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Tort Law Implications of Compelled Physician Speech

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Tort Law Implications of Compelled Physician Speech

NADIA N. SAWICKI*

Abortion-specific informed consent laws in many states compel physicians to communicate state-mandated information that is arguably inaccurate, immaterial, and inconsistent with their professional obligations. These laws face ongoing First Amendment challenges as violations of the constitutional right against compelled speech. This Article argues that laws compelling physician speech also pose significant problems that should concern scholars of tort law.

State laws that impose tort liability on physicians who refuse to communicate a state-mandated message often do so by deviating from foundational principles of tort law. Not only do they change the substantive disclosure duties of physicians under informed consent law, but many modify or even reject the procedural requirements for tort liability. Most significantly, these laws relieve prospective plaintiffs of the burden of proving two fundamental elements of negligence—causation in fact and proximate causation. Thus, when states compel physician speech for political reasons, their actions challenge not only constitutional principles, but tort principles as well.

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INTRODUCTION

Abortion informed consent laws have been the subject of much political and scholarly debate. These state laws require physicians to communicate information that may be scientifically inaccurate or medically irrelevant to patients seeking abortions. Among legal scholars, the primary issue of concern is whether these informed consent requirements are constitutional under the First and Fourteenth Amendments.¹

Scholars of health law, public policy, medicine, and medical ethics have also turned their attention to abortion informed consent laws. Many have argued that the disclosures required by these laws are inconsistent with the ethical and legal principles of informed consent, and that by imposing additional requirements, state legislatures are co-opting medical practice for political goals.² Recent tort scholarship questions whether state-specific compelled speech requirements might spill over to modify the medical standard of care nationwide.³

In this Article, I consider a different issue at the intersection of compelled speech and tort law. Rather than focusing primarily on the substantive content of legislatively mandated abortion disclosures, I highlight the ways in which these laws may undermine the fundamental procedural requirements of tort litigation. Every first-year law student is taught that the elements of negligence are duty, breach, cause in fact, proximate causation, and damages. However, these foundational elements are called into question by laws that compel physicians to communicate state-mandated information about abortion and punish them for failing to do so, even in the absence of proof that there was a causal relationship between breach and injury.

Certainly, legislatures have the authority to reject common law tort principles and craft their own standards for liability. However, the abandonment of actual and proximate causation as elements of an informed consent claim in the abortion context has broader implications for negligence law generally. These laws set a dangerous

1. See *infra* Section I.B.

2. See *infra* Section I.C.

3. See Katherine Shaw & Alex Stein, *Abortion, Informed Consent, and Regulatory Spillover*, 92 IND. L.J. 1 (2016).

precedent by allowing legislatures to dismantle the fundamental elements of tort liability in order to achieve political and ideological goals.

I. COMPELLED PHYSICIAN SPEECH: ABORTION DISCLOSURE LAWS

Under common law, physicians have a duty to secure a patient's informed consent before proceeding with medical treatment. Generally, tort law imposes a duty to disclose the patient's diagnosis and prognosis, the risks and benefits of the proposed treatment, and the risks and benefits of alternative treatments (including the risks and benefits of forgoing treatment).⁴ This duty exists across all areas of medical practice, regardless of the patient's condition or the proposed treatment.⁵ Just as medical custom generally sets the standard of care in medical malpractice litigation,⁶ common law informed consent requirements have historically been grounded in the medical profession's customary practice.⁷

Some states have codified these general disclosure duties, providing statutory reinforcement for the common law obligations grounded in medical custom.⁸ However, in recent years, many state legislatures have passed informed consent laws imposing additional disclosure duties that deviate from the customary practices of the medical community.

It should come as no surprise that these new informed consent laws apply only in the context of one controversial medical service—abortion.⁹ Just as the political rhetoric surrounding abortion has translated into targeted legal and regulatory requirements for facilities that perform abortions¹⁰ and legal limitations on the options available for termination of pregnancy,¹¹ it has also affected the freedom that physicians have to communicate with patients seeking abortions.

4. Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821, 831 (2016).

5. Historically, however, the duty to secure informed consent has often been limited to procedures that involve violation of bodily integrity, such as surgery. *Id.* at 832.

6. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS & ROBERT L. SCHWARTZ, *HEALTH LAW* 77 (3d ed. 2015).

7. Sawicki, *supra* note 4, at 829. Over time, however, about half of jurisdictions shifted to a patient-based standard. *Id.*

8. *See id.* at 831 (citing representative statutes).

9. Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1602 (2008) (“Abortion is one of the few medical procedures governed by specific statutory informed consent requirements.”); *see also* NEB. REV. STAT. ANN. § 28-327.12(2) (West 2010) (“Nothing in section 28-327 [informed consent provisions] shall be construed as defining a standard of care for any medical procedure other than an induced abortion.”).

10. *See* Marshall H. Medoff, *State Abortion Politics and TRAP Abortion Laws*, 33 J. WOMEN, POL., & POL'Y 239 (2012); *Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INST. (Jan. 22, 2020), <https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws> [<https://perma.cc/8CRL-X7FQ>].

11. These may include prohibitions on abortion after a specific gestational age, partial birth abortion bans, restrictions on emergency contraception, and others.

A. Abortion Disclosure and Consent Laws

Currently, the majority of U.S. states have abortion-specific informed consent laws.¹² These laws, sometimes called “Women’s Right to Know Acts,” require physicians to go beyond the traditional disclosures required under the common law of informed consent.¹³ They identify additional information that legislators believe is important to a patient’s abortion decision and mandate that physicians communicate this information whether or not they believe it is medically appropriate. While a comprehensive summary of disclosure requirements is beyond the scope of this Article, there are a few categories of state-mandated disclosures that have been highlighted as particularly problematic by commentators in law, medicine, and ethics.¹⁴

12. *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Sept. 1, 2021), <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion> [<https://perma.cc/8KJP-AB48>] (identifying thirty-three states with abortion-specific informed consent laws); see also *Mandatory Counseling for Abortion*, GUTTMACHER INST. (Jan. 22, 2020), <https://www.guttmacher.org/evidence-you-can-use/mandatory-counseling-abortion> [<https://perma.cc/S6MA-SXQW>] (describing requirements of abortion informed consent laws).

13. See generally Dresser, *supra* note 9, at 1617–20 (describing categories of abortion disclosures and explaining that none are required under standard informed consent doctrine); Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL’Y REV. 6, 7 (2007) (noting that abortion informed consent laws “often do little to further the underlying values of the consent process, and sometimes are even directly at odds with them”); Zita Lazzarini, *South Dakota’s Abortion Script—Threatening the Physician-Patient Relationship*, 359 NEW ENG. J. MED. 2189 (2008) (describing South Dakota’s law as “unique in ways that should cause concern to physicians, patients, and protectors of the physician-patient relationship”); Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, 39 HASTINGS CTR. REP. 21 (2009) (describing abortion-specific informed consent laws as abrogating the process of informed consent); Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 111 (2008) (arguing that these laws “abandon well-settled principles of informed consent . . . in favor of legislative judgments”); Ian Vanderwalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1 (2012) (describing biased abortion disclosure laws as exceeding the scope of traditional informed consent, and as an example of abortion exceptionalism). Cf. Nadia N. Sawicki, *Abortion Informed Consent Laws: More Light, Less Heat*, 21 CORNELL J. L. & PUB. POL’Y 1, 5 (2011) (arguing that the doctrine of informed consent inherently takes into account social values and gives physicians discretion in deciding what to communicate to their patients, and that although abortion informed consent laws are in many ways unique, they could also be viewed as “explicit manifestations of the sort of value judgments that have long been implicit in the law and doctrine of informed consent”).

14. See Dresser, *supra* note 9, at 1609 (grouping the supplemental information required by abortion informed consent laws into three categories: “(1) risk information that is unsupported by medical evidence, (2) graphic material about the fetus, and (3) information regarding assistance to women deciding whether to continue their pregnancies”).

First, many abortion disclosure laws require physicians to communicate information that is medically or scientifically inaccurate.¹⁵ Examples include statements that abortion is linked to an increased risk of infertility,¹⁶ breast cancer,¹⁷ psychological harm, and suicide;¹⁸ that medication abortion is reversible;¹⁹ that

15. *Counseling and Waiting Periods for Abortion*, *supra* note 12 (identifying several states that inaccurately portray the risks of future infertility, breast cancer, and negative emotional response, and that provide inaccurate information on medication abortion); *see also* Caroline Mala Corbin, *Abortion Distortions*, 71 WASH. & LEE L. REV. 1175, 1175–76 (2014); Dresser, *supra* note 9, at 1609–10; Gold & Nash, *supra* note 13, at 11; Minkoff & Marshall, *supra* note 13, at 21; Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 GUTTMACHER POL’Y REV. 6 (2006); Sawicki, *supra* note 13, at 12–13.

16. Vanderwalker, *supra* note 13, at 14 (describing research contradicting compelled disclosures about risks of infertility associated with abortion).

17. *Counseling and Waiting Periods for Abortion*, *supra* note 12; Richardson & Nash, *supra* note 15, at 7–8 (finding that in five states, state-mandated abortion counseling materials include “inaccurate[] assert[ions] [of] a link between abortion and an increased risk of breast cancer”); *see also* Planned Parenthood Minn., N.D., S.D. v. Daugaard, 799 F. Supp. 2d 1048, 1072 (D.S.D. 2011) (finding that statute requiring disclosure of any “risk factor associated with abortion” would require physicians to communicate “misleading” information regarding breast cancer risk); Dresser, *supra* note 9, at 1609–10 n.79 (citing medical evidence that abortion is not correlated with an increased risk of breast cancer); Vanderwalker, *supra* note 13, at 18–19 (describing evidence contradicting claims of a causal relationship between abortion and breast cancer).

18. *Planned Parenthood of the Heartland v. Heineman*, 724 F. Supp. 2d 1025, 1048 (D. Neb. 2010) (granting preliminary injunction against enforcement of a bill that would require providers to disclose “any adverse physical, psychological, or emotional reaction that is reported in a peer-reviewed journal to be statistically associated with abortion such that there is less than a five percent probability ($P < .05$) that the result is due to chance” on the grounds that it would “require medical providers to give untruthful, misleading and irrelevant information to patients”); Richardson & Nash, *supra* note 15, at 8–9 (finding that in nineteen states, state-mandated abortion counseling materials include unsupported information on the psychological effects of abortion, including the risk of “postabortion traumatic stress syndrome” and suicide); *see also* Corbin, *supra* note 15, at 1178–87 (describing the “abortion syndrome that wasn’t there”); Dresser, *supra* note 9, at 1610 (noting that there is little empirical evidence to support “postabortion syndrome” causing psychological trauma); Vanderwalker, *supra* note 13, at 15–18 (describing evidence contradicting claims of a causal relationship between abortion and psychological problems). *But see* *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889 (8th Cir. 2012) (upholding, as truthful and not misleading, South Dakota informed consent law requiring disclosure that abortion carries an “increased risk” of suicide and suicidal ideation).

