have similar effects.

The South Dakota effect is also detrimental to the practice of medicine, intruding into the doctor-patient relationship and compelling doctors to provide information they do not believe is necessary, medically accurate, or in their patients’ best

196. PLANNED PARENTHOOD, *supra* note 142.

197. *Id.*

198. *See supra* Part II. Arguably, Planned Parenthood may also be trying to prevent unfavorable legislation in the states that have yet to follow the South Dakota example by making such legislation unnecessary. *Cf.* Guy Halfteck, *Legislative Threats*, 61 STAN. L. REV. 629 (2008) (revealing that organizations often have reasons for acting preemptively to make unfavorable legislation unnecessary). We thank Judge Joseph Colquitt for alerting us to this possibility.

199. PLANNED PARENTHOOD, *supra* note 142.

200. *See* Cynthia R. Daniels, Janna Ferguson, Grace Howard & Amanda Roberti, *Informed or Misinformed Consent? Abortion Policy in the United States*, 41 J. HEALTH POL. POL’Y & LAW 181, 181 (2016) (finding states’ statutory informed-consent materials regarding embryological and fetal development medically inaccurate and misleading).

201. Catherine Cozzarelli & Brenda Major, *The Effects of Anti-Abortion Demonstrators and Pro-Choice Escorts on Women’s Psychological Responses to Abortion*, 13 J. SOC & CLINICAL PSYCHOL. 404 (1994); Catherine Cozzarelli, Brenda Major, Angela Karrasch & Kathleen Fuegen, *Women’s Experiences of and Reactions to Antiabortion Picketing*, 22 BASIC & APPLIED SOC. PSYCHOL. 265 (2000). Such research suggests that warnings about post-abortion depression may turn into self-fulfilling prophecies. *See* Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 125 (2008) (“The harm of such requirements most likely lies less in scaring women into not getting abortions, but in elevating the fear and anxiety women experience when they do have abortions.”). *But see* Diana Greene Foster, Katrina Kimport, Heather Gould, Sarah C.M. Roberts & Tracy A. Weitz, *Effect of Abortion Protesters on Women’s Emotional Response to Abortion*, 87 CONTRACEPTION 81, 86 (2013) (showing that protesters do upset women seeking abortion services, but the women’s negative emotions are transient).

interests.²⁰² With all this in mind, we now turn to developing a legal mechanism that will eliminate these effects. This mechanism will prevent South Dakota–style informed-consent requirements from taking hold nationwide.

III. SOLUTIONS

The South Dakota effect poses a real threat—to women seeking to exercise the right announced in *Roe* and reaffirmed in *Casey*, to doctors seeking to provide their patients with appropriate and personalized care, and to basic precepts of federalism.²⁰³ Absent the South Dakota effect, women who sought to terminate their pregnancies in most states could do so without encountering a litany of medically unnecessary warnings designed to communicate a preference for childbirth over abortion and, ultimately, to dissuade them from electing the abortion procedure. And absent the South Dakota effect, states would not be burdened by spillovers that interfere with their determinations of how to balance the competing interests identified in *Roe* and *Casey*.

Moreover, women who find themselves subject to heightened warnings in states that do not legislatively mandate such warnings could find themselves in a difficult position, beyond the burden of simply receiving the warnings; that is, though the warnings themselves may be untruthful and misleading and thus contravene *Casey*, women in such states will be unable to mount constitutional challenges to these potentially unconstitutional warnings because they are not mandated by statute or otherwise the product of state action.²⁰⁴

As we have shown, the South Dakota effect works not because of the *quality* of the information that it spreads across the states. Indeed, the prevailing view of the medical community is that the risk of postabortion depression is likely to be insignificant for the majority of patients and, in any event, comparable to the risk of depression faced by women who carry pregnancies to term, particularly unwanted pregnancies.²⁰⁵ The effect works, instead, because of the nature of the law of informed consent. Because many states mandate the provision of information about all conceivable risks of substantial harm, the South Dakota effect exposes doctors, even in states that have not mandated any abortion-specific warnings, to suit for informed-consent violation while offering them an expedient way to avoid suit. And because the remaining states base their informed-consent standards on dominant medical

202. See Lazzarini, *supra* note 139, at 2189 (“The [South Dakota] law is unique in ways that should cause concern to physicians, patients, and protectors of the physician–patient relationship. As part of an ongoing challenge to abortion, it has import far beyond the borders of South Dakota.”).

203. Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right To Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451, 463 (1992) (“American citizens may be subject to different moral agendas in different locations. This is the essence of American federalism.”).

