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State Abortion Counseling Policies and the Fundamental Principles of Informed Consent

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Before the U.S. Supreme Court handed down its decision in *Gonzales v. Carhart* this spring, many expected that the justices would limit their discussion to the constitutionality of the federal Partial-Birth Abortion Ban Act, specifically in light of the law's lack of an exception for cases in which the procedure may be medically necessary to protect the pregnant woman's health. But that was by no means all that the Court proffered.

However indirectly, Justice Anthony M. Kennedy's majority opinion also moved the Court—and likely the future of the abortion debate in the states—to the very heart of the issue of informed consent. Replete with paternalistic and moralistic pronouncements, Kennedy's opinion asserts the "reality" that "respect for human life finds an ultimate expression in the bond of love the mother has for her child." Although forthrightly acknowledging the existence of "no reliable data to measure the phenomenon," it nonetheless labels "unexceptionable" the conclusion that "some women come to regret their choice to abort the infant life they once created and sustained." In turn, it suggests that this may be the result of the information women receive, or do not receive, prior to consenting to the procedure. "It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form."

Kennedy's implication that the preabortion counseling process could and perhaps should be used as a forum for dissuading a woman from having the procedure is widely viewed as an invitation to states to take a new look at their abortion-specific "informed consent" policies. In response, states could adopt policies requiring that women hear lurid descriptions of various abortion procedures along the lines of the lengthy, highly rhetorical descriptions of the dilation and extraction procedure Kennedy used several times in his majority opinion. In addition, they could move to require (as several states already do) that women be given information about abortion and its physical and mental health consequences that is scientifically unsupportable or discredited—and perhaps do so with impunity, in light of the Court's newly articulated doctrine of giving deference to legislatures, rather than to the weight of the evidence, in cases of medical disagreement. All of this could occur, despite the fact that use of the informed consent process in this way clearly runs counter to fundamental ethical principles that have long guided the practice of medicine.

Principles of Informed Consent

Under English common law, medical treatment without first having obtained the patient's consent was considered a form of battery. Beginning in the 1950s, courts in the United States have articulated and developed a requirement that health care providers must not only obtain patients' consent, but also take steps, through a process of disclosure and dialogue, to ensure that the consent they obtain is "informed."

Nearly a quarter century ago, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral

Research conducted what is widely regarded as one of the most authoritative reviews of the issue and its ethical and legal foundations. Created by Congress in 1978, the panel—whose members included leading experts in research, law, medicine and medical ethics—was tasked with studying "the ethical and legal implications of the requirements for informed consent." After hearing from numerous experts and conducting five separate hearings, the commission transmitted its report to President Reagan and Congress in 1982. In its report, the commission concluded that informed consent rests on three closely interrelated elements: Patients must possess the capacity to make decisions about their care; their participation in these decisions must be voluntary; and they must be provided adequate, appropriate information to make the decisions before them.

The issue of who is capable of making decisions related to abortion has been the subject of much public discourse since *Roe v. Wade,* with extensive legislation and litigation having occurred around the question of mandating parental involvement in a minor's abortion decision. The other two elements of informed consent have received less explicit attention in the context of abortion, but their significance is no less important.

Central to the commission's concept of informed consent is the requirement that participation be voluntary. "A choice that has been coerced, or that resulted from serious manipulation of a person's ability to make an intelligent and informed decision, is not," concluded the commission, "the person's own free choice." This fundamental principle—that the patient has a right to make his or her own decisions about medical care free from coercion—is embodied in the basic standards of the nation's leading professional medical organizations, including the American Medical Association, the American College of Surgeons and the American College of Obstetricians and Gynecologists.

The final element of informed consent—that patients should have access to the information they need to make the decisions that are theirs to make—is also fundamental to the ethical practice of medicine. Although there are several variations to this general standard of disclosure, most embody the concept that physicians should provide the information that a patient would consider germane to making a decision about his or her course of action. According to the commission, key elements of the disclosure required by physicians include the nature, risks and benefits of the procedure, as well as the availability of alternatives.