19. *Counseling and Waiting Periods for Abortion*, *supra* note 12 (identifying eight states with statutes requiring disclosure of such information, some of which have been enjoined); *see also* *Am. Med. Ass’n v. Stenehjem*, 412 F. Supp. 3d 1134 (D.N.D. 2019) (granting preliminary injunction against “misleading” abortion informed consent statute requiring physicians to inform patients that it may be possible to reverse medical abortions); *Planned Parenthood Ariz., Inc. v. Brnovich*, 172 F. Supp. 3d 1075, 1098–99 (D. Ariz. 2016) (addressing a challenge to Arizona law requiring physicians to inform patients that it may be possible to reverse a medication abortion, which the plaintiffs claim is “false, misleading, and/or irrelevant”); *Planned Parenthood of Tenn. & N. Miss. v. Slatery*, 523 F. Supp. 3d 985

fetuses at a gestational age of more than nineteen weeks may be able to survive outside the womb;²⁰ and that fetuses are able to feel pain at early stages of fetal development.²¹

Second, some state laws require physicians to communicate information that either explicitly or implicitly speaks to the moral status of the fetus. Most explicitly, state legislatures in South Dakota,²² North Dakota,²³ and Kansas²⁴ have drafted scripts that doctors must communicate, including language that “the abortion will terminate the life of a whole, separate, unique, living human being.”²⁵ Indiana requires physicians to counsel women seeking abortions that life begins at conception.²⁶ Other states include similar language in the state-drafted printed

(M.D. Tenn. 2021) (granting preliminary injunction against enforcement of informed consent statute requiring disclosure of reversibility of abortion, on the grounds that it is untruthful and/or misleading); Khadijah Z. Bhatti, Antoinette T. Nguyen & Gretchen S. Stuart, *Medication Abortion Reversal: Science and Politics Meet*, 218 AM. J. OBSTETRICS & GYNECOLOGY 315 (2018) (finding a paucity of evidence for medication abortion reversal, and suggesting that physicians and policymakers “dispel bad science and misinformation and advocate against medical abortion reversal legislation”).

20. See *Summit Med. Ctr. of Ala., Inc. v. Siegelman*, 227 F. Supp. 2d 1194, 1203–04 (M.D. Ala. 2002) (noting conflicting evidence as to the accuracy of this statement, and concluding that such a disclosure is only constitutional if the physician also informs the patient “about the meaning of the term survival as well as the nature and extent of any possible survival[.]” including the fact that the survival may be “momentary”).

21. Richardson & Nash, *supra* note 15, at 9 (finding that in five states, state-mandated abortion counseling materials include information about the fetus’s ability to feel pain, which the authors describe as “arguably the most egregious example of medical inaccuracy in state abortion counseling materials”); see also *Whole Woman’s Health All. v. Hill*, 493 F. Supp. 3d 694 (S.D. Ind. 2020), *order clarified by Whole Woman’s Health All. v. Rokita*, No. 1:18-cv-01904-SEB-MJD, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021) (finding genuine issues of material fact as to whether fetal pain disclosure constituted an undue burden); Tobin, *supra* note 13, at 113–14 (describing fetal pain disclosure laws as “misrepresent[ing] current medical knowledge”); Vanderwalker, *supra* note 13, at 21–25 (showing that many fetal pain disclosures are misleading).

22. S.D. CODIFIED LAWS § 34-23A-10.1(1)(b) (2011) (requiring, in sections (c) and (d), the disclosure that “the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota” and that “by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated”), *upheld in Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 735–36 (8th Cir. 2008) and *Planned Parenthood v. Rounds*, 653 F.3d 662 (8th Cir. 2011).

23. N.D. CENT. CODE 14-02.1-02(11)(a)(2) (2013).

24. KAN. STAT. ANN. § 65-6709(b)(5) (2017).

25. See Sawicki, *supra* note 13, at 8–9.

26. IND. CODE ANN. § 16-34-2-1.1(a)(1)(E) (West 2021). See *Planned Parenthood of Ind. v. Comm’r of Ind. State Dep’t of Health*, 794 F. Supp. 2d 892, 914 (S.D. Ind. 2011) (upholding the disclosure as being “biological” rather than “metaphysical”), *aff’d in part, rev’d in part*, 699 F.3d 962 (7th Cir. 2012); *Whole Woman’s Health All. v. Hill*, 493 F. Supp. 3d 694, 726, 751–52 (S.D. Ind. 2020) (finding genuine issues of material fact as to whether this disclosure constituted an undue burden, on the grounds that it “cloaks personal or religious beliefs regarding life’s beginning as scientific, medical fact as to the formation of a developing embryo

materials that doctors are required to share with patients.²⁷ Commentators have described these statutory requirements as problematic because they require doctors to communicate ideological messages rather than factual medical information.²⁸ Indeed, some courts have reached similar conclusions. For example, the New Jersey Supreme Court rejected a claim alleging that doctors have a common law duty to inform patients of “the scientific and medical fact that [an embryo is] a complete, separate, unique and irreplaceable human being” and that abortion would result in “killing an existing human being.”²⁹ The court described this disclosure as relating to “moral, philosophical, and religious beliefs” rather than “medical facts,” and therefore not part of common law informed consent requirements.³⁰ In Indiana, where state law requires disclosure that “human physical life begins when a human ovum is fertilized by a human sperm,” a federal district court rejected the state’s claim that this disclosure was “medically accurate, scientifically uncontroversial, and not ideologically charged,” noting that there was no “biological explanation or justification for this provision.”³¹

More implicit messages about moral status come from requirements that health care providers perform ultrasounds that are not medically necessary for women seeking abortions and display and describe the ultrasound images regardless of the woman’s wishes. Many commentators³² (and one federal appeals court³³) have

or fetus” and “requires transmission of a ‘deeply ideological’ opinion under the guise of medical fact”), *order clarified by* Whole Woman’s Health All. v. Rokita, No. 1:18-cv-01904-SEB-MJD, 2021 WL 252721 (S.D. Ind. Jan. 26, 2021).

27. See, e.g., Mo. REV. STAT. § 188.027.1(2) (2019), *upheld in* Doe v. Parson, 567 S.W.3d 625 (Mo. 2019).

28. See, e.g., Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 959–60; Lauren R. Robbins, Comment, *Open Your Mouth and Say ‘Ideology’: Physicians and the First Amendment*, 12 U. PA. J. CONST. L. 155, 162 (2009); Minkoff & Marshall, *supra* note 13; Lazzarini, *supra* note 13; Vanderwalker, *supra* note 13, at 25–28.

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

30. *Id.*

31. *Hill*, 493 F. Supp. 3d at 751–52.

32. See, e.g., Jennifer M. Keighley, *Physician Speech and Mandatory Ultrasound Laws: The First Amendment’s Limits on Compelled Ideological Speech*, 34 CARDOZO L. REV. 2347 (2013) (describing ultrasound requirements as unconstitutionally “commandeer[ing] physicians into spreading the state’s ideological belief that pregnancies should be carried to term”); Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 397 (2008) (arguing that requiring display of fetal imagery is a politically-motivated attempt to transform the woman’s conception of the moral status of the fetus); James Rocha, *Autonomous Abortions: The Inhibiting of Women’s Autonomy Through Legal Ultrasound Requirements*, 22 KENNEDY INST. ETHICS J. 35 (2012) (arguing that ultrasound requirements aimed at communicating the ontological status of the fetus inhibit women’s autonomous decision-making).

33. *Stuart v. Camnitz*, 774 F.3d 238, 242 (4th Cir. 2014) (affirming injunction of requirement that physicians perform ultrasound, display sonogram, and describe fetus to women seeking abortions on the grounds that such disclosures are “ideological”). *But see* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 573, 580 (5th Cir. 2012) (affirming constitutionality of statute requiring physicians to “perform and display a sonogram of the fetus” and “make audible the heart auscultation of the fetus for the woman to hear” as

criticized these requirements as attempts by the state to imbue the fetus with an inherent moral status in a manner that is inconsistent with the goals of informed consent. As several scholars have noted, in a society where ultrasounds are routinely used by parents to communicate the joy of an anticipated child, these images are far from objective and can be emotionally triggering for those wishing to terminate a pregnancy.³⁴

Finally, many state laws require physicians to disclose information that is not material to a patient's evaluation of medical risks and benefits. Common law limits informed consent disclosures to those relating to the medical risks and benefits of the procedure and its alternatives. Courts have almost uniformly rejected the idea that informed consent requires disclosure of information other than the risks and benefits inherent in the medical procedure itself—for example, its financial, legal, or ethical implications.³⁵ However, these types of disclosures are common in abortion informed consent laws. Many, for example, require physicians to share information about social and financial support resources available to women who choose to proceed with a pregnancy, including child support, adoption services, pregnancy help centers, and Medicaid benefits.³⁶ While such information might be practically valuable to women seeking abortions, it is far beyond the scope of what informed consent jurisprudence considers “material” to medical decision-making. Several other disclosures required by some state laws—including the description of ultrasound images, anatomical descriptions, explanation of the stages of gestational development, and statements about the fetus's status as a human being—also do not relate to the medical risks and benefits of abortion and therefore fall outside what is

being truthful and not misleading, rather than ideological); *Hill*, 493 F. Supp. 3d at 750 (granting state's motion for summary judgment regarding ultrasound requirement on the grounds that it does not impose a significant burden); *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421 (6th Cir. 2019) (rejecting First Amendment challenge to ultrasound requirement).

34. See, e.g., Jeremy A. Blumenthal, *Abortion, Persuasion, and Emotion: Implications of Social Science Research on Emotion for Reading Casey*, 83 WASH. L. REV. 1, 37–38 (2008) (citing Blackmun's concurrence in *Casey* as recognizing “power of such visual images in influencing, even biasing, an individual's decisions”); Dresser, *supra* note 9, at 1617 (noting that “informed consent doctrine does not require graphic language and vivid pictures designed to discourage patients from choosing a medical intervention”); Sanger, *supra* note 32, at 401 (describing anthropological perspectives on fetal imagery); CATHERINE MILLS, *FUTURES OF REPRODUCTION* 101–21 (David N. Weisstub ed., 2011) (arguing that ultrasound images have both “emotive” and “ethical” force).