204. We thank Reva Siegel for bringing this point to our attention.

205. See Sawicki, *supra* note 163, at 12 n.42; Siegel, *supra* note 16, at 1719 n.81.

practice, the South Dakota effect threatens to upend medical practice in those states as well.²⁰⁶

As we have noted, the Supreme Court has expressly approved heightened informed-consent warnings in the context of abortion.²⁰⁷ But even in the absence of that approval, conventional federalism doctrine would seem to offer South Dakota and like-minded states considerable latitude to experiment—within the bounds of the Constitution—with the optimal balance between women’s autonomy and dignity interests, on the one hand, and the state’s interest in protecting potential life, on the other. This latitude stems from the basic tenets of federalism, which views states as social laboratories²⁰⁸ engaged in “innovation and experimentation”²⁰⁹ while competing against each other “for a mobile citizenry.”²¹⁰

Here, however, neither truth seeking nor pluralism and fair competition is at play. Instead, the South Dakota view of postabortion depression threatens to take hold nationally regardless of merit. Rather than allow truth to prevail after a robust competition on the marketplace of ideas, the informed-consent laws of South Dakota and like-minded states may lead to the diffusion of unchecked information across state lines.

Some might argue that the South Dakota effect will be mitigated by “abortion exceptionalism.”²¹¹ States, so goes the argument, adopt and implement their distinct preferences and policies with regard to abortion. These preferences and policies are determined primarily by politically active citizens and interest groups. State courts will tend to follow these internal preferences and policies, while refusing to incorporate legal rules or norms that emanate from ideologically dissimilar states.

206. Cf. Lazzarini, *supra* note 139, at 2191 (“Although some may view South Dakota’s restrictive abortion provisions as affecting only the 700 or so women who seek an abortion in that state each year, such complacency may be misplaced. These provisions mark a substantial inroad into the physician–patient relationship that ought to worry any practicing physician.”).

207. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992); cf. *Stenberg v. Carhart*, 530 U.S. 914 (2000).

208. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

209. *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991); see also MALCOLM FEELEY & EDWARD RUBIN, *FEDERALISM 1* (2008) (cataloguing arguments in favor of federalism, including that it “maximizes the extent to which the political system can reflect the preferences of individuals living within it”); Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 397–98 (1997); Michael W. McConnell, *Federalism: Evaluating the Founders’ Design*, 54 U. CHI. L. REV. 1484, 1498–1500 (1987) (book review) (discussing “[i]nnovation and competition in government” arguments for federalism); Deborah Jones Merritt, *The Guarantee Clause and State Autonomy: Federalism for a Third Century*, 88 COLUM. L. REV. 1, 3–10 (1988).

210. *Gregory*, 501 U.S. at 458; see also Epstein, *supra* note 24, at 150 (“The great virtue of federalism is that it introduces an important measure of competition between governments.”).

211. See Caroline Mala Corbin, *Abortion Distortion*, 71 WASH. & LEE L. REV. 1175, 1210 (2014) (“Abortion exceptionalism means the rules are different for abortion cases.”).

This dynamic could immunize the informed-consent doctrines of pro-choice states against the South Dakota effect.²¹²

We believe that this mitigating effect is limited. Abortion exceptionalism is a “soft” cultural and political phenomenon, whereas the South Dakota effect is grounded in doctrine. Consider a doctor who provides abortion services in Connecticut—a “patient expectation” state²¹³ with comparatively permissive abortion laws. Once the South Dakota effect takes hold, can this doctor ignore what she feels may be an emerging duty to notify patients about the small risk of postabortion depression? We believe that the doctor cannot do so, even if she is very optimistic about the effect of Connecticut’s abortion exceptionalism on the courts’ malpractice decisions. The reason is simple: the doctor’s optimism gives her no guarantee of immunity against malpractice accusations in the event she decides not to warn her patients about postabortion depression. On the other hand, the doctor can eliminate the prospect of liability by introducing South Dakota’s information into her informed-consent dialogues with patients; and as we have explained, she can do so at a very low cost to herself.²¹⁴

For these reasons, the South Dakota effect is likely to change doctors’ practices in “patient expectation” jurisdictions—a change that will incrementally affect doctors’ customs as well.²¹⁵ We are skeptical about state courts’ ability to stop this process, given the self-updating and doctor-dependent nature of the informed-consent doctrine. Note in this connection that doctors motivated by the desire to fend off malpractice suits will respond to the South Dakota effect before courts, as illustrated by the Planned Parenthood example.²¹⁶ The South Dakota effect therefore calls for a robust countermeasure best provided by proactive legislators.

Based on this observation, we now develop two legislative solutions: federal and state. We first present these solutions and then discuss their distinct advantages and disadvantages.

A. Federalizing Informed Consent

The first possibility we envision is for Congress to create a federal default standard establishing that abortion-specific rules of informed consent can only be created by affirmative state legislation or through the organic evolution of doctors’ customs. Under this federal statute, doctors would only be required to inform patients about the risk of postabortion depression under two circumstances: 1) if such warnings were consistent with accepted standards in the field, or 2) if state statute expressly required them to do so. In either case, warnings could only be mandated subject to *Casey*’s “truthful, nonmisleading information” proviso.²¹⁷

This proposal is consistent with one of the basic precepts of mainstream theories of federalism: while generally avoiding interference with state sovereignty, Congress

212. We thank Gillian Metzger for this insight.

213. *Logan v. Greenwich Hosp. Ass’n*, 465 A.2d 294, 300–01 (Conn. 1983) (holding that reasonable patient’s expectation standard applies in Connecticut).