Together, the three elements buttress the fundamental goal of the entire informed consent process: protection of personal well-being and individual autonomy. In this, the commission was clear and explicit: Individuals are "entitled to accept or reject health care interventions on the basis of their own personal values and in furtherance of their own personal goals."

Information for Women Seeking Abortion

Either by statute or judicial precedent, all states require health care providers to obtain consent from patients prior to performing a nonemergency medical procedure, according to R. Alta Charo, professor of law and bioethics at the University of Wisconsin Law School. Generally, these requirements go no further than mandating that providers give patients information on the procedure, risks and alternatives. As is so often the case, however, the situation is vastly different when it comes to abortion, with many state laws including specific and detailed requirements for obtaining consent for an abortion on top of the general requirements already existing in the state. Ironically, these mandates often do little to further the underlying values of the consent process, and sometimes are even directly at odds with them.

Currently, 33 states have some law or policy specifically related to informed consent for abortion (see table). In 10 of these states, the abortion-specific law mandates the same types of information generally involved in the informed consent process, such as a description of the procedure to be performed (col. 3) and information on the gestational age of the fetus (col. 5).

The laws in the remaining 23 states, however, are wholly different, and include at least some

STATE POLICY ON INFORMED CONSENT FOR ABORTION

	State-Developed Written Materials Given or Offered (1)	Women Informed That Consent Cannot Be Coerced (2)	Description of Procedures		Fetal Development		Ultrasound	
			Information about specific procedure (3)	Descriptions of all common procedures (4)	Information on gestational age of fetus (5)	Descriptions of fetal development throughout pregnancy (6)	Information about how to access ultrasound services (7)	Required, and provider must offer woman opportunity to view image (8)
States with Detailed Abortion-Specific Informed Consent Requirements (23 states)								
Alabama	G	V,W	V	W	V	W	–	X
Alaska	O	–	V	W	V	W	–	–
Arkansas	O	V,W	V	W	V	W	–	‡
Georgia	O	–	V	W	V	W	V**	‡
Idaho	G	–	V	W	–	W	–	‡
Kansas	G	W	V	W	V	W	–	–
Kentucky	O	–	V	–	V	W	–	–
Louisiana	G	W	V	W	V	W	–	X
Michigan	G	–	V,W	–	V,W	–	W†	‡
Minnesota	O	–	V	W	V	W	–	–
Mississippi	O	–	V	–	V	W	–	X
Nebraska	O	–	V	W	V	W	–	–
North Dakota	O	–	V	–	V	W	–	–
Ohio	G	–	V	–	V	W	–	–
Oklahoma	O	–	V	W	V	W	V,W	–
Pennsylvania	O	W	V	W	V	W	–	–
South Carolina	O	–	V	W	V	W	–	–
South Dakota	O	–	V	W†	V	W	–	–
Texas	O	–	V	W†	V	W	–	–
Utah	G	W	V	W	V	W	V	–
Virginia	O	–	V	W	V	W	–	–
West Virginia	O	W†	V	W	V	W	–	–
Wisconsin	O	W	V	W	V	W	V,W	–
States with Customary Informed Consent Provisions (10 states)								
California	–	–	V	–	–	–	–	–
Connecticut	–	–	V	–	V	–	–	–
Delaware	–	–	V	–	V	–	–	–
Florida	–	–	V	–	V	–	–	–
Indiana	–	–	V	–	V	–	V	–
Maine	–	–	V	–	V	–	–	–
Missouri	–	–	V	–	–	–	–	–
Nevada	–	–	V	–	V	–	–	–
Rhode Island	–	–	V	–	V	–	–	–
Tennessee	–	–	–	–	V	–	–	–
U.S. TOTAL	**23**	**8**	**32**	**18**	**30**	**22**	**6**	**3***

G= given; O= offered; V= verbal; W= written. *Three states without informed consent policies but with other relevant laws are not included in this table. Arizona and Florida laws require ultrasounds whenever an abortion is performed after the first trimester. Illinois law requires that a woman obtaining an abortion after viability be given the option of providing anesthesia to the fetus. †Included absent a specific requirement in the statute. ‡If an ultrasound is provided as part of the preparation for the abortion, then the physician must offer the woman the opportunity to view it.

information not in keeping with the fundamental tenets of informed consent. In these states, the statute requires providers to impart some information verbally to women seeking an abortion. In addition, it directs the state health agency to develop written materials containing specific, detailed information that either must be given to all women seeking an abortion or must be offered to women, who may choose whether to take them (col. 1). (In many states, the materials are made available publicly on the agency's Web site.) Interestingly, in four of these states (Mississippi, Nebraska, North Dakota and Ohio) the statute specifically allows physicians to disassociate themselves from the materials, although they are still required to provide them to patients.