35. Sawicki, *supra* note 4, at 846–58; see also *Acuna v. Turkish*, 930 A.2d 416 (N.J. 2007); Allyson M. Rucinski, *Finding the Middle Ground: Acuna v. Turkish and the New Jersey Supreme Court's Reaffirmation of a Doctor's Role Under the Doctrine of Informed Consent in the Digital Age*, 29 PACE L. REV. 797 (2009) (describing the court's decision in *Acuna* as reflective of common law doctrine regarding what constitutes material information for the purpose of informed consent).

36. Richardson & Nash, *supra* note 15, at 10 (finding that materials in twenty states provide “directories with contact information for resources that offer a range of support services, including adoption services, financial assistance, child care, health services and prenatal care[,]” including crisis pregnancy centers).

typically required under common law informed consent doctrine.³⁷ Moreover, many of these disclosures convey information that is “obvious,” which is exempted from disclosure under the common law of informed consent.³⁸

B. Constitutional Challenges

Constitutional challenges to abortion informed consent laws—whether on First Amendment free speech³⁹ or Fourteenth Amendment reproductive privacy⁴⁰ grounds—have had mixed results.⁴¹ While these are two independent constitutional claims, as a practical matter they are hard to disentangle in light of Supreme Court jurisprudence on compelled speech in the abortion context.⁴²

Tort claims for failure of informed consent are essentially malpractice claims based on physician speech. Although the historical view has been that the First

37. Vanderwalker, *supra* note 13, at 19–21 (explaining the irrelevance of many state-published abortion counseling materials). For additional cases speaking to irrelevant disclosures in abortion informed consent laws, see *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978) (holding that a law requiring that women be told that their parental rights would be terminated if their abortions resulted in live births would never be relevant to early pregnancies which could not result in live births); *Summit Med. Ctr. of Ala., Inc. v. Riley*, 318 F. Supp. 2d 1109 (M.D. Ala. 2003) (invalidating disclosures relating to adoption and early childhood care as being not relevant to women with ectopic pregnancies or lethal fetal anomalies).

38. See Post, *supra* note 28, at 954 (criticizing the “human being disclosures” on obviousness grounds, and noting that “[i]t hardly seems plausible that a woman could be confused about whether she is carrying the biological fetus of a zebra, a raccoon, or a bat”); Robbins, *supra* note 28, at 190–91 (commenting that these disclosures are unnecessary because they are obvious and that states imposing such requirements “ma[ke] it seem like a woman who voluntarily goes to a clinic to get this procedure has no clue about the purpose of her visit,” or that “women do not understand the basic elements of reproduction”).

39. See discussion *infra* Section I.B. First Amendment speech claims have also been brought in connection with the imposition of fees on health care providers to pay for the distribution of state-mandated pro-childbirth materials. *Summit Med. Ctr. of Ala., Inc. v. Riley*, 274 F. Supp. 2d 1262 (M.D. Ala. 2003).

40. See, e.g., *Falls Church Med. Ctr., LLC v. Oliver*, 412 F. Supp. 3d 668, 700 (E.D. Va. 2019) (finding that informed consent statute requiring pre-abortion ultrasound does not impose a substantial obstacle to accessing abortion); *Karlin v. Foust*, 188 F.3d 446, 492 (7th Cir. 1999) (finding required disclosures about services available to women seeking abortions, and consent provisions regarding ultrasound and heartbeat, do not have the purpose or effect of imposing an undue burden on the woman’s right to choose).

41. Challenges have also been raised on First Amendment religious freedom grounds. See, e.g., *Doe v. Parson*, 960 F.3d 1115 (8th Cir. 2020), *cert. denied*, 141 S. Ct. 874 (2020) (rejecting Establishment Clause and Free Exercise challenges to abortion informed consent requirements).

42. See generally Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047 (2014) (arguing that the *Casey* “undue burden” standard for reproductive privacy due process claims has effectively overtaken courts’ analysis of all constitutional claims in the reproductive health context, including compelled speech claims).

Amendment is inapplicable to physician speech,⁴³ modern courts and commentators have recognized that the state's authority to regulate the practice of medicine is not absolute, and that physician speech is entitled to some constitutional protections.⁴⁴ The precise scope of physicians' First Amendment rights, however, is not clear.

The most authoritative statement on physicians' speech rights comes from *Planned Parenthood v. Casey*, where the Supreme Court succinctly dismissed a First Amendment challenge to Pennsylvania's abortion informed consent law, finding it to be a reasonable regulation of the practice of medicine.⁴⁵ However, the only two cases cited by the Court in its First Amendment analysis—*Wooley v. Maynard* and *Whalen v. Roe*—were inapplicable in the context of First Amendment challenges to professional speech.⁴⁶ Earlier in the *Casey* opinion, the Court expressed support for “truthful, nonmisleading information” that is “relevant” to a woman's decision about whether to terminate her pregnancy—but it did so in the context of analyzing the Fourteenth Amendment reproductive privacy claim rather than the First Amendment claim.⁴⁷

43. See Post, *supra* note 28, at 950–51 (concluding that traditional First Amendment values “seem to carry very little force” in the context of professional speech by physicians).

44. See generally Claudia E. Haupt, *Professional Speech*, 125 YALE L.J. 1238 (2016) (arguing that First Amendment protection of professional speech is necessarily tied to the profession as a “knowledge community”); B. Jessie Hill, *The First Amendment and the Politics of Reproductive Health Care*, 50 WASH. U. J.L. & POL'Y 103 (2016) (arguing that courts' First Amendment analyses of compelled physician speech are linked to their understanding of whether reproductive health care is primarily medical in nature); Leslie Gielow Jacobs, *What the Abortion Disclosure Cases Say About the Constitutionality of Persuasive Government Speech on Product Labels*, 87 DENV. L. REV. 855 (2010) (arguing that abortion disclosure laws and tobacco labeling laws should receive the same treatment under the First Amendment); Keighley, *supra* note 32 (challenging abortion ultrasound laws as compelled ideological speech); Post, *supra* note 28 (comparing First Amendment restrictions on commercial speech and professional speech in the context of abortion disclosure laws); Robbins, *supra* note 28 (challenging abortion disclosure laws as compelling misleading and ideological speech); Nadia N. Sawicki, *Informed Consent as Compelled Professional Speech: Fictions, Facts, and Open Questions*, 50 WASH. U. J.L. & POL'Y 11 (2016) (analyzing the boundaries of physicians' First Amendment rights when communicating with patients); Sonia M. Suter, *The First Amendment and Physician Speech in Reproductive Decision Making*, 43 J.L. MED. & ETHICS 22 (2015) (arguing that heightened scrutiny should apply to abortion informed consent laws); Tobin, *supra* note 13 (arguing that compelled abortion disclosures should be subject to non-deferential judicial review of their accuracy and fairness under the *Casey* standard).

45. “All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated, see *Wooley v. Maynard*, 430 U.S. 705, 97 S.Ct. 1428, 51 L.Ed.2d 752 (1977), but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State, cf. *Whalen v. Roe*, 429 U.S. 589, 603, 97 S.Ct. 869, 878, 51 L.Ed.2d 64 (1977). We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992).

46. See Sawicki, *supra* note 44, at 18.

47. *Casey*, 505 U.S. at 882–83; see also *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 450 (6th Cir. 2019) (Donald, J., dissenting) (“The analysis in *Casey* that the

Critics have described the Court's approach in *Casey* as “puzzling,”⁴⁸ “cryptic,”⁴⁹ “oblique[,],”⁵⁰ and of “little guidance,”⁵¹ particularly in the context of compelled physician speech outside the abortion context.⁵² Perhaps unsurprisingly, then, no consistent or coherent doctrine has coalesced as to how to evaluate First Amendment claims by physicians generally⁵³ or compelled speech challenges to informed consent requirements more specifically.

When it comes to abortion-specific informed consent laws, however, courts most commonly apply *Casey*'s truthful, not misleading, and relevant standard.⁵⁴ This approach has continued even after the Supreme Court's 2018 decision in *National*

majority relies upon applies to an undue burden challenge, not a First Amendment challenge.”).

48. Post, *supra* note 28, at 946.

49. Haupt, *supra* note 44, at 1259.

50. B. Jessie Hill, *Casey Meets the Crisis Pregnancy Centers*, 43 J.L. MED. & ETHICS 59, 60 (2015).

51. Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 773 (1999).

52. See generally Sawicki, *supra* note 44. Beyond the context of informed consent to abortion discussed below, courts have also considered physicians' First Amendment rights in *Wolfschlaeger v. Governor of Florida*, 848 F.3d 1293, 1319 (11th Cir. 2017) (finding that elements of a Florida law banning doctors from inquiring about patients' gun ownership constituted content- and speaker-based restrictions violating the First Amendment); *Pickup v. Brown*, 740 F.3d 1208, 1236 (9th Cir. 2014) (upholding California ban on sexual orientation conversion therapy for children under rational basis review); *King v. Governor of New Jersey*, 767 F.3d 216, 246–47 (3d Cir. 2014) (upholding New Jersey ban on sexual orientation conversion therapy under intermediate scrutiny); *Otto v. City of Boca Raton*, 981 F.3d 854, 879–80 (11th Cir. 2020) (finding that ban on sexual orientation change therapy was an unconstitutional content-based regulation subject to strict scrutiny); *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (holding that “professional speech may be entitled to ‘the strongest protection our Constitution has to offer’” and enjoining, as content-based, a federal policy that would revoke a physician's license on the basis of the physician's recommendation of medical marijuana); *Final Exit Network, Inc. v. State*, 722 S.E.2d 722, 724–25 (Ga. 2012) (applying strict scrutiny to enjoin a law prohibiting doctors from offering assistance in the commission of suicide); *State v. Melchert-Dinkel*, 844 N.W.2d 13, 22 (Minn. 2014) (applying strict scrutiny to enjoin a law prohibiting doctors from encouraging or advising patients to commit suicide); *Nat'l Inst. of Fam. & Life Advocs. v. Schneider*, 484 F. Supp. 3d 596, 609 (N.D. Ill. 2020) (finding a genuine dispute of material fact as to whether a requirement that healthcare providers discuss services that they oppose on conscience grounds—including abortion, contraception, and sterilization—violates their First Amendment rights).