214. *See supra* notes 35–37 and accompanying text.

215. *See supra* notes 133–35 and accompanying text.

216. *See supra* notes 195–99 and accompanying text.

217. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

should step in to protect states from undesirable spillover effects from other states.²¹⁸ As Professor Gillian Metzger has noted in connection with interstate relations, “[i]nstitutionally, Congress is best positioned to determine the national interest and the need for state restrictions.”²¹⁹ Indeed, even scholars who contend that interstate spillovers should under some circumstances be celebrated—as do Professor Heather Gerken and Ari Holtzblatt²²⁰—also believe that Congress has a role to play in mediating such spillovers.²²¹

We turn now to the mechanics of this proposal. We begin by sketching out the core elements of a federal legislative solution to the problems posed by the South Dakota effect. We then defend the constitutionality of that solution.

1. The Proposed Legislation

A federal legislative solution to the South Dakota effect could take a number of different forms, ranging from the creation of a federal default standard to complete preemption of state law.²²² Among these solutions, we restrict our discussion to the

218. See POSNER, *supra* note 24, at 892–93; Richard L. Revesz, *Federalism and Environmental Regulation: A Public Choice Analysis*, 115 HARV. L. REV. 553, 557 n.3 (2001) (“The presence of interstate externalities is a compelling argument for federal regulation.”); see also Gary T. Schwartz, *Considering the Proper Federal Role in American Tort Law*, 38 ARIZ. L. REV. 917, 922 (1996) (“The most obvious justifications for federal law that supercedes state law is that state law produces effects that are felt beyond the territorial limits of the states themselves or that there is some significant need for national uniformity in the content of legal rules.”). Although Schwartz argues against federal regulation of medical malpractice, his argument is both focused on proposed liability caps and premised on the assumption that “malpractice seems strikingly lacking in . . . spill-over effects.” *Id.*; cf. Richard L. Revesz, *The Race to the Bottom and Federal Environmental Regulation: A Response to Critics*, 82 MINN. L. REV. 535, 536–37 (1997) (favoring decentralization as a presumptive norm for environmental protection due to regional diversities, variegated benefits and differential costs of compliance). Note, however, that Revesz’s presumption in favor of decentralization does not apply in the presence of interstate spillovers. Richard L. Revesz, *Rehabilitating Interstate Competition: Rethinking the “Race-to-the-Bottom” Rationale for Federal Environmental Regulation*, 67 N.Y.U. L. REV. 1210, 1222–23 (1992) [hereinafter Revesz, *Interstate Competition*].

219. Metzger, *supra* note 45, at 1531. See also POSNER *supra* note 24, at 893 (“Insofar as a coordinated response is optimal, and given transaction costs, . . . it doesn’t make sense to leave the response to state and local governments.”); cf. Revesz, *Interstate Competition*, *supra* note 218, at 1222–24 (justifying federal regulation that counters interstate externalities and race to the bottom).

220. Gerken & Holtzblatt, *supra* note 45, at 108 (“Congress is the most obvious institution safeguarding horizontal federalism, just as it was Wechsler’s prime candidate for safeguarding vertical federalism.” (footnote omitted)).

221. *Id.*; see also Mark D. Rosen, Essay, *State Extraterritorial Powers Reconsidered*, 85 NOTRE DAME L. REV. 1133, 1134 (2010) (arguing that Congress, not the courts, is best situated to check “states’ exercise of extraterritorial powers”).

222. The more aggressive approach would involve the creation of a uniform federal standard for informed consent to abortion, preempting all state informed-consent laws in the context of abortion. See O’Connor & Ribstein, *supra* note 111 at 664 (arguing that where states do not

one that would be least politically controversial: the creation of a federal default standard that would allow doctors in most states to practice without fear of the spillover effects described above. As we envision it, the federal statute would provide that, absent state legislative action to the contrary, no abortion-specific informed-consent warnings would be read into doctors' professional norms of conduct, *unless* doctors' customs had coalesced around the provision of such warnings. This statute would counteract the South Dakota effect, preserving the general standards in effect in the majority of states.

Importantly, states would remain free to legislate around our proposed default rule—South Dakota, for example, would not be prevented by such a rule from implementing its chosen informed-consent law. Federal law would merely create a safe harbor for doctors working in the states that did *not* legislate any heightened warnings. These doctors would be able to practice without fear of suit for failure to provide their patients with South Dakota's (or similar) warnings about the risks of abortion.

Prior to legislating, Congress would be well advised to engage in factfinding around the actual risks of abortion procedures, including in particular any risks related to depression and suicide ideation. This factfinding undertaking should rely on testimony by medical experts, psychologists, and social scientists. Consideration of the views and research of experts would substantially improve the quality of the resulting legislation.²²³

As we have noted, there is broad consensus within the medical profession that no serious risks of depression, suicide, or suicide ideation attend ordinary abortion procedures.²²⁴ We expect that a thorough assessment of the available evidence would lead Congress to that conclusion. But even if some conflicting evidence were presented during the course of congressional factfinding—and there likely would be²²⁵—Congress would still be entitled to act. As the Supreme Court explained in *Gonzales v. Carhart*, “The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty. . . . Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.”²²⁶ Accordingly, so long as the

coordinate among themselves, “Congress can exercise its Commerce Clause or other constitutional authority to supplant state substantive laws with uniform federal law”).

223. In addition, some factfinding around the nexus of abortion and informed consent with interstate commerce would ensure that the statute was on firm constitutional footing.

224. See *supra* notes 70–76 and accompanying text.

225. Although the weight of authority supports the position that there is minimal risk, some studies have concluded that abortion is linked to depression. See *supra* note 108.

226. 550 U.S. 124, 163–64 (2007). The *Carhart* Court made clear, however, that “uncritical deference” to Congress’s findings was unwarranted where at least two congressional findings were demonstrably false. *Id.* at 165–66. And the Court confirmed in *Whole Woman’s Health v. Hellerstedt* that where medical or scientific evidence does *not* support a particular regulation of abortion, courts are not required to defer to legislatures. No. 15-274, slip op. at 23 (U.S. June 27, 2016) (finding that “nothing in Texas’ record evidence” established that “the new law advanced Texas’ legitimate interest in protecting women’s health.”). See generally Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman’s Health*, 126 YALE L.J. FORUM (forthcoming 2016).

weight of medical and scientific authority was found to support the view that warnings about postabortion depression are unnecessary as a blanket matter, Congress would be well within its power to enact the proposed statute.²²⁷

2. Constitutional Foundation

Congress, of course, may only act pursuant to a specific constitutional grant of power.²²⁸ The congressional action we propose—legislation to set a federal default standard for informed consent in the context of abortion procedures—would be undertaken under the Commerce Clause.²²⁹ A brief overview of recent Commerce Clause jurisprudence establishes that our proposal would clearly constitute a permissible exercise of congressional power.²³⁰

Although the past twenty years have seen substantial shifts, as well as a number of competing strains, in the Supreme Court’s Commerce Clause jurisprudence,²³¹ the Court has continued to affirm that “Congress has broad authority under the [Commerce] Clause.”²³² Among other things, Congress has the power to “regulate activities that substantially affect interstate commerce.”²³³

*United States v. Morrison*²³⁴ supplies a four-part test that a number of courts have applied when assessing Commerce Clause challenges to federal enactments: first, whether the regulated activity is economic in nature; second, whether the relevant federal statute contains an explicit jurisdictional requirement that the activity in question has a connection to, or effect on, interstate commerce; third, the existence of

227. *But cf.* Neal Devins, *Congressional Factfinding and the Scope of Judicial Review: A Preliminary Analysis*, 50 DUKE L.J. 1169, 1170 (2001) (challenging the Court’s fact/law distinction as largely artificial and critiquing congressional factfinding).

228. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2577 (2012).

229. U.S. CONST. art I, § 8 (“Congress shall have the power . . . [t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian tribes . . .”).

230. Because our proposed legislation would regulate informed consent for abortion, rather than the abortion right as such, it would not rely on Section 5 of the Fourteenth Amendment—a provision that grants Congress the “power to enforce, by appropriate legislation, the provisions of this article.” *See* Samuel Estreicher & Margaret H. Lemos, *The Section 5 Mystique, Morrison, and the Future of Federal Antidiscrimination Law*, 2000 SUP. CT. REV. 109 (2000); Robert C. Post & Reva B. Siegel, *Legislative Constitutionalism and Section Five Power: Policentric Interpretation of the Family and Medical Leave Act*, 112 YALE L.J. 1943, 1947 (2003).

231. Between 1937 and 1995, the Court did not sustain a single Commerce Clause challenge to a federal enactment. *See generally* David A. Strauss, *Commerce Clause Revisionism and the Affordable Care Act*, 2012 SUP. CT. REV. 1 (2013). *United States v. Lopez*, 514 U.S. 546 (1995), seemed to signal a renewed judicial interest in policing the limits of Congress’s Commerce Clause powers.

232. *NFIB*, 132 S. Ct. at 2585.

233. *Gonzales v. Raich*, 545 U.S. 1, 17 (2007); *see also NFIB*, 132 S. Ct. at 2578 (“Congress may regulate . . . ‘those activities that substantially affect interstate commerce.’” (quoting *United States v. Morrison*, 529 U.S. 598, 609 (2000))). Though not relevant here, Congress also has the power to regulate the “channels” and “instrumentalities” of interstate commerce. *Raich*, 545 U.S. at 16–17.