53. Carl H. Coleman, *Regulating Physician Speech*, 97 N.C. L. REV. 843, 843 (2019) (describing the “hodgepodge of approaches” taken by lower courts in the absence of a clear constitutional standard).

54. *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 576 (5th Cir. 2012) (upholding ultrasound and heartbeat requirements under the “truthful, nonmisleading, and relevant” standard); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 904–05, 907 (8th Cir. 2012) (upholding risk of suicide disclosure under “truthful, non-misleading, and relevant” standard). But see *Stuart v. Camnitz*, 774 F.3d 238, 255–56 (4th Cir. 2014) (enjoining ultrasound requirements under intermediate scrutiny).

Institute of Family & Life Advocates v. Becerra,⁵⁵ which concerned compelled speech relating to abortion but did not establish a First Amendment standard for evaluating informed consent laws.⁵⁶

However, despite lower courts' relatively consistent reliance on the *Casey* standard when considering First Amendment challenges to abortion informed consent laws, there is little consistency in the outcomes from applying that standard across the country. Courts have reached divergent conclusions as to whether compelled disclosures of "human being" language,⁵⁷ risk information about suicide,⁵⁸ and ultrasound images⁵⁹ are constitutionally permissible.⁶⁰

55. *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2378 (2018) [hereinafter *NIFLA*] (enjoining California law requiring crisis pregnancy centers to make certain disclosures as a content-based regulation of speech). The Supreme Court in *NIFLA* held that there are only two exceptions to the application of strict scrutiny to content-based speech regulations: "laws that require professionals to disclose factual, noncontroversial information in their 'commercial speech'" and laws regulating professional conduct that "incidentally involve[] speech." *Id.* at 2372 (citing *Zauderer v. Off. of Disciplinary Couns.*, 471 U.S. 626, 651 (1985) and *Casey*, 505 U.S. at 884)).

56. *See Nat'l Inst. of Fam. & Life Advocs. v. Schneider*, 484 F. Supp. 3d 596, 614 (N.D. Ill. 2020) ("There is disagreement among courts regarding the level of scrutiny to be applied to informed-consent laws, and *NIFLA* did not address whether rational basis or intermediate scrutiny was required.").

57. *See Whole Woman's Health All. v. Hill*, 493 F. Supp. 3d 694, 751–52 (S.D. Ind. 2020) (enjoining "human being" disclosure as misleading); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 375 F. Supp. 2d 881, 887 (D.S.D. 2005), *vacated and remanded*, 530 F.3d 724, 735–38 (8th Cir. 2008) (enjoining "human being" disclosure as compelled ideological speech); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 650 F. Supp. 2d 972, 976–77 (D.S.D. 2009); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 653 F.3d 662, 667–68 (8th Cir. 2011) (upholding "human being" disclosure as being truthful, not misleading, and relevant).

58. *See Planned Parenthood Minn., N.D., S.D. v. Rounds* 530 F.3d 724, 738 (8th Cir. 2008); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, at 898–99 (8th Cir. 2012) (upholding, as truthful and not misleading, a South Dakota informed consent law requiring disclosure that abortion carries an "increased risk" of suicide and suicidal ideation); *Planned Parenthood of the Heartland v. Heineman*, 724 F. Supp. 2d 1025, 1048 (D. Neb. 2010) (enjoining requirements that providers disclose "any adverse physical, psychological, or emotional reaction that is reported in a peer-reviewed journal to be statistically associated with abortion such that there is less than a five percent probability ($P < .05$) that the result is due to chance" on the grounds that it would "require medical providers to give untruthful, misleading and irrelevant information").

59. *See EMW Women's Surgical Ctr. v. Beshear*, 920 F.3d 421, 446 (6th Cir. 2019) (upholding ultrasound and heartbeat requirements as "truthful and nonmisleading"); *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 584 (5th Cir. 2012) (upholding ultrasound and heartbeat requirements as being truthful and not misleading, rather than ideological); *Stuart v. Camnitz*, 774 F.3d 238, 255–56 (4th Cir. 2014) (enjoining ultrasound requirements under intermediate scrutiny on the grounds that such disclosures are "ideological"); *Whole Woman's Health All. v. Hill*, 493 F. Supp. 3d 694, 750 (S.D. Ind. 2020) (granting state's motion for summary judgment regarding ultrasound requirement on the grounds that it does not impose a significant burden).

60. Statutes requiring disclosure of the reversibility of medication abortion have, however, been uniformly enjoined. *Am. Med. Ass'n v. Stenehjem*, 412 F. Supp. 3d 1134, 1151 (D.N.D. 2019) (enjoining abortion reversal disclosure as being "misleading"); *Planned*

Beyond these formal legal challenges, numerous scholars of constitutional law have also offered more nuanced perspectives on the constitutionality of laws compelling physician speech, particularly in the context of abortion.⁶¹

C. Scholarly Criticism

Abortion disclosure laws have been challenged beyond their constitutional implications. Scholars of law, public policy, medicine, ethics, and feminist studies have developed a wide body of literature addressing the ways in which abortion disclosure laws are problematic as a matter of policy. While a full overview of the scholarly debate is beyond the scope of this Article, I wish to highlight two major points of concern.

First, as explained in Section II.A *infra*, these laws modify the standard of care for informed consent in ways that conflict with the medical community's own practices. This is problematic from a tort perspective, given that standards of care are traditionally grounded in the practices of reasonable physicians. However, it also poses ethical concerns. Many commentators in medicine, medical ethics, and health policy argue that the principles of medical ethics underlying informed consent—autonomy, beneficence, justice, non-maleficence—are violated when states compel doctors to communicate some types of information about abortion.⁶² Prominent professional medical associations have expressed similar concerns. The American Congress on Obstetrics and Gynecology's Committee on Ethics criticizes abortion disclosure laws as interfering with physicians' ethical obligations, including their obligations to have "open, honest, and confidential communications with their patient[]" and to counsel patients "according to the best currently available medical

Parenthood of Tenn. & N. Miss. v. Slatery, No. 3:20-CV-00740, 2021 WL 765606, at *17 (M.D. Tenn. Feb. 26, 2021) (enjoining abortion reversal disclosure on the grounds that it is untruthful and/or misleading). *See also* Planned Parenthood Ariz., Inc. v. Brnovich, 172 F. Supp. 3d 1075, 1098–99 (D. Ariz. 2016) (finding that abortion providers have standing to challenge abortion reversal disclosure as "false, misleading, and/or irrelevant").

61. *See, e.g.*, Post, *supra* note 28 (analyzing the First Amendment implications of abortion informed consent laws); Helen Norton, *Pregnancy and the First Amendment*, 87 FORDHAM L. REV. 2417, 2418–31 (2018) (offering an alternative view of the First Amendment's protections as focusing on the interests of the listener, rather than the speaker); Tobin, *supra* note 13, at 114 (arguing that disclosures of "specific factual claims" should be "subject to non-deferential judicial review of their accuracy and fairness"); Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. REV. 939, 939–1016 (2009) (using abortion counseling and disclosure laws to argue for a listener-based First Amendment right against compelled listening); Haupt, *supra* note 44 (arguing that First Amendment protection of professional speech should be grounded in the understanding of professionals as "knowledge communities"); Coleman, *supra* note 53 (arguing that courts should apply intermediate scrutiny to laws interfering with physician-patient communications, and consider whether the laws are reasonably related to the government's interest in upholding the quality of medical practice).

62. *See* Minkoff & Marshall, *supra* note 13, at 21 (arguing that abortion disclosure laws violate patient autonomy); Vanderwalker, *supra* note 13, at 4, 33–39 (arguing that "in addition to their shortcomings when judged by the standards of the Constitution, biased counseling laws have serious problems when judged by the standards of medical ethics").

evidence and the physician's professional medical judgment."⁶³ In a 2013 article in the American Journal of Obstetrics and Gynecology, one hundred professors of obstetrics and gynecology argued that abortion informed consent laws developed in the forty years since *Roe v. Wade* have "interfered in the consent process by requiring that irrelevant, even untrue information, be given by the physician."⁶⁴ The American Medical Association has likewise opposed "procedure-specific" informed consent requirements.⁶⁵

Second, feminist legal scholarship has highlighted abortion informed consent laws as yet another example of "abortion exceptionalism," where state actors regulate abortion in ways that would be inconceivable in any other context.⁶⁶ Much of this exceptionalism, according to scholars, is driven by patriarchal and paternalistic perspectives regarding women's ability to make their own decisions,⁶⁷ as well as

63. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS COMM. ON ETHICS, ACOG COMMITTEE OPINION NUMBER 819: INFORMED CONSENT AND SHARED DECISION MAKING IN OBSTETRICS AND GYNECOLOGY 34, 38 (2021), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf> [<https://perma.cc/QRL2-TVAZ>].

64. One Hundred Professors of Obstetrics and Gynecology, *A Statement on Abortion by 100 Professors of Obstetrics: 40 Years Later*, 88 CONTRACEPTION 568, 570 (2013); see also Jody Steinauer & Carolyn Sufrin, *Legislating Abortion Care*, 16 AM. MED. ASS'N J. ETHICS 266 (2014) (commenting on the One Hundred Professors Statement, and arguing that requiring that "clinicians give inaccurate information to patients is, to say the least, unethical").

65. Am. Med. Ass'n, *AMA Opposition to "Procedure-Specific" Informed Consent*, House of Delegates Resolution 226 (passed 1999, reaffirmed 2021), <https://policysearch.ama-assn.org/policyfinder/detail/226%20A-99?uri=2FAMADoc%2FHOD.xml-0-2623.xml> [<https://perma.cc/325C-X87A>] ("Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.").

66. See Borgmann, *supra* note 42, at 1048 (defining "abortion exceptionalism" as "a term that has been used to describe the tendency of legislatures and courts to subject abortion to unique, and uniquely burdensome, rules"); Corbin, *supra* note 15, at 1176 (describing one form of "abortion distortion" as the development of abortion jurisprudence where "normal [constitutional] doctrine does not apply"); see also Erwin Chemerinsky & Michele Goodwin, *Constitutional Gerrymandering Against Abortion Rights: NIFLA v. Becerra*, 94 N.Y.U. L. REV. 61 (2019) (arguing that the Supreme Court's conclusion in *NIFLA* was at odds with *Casey*, and that it reflects judicial hostility to abortion rights rather than any consistent constitutional doctrine).