234. 529 U.S. 598.

congressional findings regarding impact on interstate commerce; and fourth, the strength of the link between the activity in question and interstate commerce.²³⁵

Federal informed-consent legislation would clearly satisfy *Morrison*'s four-part test. As a threshold matter, abortion itself is ordinarily a commercial transaction—the provision of medical services for compensation.²³⁶ The Court has not always spoken with perfect clarity about the relationship between “commercial activity” and “economic activity,” but the activities it found to be outside of congressional reach in both *Morrison* itself and *United States v. Lopez*—violence against women and gun possession, respectively—clearly lacked the critical feature of a compensated transaction. Here, the requisite transactional component is unquestionably present.²³⁷

Our proposed statute would also contain the language “in or affecting interstate commerce,” which would satisfy *Morrison*'s requirement of a jurisdictional element. And the “congressional findings” requirement is a central element of our legislative proposal: as noted earlier, the legislation we contemplate would be preceded by a rigorous congressional investigation into the psychological effects of abortion.

Equally clear is the nexus of abortion services with interstate commerce. Even with a rash of state laws designed to shut down clinics and limit abortions,²³⁸ abortion remains one of the most common surgical procedures performed in the country.²³⁹ Patients seeking abortions may, and often do, cross state lines to visit clinics; doctors

235. *Id.* at 610–12.

236. Of course, some procedures are offered at a reduced rate, perhaps even free of charge; and it could be argued that as-applied challenges should be possible to test Congress's power to reach such transactions. But the Court has made clear that the existence of some such transactions does not defeat Congress's ability to reach a category of conduct that is ordinarily commercial: “[W]here the class of activities is regulated and that class is within the reach of federal power, the courts have no power ‘to excise, as trivial, individual instances’ of the class.” *Raich*, 545 U.S. at 23 (alteration in original) (quoting *Perez v. United States*, 402 U.S. 146, 154 (1971)).

237. The transactional element is present in all medical services except those rendered under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012), which obligates hospitals to provide stabilizing treatment to patients with an “emergency medical condition” regardless of the patient's ability to pay for the treatment. *Id.* § 1395dd(b)(1). Services covered by EMTALA include a life-saving abortion, but not an elective abortion. Outside the EMTALA framework, malpractice suits against doctors and other providers of medical care are sometimes based on contract. Stein, *supra* note 82, at 1236 n.191.

238. See *Whole Woman's Health v. Lakey*, 135 S. Ct. 399 (2014) (mem.) (reinstating district court injunction of Texas law requiring abortion providers to have admitting privileges at local hospitals and imposing state standards for ambulatory surgical centers). *But see Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015) (lifting injunction, with limited exception); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448 (5th Cir. 2014) (invalidating Mississippi's admitting-privileges requirement); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330 (M.D. Ala. 2014) (invalidating Alabama's admitting-privileges requirement).

239. Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 PERSP. SEXUAL & REPROD. HEALTH 6, 8 (2003); Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. SEXUAL & REPROD. HEALTH 3, 3 (2014) (estimating that 1.1 million abortions were performed in the United States in 2011).

and clinic staff do the same.²⁴⁰ Medical supplies may be purchased across state lines; insurance plans may originate in another state, or be administered there.²⁴¹

Abortion itself, then, clearly impacts interstate commerce. But the precise subject of federal regulation contemplated here—the standards governing legal liability for conduct related to patient warnings in the course of providing abortion services—also has a significant impact on interstate commerce. Doctors secure medical malpractice insurance on interstate markets; they may be sued for informed-consent violations in state or federal courts, by citizens of their own state or other states; and they may choose jurisdictions in which to practice based on different liability regimes, some of which are expressly designed to attract doctors from other states.²⁴²

Admittedly, the Court's most recent Commerce Clause pronouncement, *NFIB v. Sebelius*,²⁴³ suggests a contraction in the scope of Congress's Commerce Clause authority; and, since the broad subject matter of the statute scrutinized in *NFIB*—health care—is related to the present issue, the case warrants careful consideration. But such consideration establishes that none of the infirmities the Court found in *NFIB* is present here.

At issue in *NFIB* was the Affordable Care Act's requirement that all individuals purchase health insurance or pay a penalty ("the individual mandate"). In finding that the individual mandate exceeded the scope of Congress's Commerce Clause power, Chief Justice Roberts's opinion focused first on the *novelty* of the individual mandate, explaining that "sometimes 'the most telling indication of [a] severe constitutional problem . . . is the lack of historical precedent' for Congress's action."²⁴⁴ No

240. See John H. Richardson, *The Abortion Ministry of Dr. Willie Parker*, ESQUIRE (July 30, 2014), <http://www.esquire.com/news-politics/a23771/abortion-ministry-of-dr-willie-parker-0914/> [<https://perma.cc/NSF7-DS7B>] (describing extensive interstate travel by patients seeking abortions and by the subject of the piece, a doctor who performs abortions in a number of states); cf. *United States v. Soderna*, 82 F.3d 1370, 1373 (7th Cir. 1996) (Posner, J.) (rejecting Commerce Clause challenge to federal Freedom of Access to Clinics Entrances Act, 18 U.S.C. § 248(a)(1) (2012)).