67. See, e.g., Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1726, 1730 (2007) (describing Supreme Court abortion jurisprudence as being grounded in the belief that women's decision-making is "coerced or confused," and that women are unable to make rational decisions on their own); Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193, 1221 (2010) (describing the rationale behind *Casey*'s acceptance of informed consent and spousal consent requirements as "protect[ing] women from psychological injury"); Vanderwalker, *supra* note 13, at 13 (pointing to *Casey* and *Carhart* as exemplifying the Supreme Court's "willingness to accept the notion that women's decision-making abilities are deficient"). Issues of paternalism in reproductive health care also arise in the context of the rights of pregnant persons to make choices about medical treatment during pregnancy and

unfounded assumptions about women's emotional responses to abortion.⁶⁸ According to Maya Manian, the Supreme Court's abortion jurisprudence (and particularly its discussion of informed decision-making in *Carhart*) "exposes abortion law's treatment of women as less capable decision-makers."⁶⁹ Likewise, Pamela Laufer-Ukeles criticizes abortion laws as being grounded in unfounded stereotypes about women's emotional stability and assumptions about the "pull of motherhood."⁷⁰

Both these arguments speak to concerns about the state's involvement in the doctor-patient relationship, and in particular, its lack of deference to professional and personal values. Legislatures that have passed abortion informed consent laws have effectively indicated that they trust neither the medical judgment of health care providers, nor the personal judgment of women seeking abortions.

II. MODIFYING THE ELEMENTS OF TORT LIABILITY FOR FAILURE TO DISCLOSE

Under common law, physicians who breach their duty to secure a patient's informed consent are liable for damages. To prove an informed consent claim, much like a claim for traditional medical malpractice, a plaintiff must demonstrate duty, breach, causation in fact, proximate causation, and compensable injury.

Abortion informed consent laws have been most widely criticized for modifying the scope of the physician's substantive duty to disclose.⁷¹ However, this author's analysis of state laws suggests that they do more than that—most of the statutes seem to completely eliminate the plaintiff's burden of proving causation in fact and proximate causation. Scholarship has not yet recognized that abortion disclosure laws impose liability on physicians by apparently jettisoning two foundational elements of a tort cause of action. This Article explains this exceptional and dangerous legal strategy and demonstrates why it should be resisted.

Notably, there are several other ways in which abortion disclosure laws deviate from traditional tort law principles that cannot be addressed in an article of this length. Among other things, the laws may impose fixed statutory damages in addition to compensatory damages (and sometimes treble damages);⁷² establish statutes of

birth. See generally Jamie R. Abrams, *The Illusion of Autonomy in Women's Medical Decision-Making*, 42 FLA. ST. U. L. REV. 17 (2014); Rebecca A. Spence, *Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75 (2012).

68. See Corbin, *supra* note 15, at 1178 (arguing that many abortion regulations are based on the "alleged deleterious effect of abortion on women's mental health").

69. Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 255 (2009).

70. See Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy*, 37 AM. J.L. & MED. 567, at 592–95 (2011).

71. See *infra* Section II.A.

72. ARIZ. REV. STAT. ANN. § 36-2153(L)(2) (2021) (imposing statutory damages of \$5000 or three times the cost of the abortion, whichever is greater); LA. STAT. ANN. § 40:1061.29 (2019) (imposing a \$1000 civil fine for violations of consent requirements); KAN. STAT. ANN. § 65-6705(q)(2)(C) (West 2014) (imposing statutory damages equal to three times the cost of the abortion); N.D. CENT. CODE ANN. § 14-02.1-03.2 (West 1991) (imposing punitive damages

limitations that differ from those of traditional negligence or malpractice actions;⁷³ prohibit patients from waiving their right to informed consent;⁷⁴ and establish breach of a physician's disclosure duty to a patient as grounds for liability to family members,⁷⁵ including unrelated torts, like family disruption.⁷⁶ These issues are ripe for future research, and should be examined further by torts scholars.

A. Duty and Scope of Disclosure

Numerous scholars have challenged abortion disclosure laws on the grounds that they deviate from the common law standard regarding the type of information doctors have a duty to disclose.⁷⁷ Traditionally, common law imposes a duty to disclose the patient's diagnosis and prognosis, the medical risks and benefits of the proposed treatment, and the medical risks and benefits of alternative treatments.

of \$10,000 or \$5,000, depending on the violation, and treble actual damages); 18 PA. STAT. AND CONS. STAT. ANN. § 3217 (West 1988) (imposing statutory damages of \$5,000); S.D. CODIFIED LAWS § 34-23A-22 (2011) (imposing punitive damages of \$10,000 or \$5,000, depending on the violation); S.D. CODIFIED LAWS § 34-23A-60 (imposing statutory damages of \$10,000); WIS. STAT. ANN. § 253.10(6)(b) (West 2016) (imposing punitive damages of not less than \$1,000 nor more than \$10,000).

73. For example, ARIZ. REV. STAT. ANN. § 36-2153(M) (2021) establishes a six-year statute of limitations.

74. S.D. CODIFIED LAWS § 34-23A-61(5) (2012) ("No patient or other person responsible for making decisions relative to the patient's care may waive the requirements of this chapter, and any verbal or written waiver of liability for malpractice or professional negligence arising from any failure to comply with the requirements of this chapter is void and unenforceable."). Cf. FURROW ET AL., *supra* note 6, at 141 (recognizing that patients have a legal right to waive their right to informed consent).

75. See *infra* Section II.B.

76. KY. REV. STAT. ANN. §§ 311.732, 311.735 (West 2019) (establishing that a physician's failure to notify a spouse and failure to obtain consent for a minor are prima facie evidence of "interference with family relations").

77. See, e.g., Dresser, *supra* note 9, at 1617–20 (identifying several categories of abortion disclosures that would not be required under traditional informed consent doctrine); Robbins, *supra* note 28, at 161 (describing abortion disclosure laws as resulting in "a breed of informed consent statute that glaringly stands out from all others"); Gold & Nash, *supra* note 13, at 7–8 (noting that abortion laws require disclosure of "some information not in keeping with the fundamental tenets of informed consent"); Lazzarini, *supra* note 13, at 2189 (referring to South Dakota's law as an "informed consent" law, in quotes, and noting that "[t]he law is unique in ways that should cause concern to physicians, patients, and protectors of the physician-patient relationship"); Minkoff & Marshall, *supra* note 13, at 21 (describing abortion disclosure laws as "replac[ing] the concept of informed consent as a discussion of risks, benefits, and alternatives with a coercive process focusing almost exclusively on risks, misinformation, and implied government opprobrium"); Tobin, *supra* note 13, at 111 (describing abortion laws requiring disclosure of fetal pain as "abandon[ing] well-settled principles of informed consent . . . in favor of legislative judgments about what particular facts should be told to patients and how these facts should be shared"). See also EMW Women's Surgical Ctr., P.S.C. v. Beshear, 920 F.3d 421, 438 (6th Cir. 2019) (recognizing that the Supreme Court in *Casey* upheld informed consent requirements that the district court found were "directly contrary to alleged medical-profession custom").

However, as described above, many state legislatures have dramatically expanded the scope of disclosure in the context of informed consent to abortion, requiring physicians to communicate information that goes far beyond the medical risks and benefits of the abortion procedure (and its alternative, pregnancy). Although not all states have taken this approach, there is a risk that these new disclosure requirements will spill over to be viewed as the national standard of care, even in states without abortion-specific consent laws.⁷⁸

There is certainly merit to the argument that the scope of disclosure in informed consent to abortion deviates from the traditional common law scope of disclosure. However, as I have previously argued, a more nuanced understanding of informed consent doctrine suggests that this argument may not serve critics' purposes as effectively as they might hope.⁷⁹ Although "there is a sense of certainty . . . in the standard litany of informed consent disclosure requirements . . . almost as if the content of the required disclosures were etched in stone for each procedure[.]" this is not necessarily an accurate perspective.⁸⁰ Rather, I have argued, informed consent is a socially constructed doctrine that is inherently flexible, and necessarily incorporates some value judgments.⁸¹ Common law standards of medical materiality change over time, and while courts have generally taken a traditional approach to defining the scope of informed consent disclosure, the doctrine is not static.⁸² Of course, it is still possible to challenge many aspects of abortion disclosure laws as being inconsistent with traditional informed consent disclosure duties—for example, the requirement that physicians disclose only information that is factual and material, and the ability of patients to waive consent and/or decline to hear information about the procedure. However, in light of the evolving common law of informed consent, legal challenges to the scope of disclosure may be less compelling than they initially appear.⁸³

B. Factual and Legal Causation

From a tort scholar's perspective, a particularly problematic aspect of abortion compelled speech laws—and one that has not yet been addressed in tort law scholarship—is that they eliminate a plaintiff's burden of proving causation, which is fundamental to any negligence claim.

The causation requirements for informed consent claims are somewhat different from the causation requirements for medical malpractice and other negligence claims. To prove negligence, a plaintiff must first demonstrate causation in fact—that the defendant's breach actually caused the plaintiff's injury, and that but for that breach, the plaintiff more likely than not would not have been injured. The plaintiff must also prove proximate causation, which requires a showing that it was foreseeable that the defendant's breach might cause the injury that occurred, such that it would be justified as a matter of policy to impose liability.

78. See generally Shaw & Stein, *supra* note 3.

79. Sawicki, *supra* note 13, at 29.

80. *Id.* at 18.

81. *Id.* at 5.

82. See Sawicki, *supra* note 4.

83. See Sawicki, *supra* note 13, at 22.

In informed consent cases, however, the required elements of causation are treated somewhat differently. The elements of cause in fact and proximate cause have developed to require more specific proof that closely aligns with the facts underlying the informed consent cause of action.

First, the plaintiff-patient in an informed consent case must demonstrate that if the defendant-physician had made the legally required disclosures, a reasonable patient would have chosen an alternate course of treatment, and in turn would not have suffered the injury that occurred. This requirement, commonly referred to as “decision causation,” tracks factual causation under the traditional but-for test but approaches it from an objective rather than subjective perspective.⁸⁴ Second, the plaintiff must prove that the injury they suffered was a manifestation of the specific risk the physician failed to disclose (referred to as “injury causation”). This requirement is similar to the traditional test for proximate causation, requiring proof that the defendant’s breach was closely connected enough to plaintiff’s injury to warrant imposition of liability.