241. See, e.g., *United States v. Wilson*, 73 F.3d 675, 680 (7th Cir. 1995) ("[Health] facilities will obviously purchase, use, and distribute goods from other States.").

242. Anup Malani, *Valuing Laws as Local Amenities*, 121 HARV. L. REV. 1273, 1284 (2008) ("[E]xamples of migration due to legal changes can be found in the medical community, where there are numerous anecdotes of doctors, in order to curb their malpractice liability costs, leaving states that do not enact tort reform. In fact, there is some empirical support for the proposition that doctors systematically move to avoid tort liability. As in the gay and lesbian community, there are advocacy groups—the American Medical Association, for one—that maintain websites to inform doctors of states with friendly tort law environments." (internal citations omitted)).

243. 132 S. Ct. 2566, 2577 (2012).

244. *Id.* at 2586 (alteration in original) (quoting *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 505 (2010)). A number of commentators, even those who advocate a more limited view of Congress's Commerce Clause authority, have been critical of this aspect of the decision, noting that the "same charge could be leveled at every major piece of Commerce Clause legislation—labor and employment statutes, the Civil Rights Act, environmental laws, and the like. All new laws are, by definition, novel." Robert J. Pushaw, Jr. & Grant S. Nelson, *The Likely Impact of National Federation on Commerce Clause Jurisprudence*, 40 PEPP. L. REV. 975, 991 (2013).

such suggestion could be made here. Congress has a long history of regulating the medical profession,²⁴⁵ including in the context of both medical malpractice and abortion.

The Healthcare Quality Improvement Act of 1986, which, among other things, created the National Practitioner Data Bank (NPDB), supplies the most important precedent. The NPDB collects data on malpractice judgments, settlements, and disciplinary actions, and makes that data available to hospitals and other medical care organizations.²⁴⁶ Although the Supreme Court has never considered the question, courts of appeals have uniformly rejected Commerce Clause and other constitutional challenges to the NPDB.²⁴⁷ This fact is of paramount importance for our purposes: among other things, the NPDB collects information about doctors' informed-consent violations.²⁴⁸ This information becomes part of doctors' malpractice records, which hospitals and other medical care organizations use for purposes of hiring, promoting, and credentialing.²⁴⁹

In addition, the legislation we propose is consistent with a tradition of congressional regulation of a number of aspects of abortion. First, in the Freedom of Access to Clinic Entrances Act of 1994 (FACE),²⁵⁰ Congress broadly prohibited threats and violence directed at either providers or consumers of abortion services. Every federal appellate court to consider the constitutionality of FACE has upheld it as a permissible exercise of Congress's Commerce Clause power.²⁵¹ And, although the Supreme Court has not directly considered FACE's constitutionality, in 2014 it suggested that Massachusetts could avoid the First Amendment infirmities that doomed that state's "buffer zone" law²⁵² by modeling its state law after the federal FACE.²⁵³

Perhaps still more telling is the Partial-Birth Abortion Ban Act of 2003 (PBABA),²⁵⁴ which the Court upheld in *Gonzales v. Carhart*.²⁵⁵ Although the *Carhart* Court did not undertake any sustained examination of Congress's power to

245. See, e.g., *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 329 (1991) (finding interstate commerce requirements of antitrust laws satisfied by hospital petitioners and noting that "although Midway's primary activity is the provision of health care services in a local market, it also engages in interstate commerce").

246. 42 U.S.C. §§ 11101–11115, 11131–11153 (2012).

247. See, e.g., *Rochling v. Dep't Veteran's Affairs*, 725 F.3d 927 (8th Cir. 2013); *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 210 (4th Cir. 2002).

248. See 42 U.S.C. §§ 11101–11115, 11131–11153 (2012).

249. Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank*, 33 *CARDOZO L. REV.* 2031 (2012).

250. 18 U.S.C. § 248(a)(1) (2012).

251. See, e.g., *Norton v. Ashcroft*, 298 F.3d 547, 555–56 (6th Cir. 2002); *United States v. Gregg*, 226 F.3d 253, 261 (3d Cir. 2000); *United States v. Soderna*, 82 F.3d 1370, 1373–74 (7th Cir. 1996); *United States v. Dinwiddie*, 76 F.3d 913, 919 (8th Cir. 1996).

252. MASS. ANN. LAWS, ch. 266, § 120E1/2(a), (b) (2010) (amended 2014), *invalidated by McCullen v. Coakley*, 134 S. Ct. 2518 (2014).