While proof of these two elements is required in any common law action for informed consent, statutes that establish physician liability for failure to communicate state-mandated messages about abortion are drafted so broadly as to negate these two requirements. Few of the abortion informed consent statutes explicitly require plaintiffs to prove *any* causal connection between the doctor’s act and the plaintiff’s injury. A plaintiff can recover damages simply by claiming that an abortion or attempted abortion took place, and that the physician did not disclose information required under the statute, regardless of whether the disclosure would have prevented the plaintiff’s injury.

1. Causation in Fact

As noted above, the cause in fact requirement in informed consent cases differs from that in traditional malpractice actions. Rather than asking whether, as a factual matter, correction of the defendant’s breach would more likely than not have prevented this plaintiff’s injury, courts in informed consent cases view this question through a theoretical lens. They instead ask whether appropriate disclosure by the defendant would have caused an objectively reasonable patient to make a different choice regarding medical treatment. This is commonly referred to as “decision causation,” and is the standard in all but four states.⁸⁵

84. See *infra* Section II.B.

85. Evelyn M. Tenenbaum, *Revitalizing Informed Consent and Protecting Patient Autonomy: An Appeal to Abandon Objective Causation*, 64 OKLA. L. REV. 697, 709–18 (2012) (describing the objective decision causation requirement in informed consent cases); see also RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 34 (1986) (describing the subjective causation rule as having been “largely . . . neglected in judicial opinion and legal commentary”). Many scholars have criticized the objective decision causation standard as inconsistent with informed consent doctrine’s theoretical grounding in the principle of patient autonomy, but those criticisms have not impacted the legal standard. See, e.g., Tenenbaum, *supra*, at 717–19; FADEN & BEAUCHAMP, *supra*, at 35. Commentators have also challenged the objective decision causation standard as having significant practical challenges. See, e.g., Tenenbaum, *supra*, at 720–25 (arguing that given the breadth of

Consider a patient with severe back pain who is choosing between invasive surgery and medical management using prescription painkillers. The patient's doctor negligently fails to disclose that the prescription painkiller's side effects include nausea and vomiting. Unaware of these risks, the patient chooses to proceed with medical management of their back pain. The patient experiences nausea and vomiting as a result of the medication and brings an informed consent claim to recover damages for these injuries. To prove causation in fact, they must demonstrate that if an objectively reasonable patient had been told of these risks, that prudent patient would have chosen surgery instead of medical management. It is insufficient for the patient to show that they personally would have chosen surgery if they had known of the prescription's side effects. Thus, if a fact finder determines that most reasonable patients would prefer to take a medication with these side effects than to undergo invasive surgery, an injured patient who claims they would have made a different choice has no remedy.⁸⁶

Abortion compelled speech laws, however, do not require plaintiffs to make a showing of decision causation, either objective or subjective. These laws entitle an injured patient to damages for a physician's breach of informed consent without requiring the patient to prove that a reasonable patient (or even this patient) would have proceeded differently had their physician made the full disclosures required by statute.

Consider a patient who is planning to terminate her pregnancy and whose physician is in the process of securing her consent to the procedure. Imagine that the physician makes those disclosures that are traditionally required under the common law of informed consent—about the medical risks and benefits of abortion and its alternative, pregnancy—but fails to communicate some of the information required by state statute. Perhaps the physician fails to provide information about the fetus's status as a "human being," about the risk of suicide, or about the availability of adoption services. Many statutes would allow the patient to recover damages associated with the abortion, even if the undisclosed information would have had no impact on a reasonable patient's decision.⁸⁷

Of the states with abortion-specific physician disclosure statutes, all but three are silent as to causation in fact. Most simply state that a physician's failure to comply with the statutory informed consent requirements provide a basis for tort recovery.⁸⁸

treatment options and the variety of patient perspectives on these options, most informed consent claims will fail the objective causation test); Aaron D. Twerski & Neil B. Cogen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 626 (1988) (arguing that regardless of the model of causation, psychological research about human decision-making suggests that the issue of causation is not practically justiciable).

86. See Tenenbaum, *supra* note 85, at 712–13 (“Given this objective standard, a patient could be denied relief even if: (1) the information he received from the physician was totally deficient, (2) the patient himself would not have chosen the surgery if he had been informed of the risks and alternatives, and (3) he was severely injured.”).

87. See *infra* note 88.

88. ALA. CODE § 26-23A-10 (2009) (“[F]ailure to comply with the requirements of this chapter shall: (1) Provide a basis for a civil action for compensatory and punitive damages . . . based on a claim that the act was a result of simple negligence, gross negligence, wantonness,

willfulness, intention, or other legal standard of care . . . (3) Provide a basis for recovery for the woman for the wrongful death of the child[.]”); ARIZ. REV. STAT. ANN. § 36-2153(L) (2009) (“A civil action filed pursuant to subsection K of this section . . . may be based on a claim that failure to obtain informed consent was a result of simple negligence, gross negligence, wantonness, willfulness, intention or any other legal standard of care.”); ARK. CODE ANN. § 20-16-1710(a) (2015) (“In addition to any remedies available under the common law or statutory law of this state, failure to comply with the requirements of this subchapter shall provide a basis for a: (1) Civil malpractice action for actual and punitive damages”); IDAHO CODE ANN. § 18-618(1) (West 2015) (providing that a plaintiff “may maintain an action for actual damages against the person who in knowing or reckless violation of section 18-617, Idaho Code, attempted or performed the abortion[.]” where section § 18-617 regulates chemical abortions and incorporates § 18-609 informed consent requirements); IOWA CODE ANN. § 146B.3 (West 2015) (providing that a plaintiff “may maintain an action against the physician who performed the abortion in intentional or reckless violation of this chapter for actual damages”); KAN. STAT. ANN. § 65-6710(a)(1) (West 2014) (requiring that state-provided documentation inform patients that “any physician who performs an abortion upon a woman without her informed consent may be liable to her for damages”); KAN. STAT. ANN. § 65-6705(q) (West 2014) (establishing that, in the context of abortion on minors, a “custodial parent or legal guardian of the minor may pursue civil remedies against [those] who violate the rights of parents, legal guardian or the minor as set forth in this section”); LA. STAT. ANN. § 40:1061.29(B)–(C) (2019) (establishing that informed consent violations will result in “a civil fine of one thousand dollars per incidence or occurrence In addition to whatever remedies are otherwise available under the law of this state, failure to comply with the provisions of this Chapter shall: (1) Provide a basis for a civil malpractice action . . . (3) Provide a basis for recovery for the woman for the death of her unborn child.”); MINN. STAT. ANN. § 145.4247(1) (West 2003) (providing that a person upon whom an abortion has been performed or attempted without the physician’s compliance with statutory informed consent requirements “may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages”); MONT. CODE ANN. § 50-20-307(1) (1995) (“A person who performs an abortion in knowing or reckless violation of this chapter may be liable for actual and punitive damages.”); N.C. GEN. STAT. ANN. § 90-21.88(a) (West 2011) (establishing that a plaintiff “may maintain an action for damages against the person who performed the abortion in knowing or reckless violation of this Article”); N.D. CENT. CODE ANN. § 14-02.1-03.2 (West 1991) (“Any person upon whom an abortion has been performed without informed consent as required by [statutes] may maintain an action against the person who performed the abortion for ten thousand dollars in punitive damages and treble whatever actual damages the plaintiff may have sustained.”); OHIO REV. CODE ANN. § 2317.56(H) (West 2021) (“[A]ny physician who performs or induces an abortion with actual knowledge that [informed consent requirements] have not been satisfied or with a heedless indifference as to whether those conditions have been satisfied is liable in compensatory and exemplary damages in a civil action.”); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2012) (providing that a plaintiff “may commence a civil action against the abortion provider, against the prescriber of any drug or chemical intended to induce abortion, and against any person or entity which referred the woman to the abortion provider or prescriber and which knew or reasonably should have known that the abortion provider or prescriber had acted in violation of [informed consent provisions of the Oklahoma Statutes] for actual damages and, in cases of gross negligence, for punitive damages”); 18 PA. STAT. AND CONS. STAT. ANN. § 3217 (West 1988) (“Any physician who knowingly violates any of the provisions of section 3204 or 3205 [relating to informed consent] shall . . . be civilly liable to his patient for any damages caused thereby and, in

And the three state statutes that explicitly speak to the issue of causation significantly deviate from the traditional requirement that a plaintiff in an informed consent suit prove objective decision causation. Alaska requires the plaintiff to prove decision causation under a subjective standard.⁸⁹ Nebraska⁹⁰ and South Dakota⁹¹ relieve the plaintiff of this burden by establishing that a physician's non-disclosure of statutorily required information creates a rebuttable presumption of subjective decision causation.

Alaska's abortion informed consent statute imposes liability only if the plaintiff can prove that, "but for [the physician's] failure [to disclose], the person would not have consented to the abortion procedure."⁹² This subjective decision causation standard is less stringent than the objective standard traditionally used in informed consent cases, but at least it requires some proof of causation on the part of the plaintiff. Interestingly, Alaska's statute seems drafted specifically to avoid concerns about informed consent claims being brought based on a physician's failure to disclose state-mandated information that may not be relevant to the abortion decision. Alaska's statute says that consent is proven when the patient certifies in writing that a physician has provided *either* information drafted by the Department of Health and Social Services and available on the internet,⁹³ *or* "information about

addition, shall be liable to his patient for punitive damages in the amount of \$5,000."); TENN. CODE ANN. § 39-15-218(1) (West 2020) (providing that, in the context of chemical abortions only, a plaintiff "may bring an action against the person who performed the abortion in knowing or reckless violation of this act [relating to informed consent] for actual and punitive damages"); WIS. STAT. ANN. § 253.10(6) (West 2015) ("A person who violates [informed consent provisions] is liable to the woman on or for whom the abortion was performed or induced for damages arising out of the performance or inducement of the abortion, including damages for personal injury and emotional and psychological distress." This statute also establishes liability to fathers and grandparents of the unborn child).

89. ALASKA STAT. ANN. § 18.16.010(h) ("A physician or other health care provider is liable for failure to obtain the informed consent of a person as required under AS 18.16.060 if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the person of the common risks and reasonable alternatives to the proposed abortion procedure and that, but for that failure, the person would not have consented to the abortion procedure.")

90. NEB. REV. STAT. ANN. § 28-327.11(1) ("In determining the liability of the physician and the validity of the consent of a pregnant woman, the failure to comply with the requirements of section 28-327 shall create a rebuttable presumption that the pregnant woman would not have undergone the recommended abortion had section 28-327 been complied with by the physician.")