253. *McCullen*, 134 S. Ct. at 2537 ("If Massachusetts determines that broader prohibitions along the same lines are necessary, it could enact legislation similar to the federal Freedom of Access to Clinic Entrances Act of 1994 (FACE Act), 18 U.S.C. § 248(a)(1) . . .").

254. 18 U.S.C. § 1531 (2012).

255. 550 U.S. 124 (2007).

enact the PBABA, it did note in passing that “the legislative power” was “exercised in this instance under the Commerce Clause.”²⁵⁶ Justice Thomas, joined by Justice Scalia, wrote separately to state his view that “whether the Partial-Birth Abortion Ban Act of 2003 constitutes a permissible exercise of Congress’ power under the Commerce Clause [was] not before the Court.”²⁵⁷ But the majority was silent on any potential Commerce Clause concerns.²⁵⁸

In light of this extensive record of federal regulation of both medical malpractice and abortion, it seems clear that the modest step we propose would be well within Congress’s Commerce Clause authority. In fact, it is likely that Congress could, if it wished, go much further than our proposal. Indeed, Professor Richard Fallon argues that “[i]f Congress so chose, it could either forbid or protect abortion on a nationwide basis.”²⁵⁹

Our proposal might face one additional constitutional objection. Arguably, legislation along the lines we suggest would inject Congress into a sphere that has traditionally been regulated by the states alone—setting substantive liability standards for a category of tort actions.²⁶⁰ *United States v. Lopez* suggested that congressional attempts to regulate areas of “traditional state concern”²⁶¹ would be constitutionally suspect.²⁶²

256. *Id.* at 166.

257. *Id.* at 169 (Thomas, J., concurring).

258. *Cf.* *Rust v. Sullivan*, 500 U.S. 173, 203 (1991) (upholding constitutionality of Department of Health and Human Services regulations, 53 Fed. Reg. 2923–2924 (1988), that prohibit Title X projects from advocating abortion as a method of family planning).

259. Fallon, *supra* note 2, at 612. Professor Fallon contends (albeit in a piece that predates *NFIB*) that “[u]nder existing Commerce Clause doctrine, congressional power to regulate and thus to prohibit abortions would seem plain. Abortions are services sold in interstate commerce, and the business of providing medical care, including abortions, is intertwined with commerce in innumerable ways.” *Id.* at 622–23. In a proposal not unlike the one we advance here, Professor Fallon suggests that Congress might also choose to regulate the practice of abortion through a federal licensing scheme for abortion doctors. *Id.* at 624; *see also* Robert J. Pushaw, Jr., Essay, *Does Congress Have the Constitutional Power to Prohibit Partial-Birth Abortion?*, 42 HARV. J. ON LEGIS. 319, 349 (2005) (“[L]ike medical services generally, abortions of all kinds are commercial exchanges” that “concern more states than one.” (quoting *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 194 (1824))).

260. *See, e.g.*, Lynn A. Baker, *Lochner’s Legacy for Modern Federalism: Pierce County v. Guillen as a Case Study*, 85 B.U. L. REV. 727, 728–29 (2005) (arguing that the Rehnquist Court’s federalism decisions can largely be explained by whether “the regulatory area at issue is one in which States ‘historically have been sovereign’ or is instead a traditional and appropriate area of federal concern”).

261. 514 U.S. 549, 577 (1995) (Kennedy, J., concurring).

262. *Id.* Note, however, that *Lopez* paired that concern with its insistence that the activity be commercial in character. *Id.* at 583 (“The statute now before us forecloses the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise, and it does so by regulating an activity beyond the realm of commerce in the ordinary and usual sense of that term.”). As we have already shown, our proposed statute squarely falls into the “commercial” category.

But Congress has long since entered the domain of torts through numerous statutory interventions into products liability,²⁶³ including liability for medications,²⁶⁴ medical devices,²⁶⁵ and vaccines.²⁶⁶ One of those interventions, the National Childhood Vaccine Injury Act of 1986,²⁶⁷ was quite far-reaching. With this Act, Congress displaced the entire regime of state products liability with a special compensation program for vaccine-related injuries.²⁶⁸ Our proposal is a far more limited one.

One final objection to this proposal, perhaps the most serious one, is grounded not in legal but in political constraints. Although “[s]pillovers can get issues on the national policymaking agenda,”²⁶⁹ politics, especially at the national level, are more polarized today than perhaps at any other time in our history.²⁷⁰ And independent of larger polarization trends, abortion has for decades been one of the most divisive issues in American politics.²⁷¹ Mindful of the possibility that tackling this subject might merely afford federal legislators an opportunity to reengage in democratic warfare over abortion, we offer an alternative solution to the South Dakota effect: legislation within the states.