91. S.D. CODIFIED LAWS § 34-23A-61(1) ("The failure to comply with the requirements of this chapter relative to obtaining consent for the abortion shall create a rebuttable presumption that if the pregnant mother had been informed or assessed in accordance with the requirements of this chapter, she would have decided not to undergo the abortion.")

92. ALASKA STAT. ANN. § 18.16.010(h) (West 2020).

93. *Id.* § 18.05.032. This includes information about (among other things) pregnancy counseling, adoption agencies, post-abortion counseling, eligibility for medical assistance, the process of obtaining child support, description of fetal development including photographs, and "objective, unbiased information that is reviewed and approved for medical accuracy by recognized obstetrical and gynecological specialists" about the risks of abortion, the risks of pregnancy and childbirth, and the impact of alcohol, tobacco, and other drugs on fetal

the nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a voluntary and informed decision of whether to undergo the procedure.”⁹⁴ However, the liability provisions that establish the subjective causation requirement impose liability *only if* the physician breaches the duty to inform the patient “of the common risks and reasonable alternatives to the proposed abortion procedure.”⁹⁵ In other words, an Alaska physician will not be liable for breach of informed consent if they accurately disclose the risks and benefits of abortion but fail to share the state-mandated materials.

The other two states with statutes that explicitly speak to causation in an abortion informed consent case are Nebraska and South Dakota. Their statutes establish that a physician’s failure to comply with the statutory disclosure requirements create a rebuttable presumption of subjective decision causation—that is, a presumption that the woman bringing the claim would not have undergone the abortion had these disclosures been made.⁹⁶ These statutes are far less stringent than a requirement that the plaintiff affirmatively prove objective decision causation, or even (as Alaska does) subjective decision causation.⁹⁷

development. *Id.*

94. *Id.* § 18.16.060(b).

95. “A physician or other health care provider is liable for failure to obtain the informed consent of a person as required under AS 18.16.060 if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the person of the common risks and reasonable alternatives to the proposed abortion procedure and that, but for that failure, the person would not have consented to the abortion procedure.” *Id.* § 18.16.010(h).

96. S.D. CODIFIED LAWS § 34-23A-61(1) (2011) (“The failure to comply with the requirements of this chapter relative to obtaining consent for the abortion shall create a rebuttable presumption that if the pregnant mother had been informed or assessed in accordance with the requirements of this chapter, she would have decided not to undergo the abortion.”); NEB. REV. STAT. ANN. § 28-327.11(1) (West 2010) (“In determining the liability of the physician and the validity of the consent of a pregnant woman, the failure to comply with the requirements of section 28-327 shall create a rebuttable presumption that the pregnant woman would not have undergone the recommended abortion had section 28-327 been complied with by the physician.”).

97. Interestingly, when it comes to causation, South Dakota maintains a subjective standard; however, the scope of the doctor’s disclosure duties is based on the objective “reasonable patient” standard. S.D. CODIFIED LAWS § 34-23A-1.7 (2005) (“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. The duty of a physician to disclose all facts about the nature of the procedure, the risks of the procedure, and the alternatives to the procedure that a reasonable patient would consider significant to her decision of whether to undergo or forego the procedure applies to all abortions. Nothing in § 34-23A-1, §§ 34-23A-1.2 to 34-23A-1.7, inclusive, § 34-23A-10.1, and § 34-23A-10.3 may be construed to render any of the requirements otherwise imposed by common law inapplicable to abortion procedures or diminish the nature or the extent of those requirements. The disclosure requirements expressly set forth in § 34-23A-1, §§ 34-23A-1.2 to 34-23A-1.7, inclusive, § 34-23A-10.1, and § 34-23A-10.3 are an express clarification of, and are in addition to, those common law disclosure requirements.”).

Interestingly, Nebraska's statute hints at the traditional objective causation standard for informed consent, effectively granting an affirmative defense if the physician can prove that the undisclosed information would not be relevant to a reasonable person's abortion decision. A physician in Nebraska can defend against abortion informed consent liability by demonstrating that they "omitted the contested information because statistically validated surveys of the general population of women of reproductive age, conducted within the three years before or after the contested abortion, demonstrate that less than five percent of women would consider the contested information to be relevant to an abortion decision."⁹⁸ In practice, however, this defense would be almost impossible to secure, given that such statistical research does not exist.

South Dakota's statute also recognizes that the presumption of causation is not absolute and can be rebutted.⁹⁹ In such cases, the statute instructs the finder of fact to determine whether causation has been satisfied, taking into account the plaintiff's "personal background and personality, her physical and psychological condition, and her personal philosophical, religious, ethical, and moral beliefs."¹⁰⁰ In effect, South Dakota doubles down on subjective decision causation—first establishing a presumption that it has been satisfied, and alternatively instructing the factfinder to look carefully at the plaintiff's subjective characteristics to determine whether she would have consented had she been given the required information.

In sum, the civil liability provisions of most abortion informed consent laws eliminate one of the fundamental legal requirements for an informed consent suit—proving that the disclosure is so significant that it would have caused a reasonable person to make a different decision. Most do not require a plaintiff to prove any causal relationship between the physician's nondisclosure and the patient's injury, and none apply the objective decision causation test traditionally used in informed consent cases.

If traditional informed consent actions took the approach that abortion informed consent laws take, physicians who fail to satisfy their disclosure duties would be liable any time their patients are injured as a result of the recommended treatment, regardless of whether the undisclosed information would have been relevant to a patient making that choice. Returning to the hypothetical at the start of this Section clarifies why such an approach would be problematic. The patient with back pain who chooses to take a prescription painkiller after the physician neglects to inform them of its side effects would be able to successfully recover against the physician if they experience those side effects, regardless of causation. Even if a reasonably prudent patient would consider the risk of nausea and vomiting to be reasonable in comparison to the risks associated with back surgery—and even if *this particular* patient, if informed of these risks, would have chosen to take the prescription rather than have surgery—the physician would still be liable. This is simply not how informed consent law was designed to operate.

98. NEB. REV. STAT. ANN. § 28-327.11(5) (West 2016).

99. S.D. CODIFIED LAWS § 34-23A-61(1). That said, the statute does not specify how this presumption might be rebutted. *See id.*

100. S.D. CODIFIED LAWS § 34-23A-61(3) (Supp. 2020).

2. Proximate Causation

The proximate cause requirement in informed consent actions under common law is also more specific than in traditional negligence actions. In a negligence action, the assessment of whether proximate cause has been satisfied is a policy-based determination, evaluating whether the harm that occurred was within the scope of risks that were foreseeable as a result of breach of duty. In an informed consent case, however, a plaintiff cannot recover unless they demonstrate that the physical injury they suffered was a manifestation of the specific medical risk that the physician failed to disclose. As explained in one of the most widely cited cases relating to the informed consent cause of action, *Canterbury v. Spence*, “[a]n unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence.”¹⁰¹ In other words, if a physician breaches their duty to disclose a risk associated with the treatment the patient is considering, the patient only has a right of recovery if that particular risk materializes. If the patient is injured in another way—by a different sort of risk than the one that was not disclosed, or by a dignitary rather than physical harm—the patient cannot recover in an informed consent action.

To illustrate this principle, consider again the patient who is choosing between medical and surgical treatment of their severe back pain. Under the common law of informed consent, the patient’s physician must disclose the risks and benefits of both options. In this example, imagine that the physician fails to satisfy this duty: he correctly informs the patient that the surgery has a ten percent risk of causing paralysis, but fails to disclose that the prescription painkillers used for medical management of the pain have a ten percent risk of causing nausea and vomiting. If the patient chooses surgery and becomes paralyzed as a result, he cannot recover for his injuries in an informed consent suit, because the risk that the doctor failed to disclose (nausea and vomiting) was not the risk that caused the patient’s injury (paralysis). Only if the doctor failed to disclose the risk of paralysis will the paralyzed patient have a right of recovery in informed consent. Alternatively, imagine that the patient suffers no physical injury as a result of the procedure; even if they allege that they suffered serious emotional or dignitary harm when they learned of the nondisclosure, informed consent law would not provide grounds for recovery.

Applying this principle to the abortion context, a common law informed consent action should succeed only if the injury for which the patient is seeking a remedy is a risk that the physician had a legal duty to disclose. For example, one of the risks of dilation and curettage is the development of scar tissue on the uterine wall.¹⁰² If the physician fails to disclose that risk when securing the patient’s consent to abortion,

101. 464 F.2d 772, 790 (D.C. Cir. 1972). In full, the *Canterbury* court states that “nonfulfillment of the physician’s obligation to disclose alone” does not establish liability. Rather, “[a]n unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable.” *Id.*

102. *Dilation and Curettage: Risks and Benefits*, CLEV. CLINIC, <https://my.clevelandclinic.org/health/treatments/4110-dilation-and-curettage-d--c> [<https://perma.cc/4FHU-VDWQ>] (Mar. 15, 2021).

and the patient subsequently suffers uterine scarring—a manifestation of the undisclosed risk—the physician will be liable under common law.

As noted in Section II.A, however, in states with abortion informed consent statutes, the scope of compelled disclosures is extremely broad. Physicians may be required to tell patients that abortion is correlated with an increased risk of suicide, that medication abortion is reversible, and that fathers have a legal obligation to pay child support, among other things. Under traditional theories of informed consent, a patient could not pursue civil recovery against a physician who failed to disclose this information unless she were injured in a way that was proximately connected to that specific nondisclosure. For example, a patient who chose to have an abortion despite not being told that abortion increases the risk of breast cancer would have a common law right of recovery *only if* she subsequently developed breast cancer. If she suffered other ill effects—physical injury as a result of the abortion, the death of the fetus, or emotional distress—the doctor’s breach would not be actionable, and tort law would provide no remedy.

However, abortion informed consent statutes are drafted so broadly that they do not limit a patient’s recovery to situations in which proximate cause is satisfied. A patient who chose to have an abortion despite not being told that abortion increases the risk of breast cancer would have a statutory right of recovery simply on the basis of that nondisclosure, regardless of the injury she alleged. Not one of the abortion informed consent statutes reviewed by this author requires that an undisclosed risk manifest itself in order for a patient to have a right of recovery against her physician for nondisclosure. In fact, many statutes explicitly identify, as compensable injuries, harms that are unrelated to the information that physicians are required to disclose under state law.

For example, many state statutes provide that a physician’s failure to comply with statutory disclosure requirements will provide a basis for “wrongful death” recovery.¹⁰³ The injury identified is the death of the fetus.¹⁰⁴ Under common law, as described above, the only situation in which a woman would be able to recover for this injury in connection with an informed consent breach would be if the physician failed to disclose that abortion causes the death of the fetus. But the broad language of abortion informed consent statutes has no such limitation.¹⁰⁵ A physician who failed to make a statutorily mandated disclosure that pregnant women are eligible for Medicaid benefits, for example, would be liable for the death of the fetus, a risk that the woman was fully aware of.

Furthermore, some state statutes impose liability on physicians for damages associated with psychological or emotional distress, even in the absence of physical injury. Nebraska’s law, for example, states that “[t]he absence of physical injury shall

103. ALA. CODE § 26-23A-10(3) (2016); NEB. REV. STAT. ANN. § 28-327.07(2) (West 2021); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2016).

104. ALA. CODE § 26-23A-10(3) (2016); LA. STAT. ANN. § 40:1061.29(C)(3) (Supp. 2021); NEB. REV. STAT. ANN. § 28-327.07(2) (West 2021); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2016); *see also* S.D. CODIFIED LAWS § 34-23A-60 (Supp. 2020) (granting a civil remedy for violation of informed consent requirements “in addition to the amounts that the [plaintiff] may be entitled to receive under any common law or statutory provisions, including but not limited to the wrongful death statutes of this state”).

105. *See supra* Section I.A.

not preclude an award of noneconomic damages including pain, suffering, inconvenience, mental suffering, emotional distress, psychological trauma, loss of society or companionship, loss of consortium, injury to reputation, or humiliation associated with the abortion.”¹⁰⁶ Kentucky takes the same approach.¹⁰⁷ Other states explicitly permit recovery for physical injuries and emotional distress but do not limit emotional distress recovery to situations where physical injury has occurred.¹⁰⁸ In states that impose liability for informed consent failures as part of “attempted” abortion, this could mean that a woman who underwent the informed consent process, failed to receive some state-mandated information, and ultimately ended up not terminating her pregnancy would be able to sue her doctor for damages.¹⁰⁹ Once again, this is at odds with the common law of informed consent, which requires proof of physical injury—manifestation of the non-disclosed medical risk—as an element of liability.¹¹⁰

Finally, some abortion disclosure laws permit spouses and/or parents of pregnant women seeking abortions to recover for informed consent violations.¹¹¹ These are

106. NEB. REV. STAT. ANN. § 28-327.11(2) (West 2021).

107. See KY. REV. STAT. ANN. § 311.735(3) (West 2019) (awarding “punitive damages or damages for emotional distress, even if unaccompanied by physical complications”).

108. ARIZ. REV. STAT. ANN. § 36-2153(L)(1) (2018) (referring to damages for “psychological” and “emotional . . . injuries”); KAN. STAT. ANN. § 65-6705(q)(2)(A) (2018) (allowing parents of unemancipated minors to recover for “psychological” injuries caused by informed consent violations); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2016) (referring to “damages for the mental anguish and emotional distress”); WIS. STAT. ANN. § 253.10(6) (West 2015) (referring to damages for “emotional and psychological distress”).

109. See *infra* Section III.C.

110. To be sure, some legal scholars have argued that requiring physical harm for informed consent recovery fails to address the true injury—loss of autonomy in medical decision-making. Some argue that the dignitary harm of being denied key information material to a medical decision should, on its own, be grounds for recovery. See, e.g., Alan Meisel, *A “Dignitary Tort” as a Bridge Between the Idea of Informed Consent and the Law of Informed Consent*, 16 L. MED. & HEALTH CARE 210 (1988); Erin Sheley, *Rethinking Injury: The Case of Informed Consent*, 2015 BYU L. REV. 63 (2015). However, at this point, these arguments remain purely academic. Courts continue to require physical injury as an element of informed consent claims, and this requirement has not been eliminated by statute in any other context besides abortion.

111. See ARIZ. REV. STAT. ANN. § 36-2153(K) (2018) (claim by the “father of the unborn child” if married to the mother, and the “maternal grandparents of the unborn child” if the mother was a minor); IDAHO CODE ANN. § 18-618(1) (West 2016) (claim by “the father of the unborn child” if married to the mother, and “a maternal grandparent of the unborn child” if the mother is deceased); KAN. STAT. ANN. § 65-6705(q)(1) (2016) (claim by the “custodial parent or legal guardian” of a minor); MONT. CODE ANN. § 50-20-307(1) (2019) (claim by “the father” and “the grandparent” of the unborn child if the woman “is under 18 years of age or is physically or mentally incapacitated”); NEB. REV. STAT. ANN. §§ 28-327.04, -327.07 (West 2021) (claim by “the parent or guardian” of a minor); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2016) (claim by “the parent or guardian” of a minor); S.D. CODIFIED LAWS § 34-23A-22 (Supp. 2020) (claim by the parent of a minor); TENN. CODE ANN. § 39-15-208(l) (2016) (claim by “the grandparent of the unborn child” if the mother is a minor or deceased); WIS. STAT. ANN. § 253.10(6) (West 2015) (claim by the “father” and “any grandparent of” of the

persons who are not involved in the informed consent conversation between doctor and patient, are not receiving medical treatment, and have no risk of physical injury as a result of the abortion procedure. Moreover, in some cases, the interests of these parties may be at odds with the interests of the woman seeking the abortion. If the physician performing the abortion fails to disclose any of the state-mandated information, no matter how immaterial it is to the woman's decision, and even if the decision was the woman's own, these third parties will be able to recover for emotional harm and other injuries. In no other context that this author is aware of does an informed consent violation subject a health care provider to liability to someone other than the patient making the treatment choice, let alone a treatment choice that is constitutionally protected from government interference.

These compelled speech laws eliminate the requirement that a plaintiff demonstrate a proximate causal connection between the physician's failure to disclose a medical risk associated with the procedure and the manifestation of that particular risk as a physical injury.

C. Injury and Damages

A final concern about abortion disclosure laws—related to the causation concerns above—is that some could be interpreted to impose liability for informed consent breaches even in the absence of any compensable injury.¹¹²

Many states impose liability on physicians who perform an abortion or “attempted” abortion without making the state-mandated informed consent disclosures.¹¹³ However, the statutes do not define what constitutes an “attempted” abortion. Nor do the statutes explicitly recognize the fact that the practice of informed consent—and the laws requiring it—contemplate the possibility that a patient, after being informed of a procedure's risks and benefits, might choose not to go forward with it.

Imagine, then, a patient who is considering terminating her pregnancy. In accordance with her state's law, the physician engages in an informed conversation with the patient twenty-four hours before the procedure is to be performed. It is possible that after this conversation, for whatever reason, the patient might rethink her choice and decide to continue the pregnancy. If, during the informed consent conversation, the physician failed to make the full disclosures required by state law, there is a possibility that they might face liability, despite the fact that no abortion took place and the patient suffered no physical harm.

As noted above, these informed consent statutes do not define “attempted” abortion. Could the process of engaging in an informed consent conversation with a patient contemplating abortion be considered a physician's “attempt” at abortion? While perhaps unlikely, it is not outside the realm of possibility. One can imagine an anti-abortion advocate seeking out a physician who provides abortions and engaging

unborn child).

112. *See supra* Sections II.B.2 and II.C.

113. *See, e.g.*, IDAHO CODE ANN. § 18-618(1) (West 2016); MINN. STAT. ANN. § 145.4247(1) (West 2017); MONT. CODE ANN. § 50-20-307(2) (2019); NEB. REV. STAT. ANN. § 28-327.04 (West 2021); N.C. GEN. STAT. ANN. § 90-21.88 (West 2020); N.D. CENT. CODE ANN. § 14-02.1-03.2 (West 2017).

in the informed consent conversation with no intent to go forward with the abortion, only for the purpose of identifying flaws in a physician's disclosure for the purposes of establishing liability. Even if a patient suffers no actual injury, many states impose fixed statutory damages on disclosure breaches, separate and apart from any compensatory damages.¹¹⁴ Indeed, the fact that some states explicitly permit abortion informed consent recovery for purely emotional harms in the absence of physical injury¹¹⁵ suggests that they contemplate this possibility.

Another context in which liability might be imposed without physical injury was referenced in Section III.B.2. Many of these statutes allow spouses and/or parents of women seeking abortions to recover for informed consent violations. In such cases, doctors will be liable to third parties who are not their patients, who did not receive medical treatment, and who suffered no physical injury. As previously explained, the common law of informed consent imposes liability only when a patient can prove that they suffered physical injury as a result of an undisclosed medical risk. Allowing spouses and parents of patients to bring informed consent claims without demonstrating any physical injury is at odds with this doctrine.

CONCLUSION

Abortion laws that impose liability on physicians for failing to communicate state-mandated information differ significantly from the traditional common law doctrine of informed consent, as well as statutes establishing general informed consent disclosure duties. They impose liability based on a different set of criteria than are usually applicable in informed consent cases. Perhaps most importantly, they eliminate the requirement that liability be limited to cases where a plaintiff has demonstrated both actual causation and proximate causation. These laws are problematic because they set the stage for future legislation that could, by dismantling the fundamental elements of negligence law, impose liability on defendants in order to achieve political and ideological goals.

114. *See supra* note 72.

115. *See* NEB. REV. STAT. ANN. § 28-327.11(2) (West 2021) (“The absence of physical injury shall not preclude an award of noneconomic damages including pain, suffering, inconvenience, mental suffering, emotional distress, psychological trauma, loss of society or companionship, loss of consortium, injury to reputation, or humiliation associated with the abortion[.]”); KY. REV. STAT. ANN. § 311.735(3) (West 2019) (awarding “punitive damages or damages for emotional distress, even if unaccompanied by physical complications”); *see also* ARIZ. REV. STAT. ANN. § 36-2153(L)(1) (2018) (providing relief in the form of “money damages for all psychological, emotional and physical injuries resulting from the violation”); KAN. STAT. ANN. § 65-6705(q)(2)(A) (2018) (granting a cause of action to parents and guardians of minors without consent, including “money damages for all injuries, psychological and physical, occasioned by the violation of this section”); OKLA. STAT. ANN. tit. 63, § 1-738.3f (West 2016) (recognizing damages including “damages for the mental anguish and emotional distress of the plaintiff”); WIS. STAT. ANN. § 253.10(6)(a) (West 2015) (imposing liability “for damages arising out of the performance or inducement of the abortion, including damages for personal injury and emotional and psychological distress”).