B. A State-by-State Solution

Another possible response to the South Dakota effect is for individual states to affirmatively repel the spillover effects identified above. The mechanics of such legislation would be relatively straightforward: in essence, state legislation would

263. See, e.g., *Geier v. Am. Honda Motor Co.*, 529 U.S. 861 (2000) (finding state common law defective design claims preempted by National Traffic and Motor Vehicle Safety Act of 1966); *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 530–31 (1992) (plurality opinion) (holding that the Public Health Cigarette Smoking Act of 1969 preempted state failure-to-warn claims); Catherine M. Sharkey, *Products Liability Preemption: An Institutional Approach*, 76 GEO. WASH. L. REV. 449, 450 (2008); Viet D. Dinh, *Reassessing the Law of Preemption*, 88 GEO. L.J. 2085, 2118 (2000).

264. Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301–397 (2012).

265. See *Riegel v. Medtronic, Inc.*, 552 U.S. 312 (2008) (holding various state tort claims against manufacturer of balloon catheter preempted by Medical Device Amendments of 1976); *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341 (2001) (holding state-law fraud-on-the-agency claims regarding approval of bone screws preempted by Medical Device Amendments of 1976).

266. 42 U.S.C. § 300aa–22(b)(1) (2012).

267. *Id.*

268. *Bruesewitz v. Wyeth LLC*, 562 U.S. 223, 228–30 (2011).

269. Gerken & Holtzblatt, *supra* note 45, at 90.

270. Jessica Bulman-Pozen, *Partisan Federalism*, 127 HARV. L. REV. 1077, 1082–83 (2014) (“[O]ur two major political parties, which compete at both the state and national levels, have grown ideologically cohesive and polarized.”); Daryl J. Levinson & Richard H. Pildes, *Separation of Parties, Not Powers*, 119 HARV. L. REV. 2312, 2338 (2006) (describing “resurgence of more internally unified, ideologically coherent, and polarized parties than we have seen in many decades”); Richard H. Pildes, *Why the Center Does Not Hold: The Causes of Hyperpolarized Democracy in America*, 99 CALIF. L. REV. 273, 275 (2011) (“American democracy over the last generation has had one defining attribute: the rise of extreme partisan polarization.”).

271. See, e.g., Bulman-Pozen, *supra* note 270, at 1104, 1116.

merely establish that informed consent in the context of abortion is no different from informed consent for other medical procedures.

The law could take several different forms. First, state law could affirmatively disclaim any blanket requirement that doctors provide women seeking abortions with information relating to depression or suicide (though doctors would remain free to provide patient-specific warnings, including warnings pertaining to potential psychological effects of abortion in individual cases). Second, state legislation could require that doctors who provide warnings about the potential psychological effects of abortion pair those warnings with information about possible psychological effects of carrying a pregnancy to term—in particular, postpartum depression.

A solution that requires individual states to ward off the South Dakota effect statutorily is in some ways less efficient than allowing Congress—a single player that operates within a framework of legal and political checks and balances, and utilizes economies of scale—to take action. But in the absence of a congressional will to act, individual states, particularly those states whose legal frameworks aim to facilitate relatively unimpeded access to abortion, would be well advised to take action.

In their novel account of horizontal federalism, Professor Heather Gerken and Ari Holtzblatt argue that “[s]pillovers are a permanent and inevitable feature of the American regulatory landscape”²⁷² and suggest that the interstate friction caused by spillovers can in fact be politically beneficial.²⁷³ Specifically, it can “spur democratic engagement” and drive productive compromise around controversial issues.²⁷⁴ The state-by-state solution we envision is arguably an example of just this sort of dynamic: the use of state-level democratic processes to deflect unwanted legal rules from crossing state lines.

CONCLUSION

Since *Roe v. Wade*, the struggle between women’s constitutional entitlement to abortion and state power to regulate that entitlement has been conventionally understood to proceed along vertical lines. The states’ boundaries have demarcated the terrain on which abortion restrictions imposed by states have clashed with the reproductive freedom secured by the U.S. Constitution.

Our account uncovers a previously invisible horizontal dimension of that struggle: the medical-malpractice penalties imposed upon doctors for failing to fully inform patients about abortion risks; the states’ power to define those risks, along with doctors’ informed-consent obligations and penalties; and, critically, the porousness of state borders in this sphere. That porousness, which allows medical standards from one state to affect doctors’ practices and informed-consent obligations across state lines, can have profound implications both for individuals and for state sovereignty.²⁷⁵

The South Dakota effect is just one dynamic by which abortion access may be limited. It is a dynamic, however, that may have serious consequences for women’s

272. Gerken & Holtzblatt, *supra* note 45, at 62.

273. *Id.*

274. *Id.* at 96.

275. Cf. Allan Erbsen, *Horizontal Federalism*, 93 MINN. L. REV. 493, 503 (2008) (“Disputes implicating horizontal federalism . . . can involve both states and individuals.”).

willingness to elect abortion and for the experiences of women who choose to go forward with abortion procedures. More broadly, it highlights the importance of widening our focus to consider interstate effects in the context of abortion regulation. And as such, it sheds new light on the law of abortion and federalism itself.