A prior Guttmacher Institute analysis examined the content of the written materials developed by the state agencies (related article, Fall 2006, page 6). Following a comprehensive review conducted in the summer of 2007 of both the oral and written information states require abortion providers

Health Risks of Abortion						Information on Ability of Fetus to Feel Pain (15)	Additional Resources		
Future Fertility		Breast Cancer		Mental Health					
Accurately portrays risk (9)	Inaccurately portrays risk (10)	Correctly reports no link (11)	Inaccurately asserts possible link (12)	Correctly reports range of emotional responses (13)	Describes only negative emotional responses (14)		Information on services for pregnant & parenting women (16)	Contact information for crisis pregnancy centers (17)	
–	–	–	–	W†	–	–	W	W†	**Alabama**
W†	–	–	W†	W	–	W	W†	W†	**Alaska**
W†	–	–	–	W	–	V§,W	V,W	W†	**Arkansas**
W†	–	–	–	W	–	V,W	V,W	W†	**Georgia**
V	–	–	–	W†	–	–	W	W†	**Idaho**
W†	–	–	W†	W†	–	–	V,W	W†	**Kansas**
–	–	–	–	–	–	–	V,W	W†	**Kentucky**
W†	–	–	–	W†	–	V**	V,W	W†	**Louisiana**
–	–	–	–	–	W	–	–	–	**Michigan**
V,W†	–	V,W†	–	W	–	V§,W	V,W	W†	**Minnesota**
V,W†	–	V	W†	–	–	–	V,W	W†	**Mississippi**
V,W†	–	–	–	–	W	–	V,W	W†	**Nebraska**
V	–	–	–	–	–	–	V,W	W†	**North Dakota**
–	–	–	–	–	–	–	V,W	W†	**Ohio**
W†	–	–	W†	W	–	V§,W	V,W	W†	**Oklahoma**
W†	–	–	–	W	–	–	V,W	W†	**Pennsylvania**
W†	–	–	–	–	W†	–	V,W	W†	**South Carolina**
V	W†	–	–	–	W†	W†	V,W	W†	**South Dakota**
V	W	V	W	–	W†	W†	V,W	W	**Texas**
–	–	–	–	–	W	–	V,W	W†	**Utah**
–	–	–	–	W	–	–	V,W	W†	**Virginia**
V	–	–	W†	–	W	–	V,W	W†	**West Virginia**
V,W	–	–	–	V,W	–	–	V,W	W†	**Wisconsin**
–	–	–	–	–	–	–	V	–	**California**
–	–	–	–	–	–	–	–	–	**Connecticut**
–	–	–	–	–	–	–	V	–	**Delaware**
–	–	–	–	–	–	–	–	–	**Florida**
–	–	–	–	–	–	–	–	–	**Indiana**
–	–	–	–	–	–	–	–	–	**Maine**
–	–	–	–	–	–	–	–	–	**Missouri**
–	–	–	–	††	–	–	–	–	**Nevada**
–	–	–	–	–	–	–	–	–	**Rhode Island**
–	–	–	–	–	–	–	V	–	**Tennessee**
17	**2**	**3**	**6**	**12**	**7**	**8***	**25**	**22**	**U.S. TOTAL**

§Information given only to women who are at least 20 weeks' gestation. **The law was enacted in 2007 and also requires the information to be included in the written materials; however, the materials have not yet been updated. ††Law requires discussion of emotional impact of abortion. *Note:* The chart reflects laws and policies that are in effect as of October 1, 2007.

to offer women, this article updates and builds upon the earlier analysis.

Voluntary Participation

In eight of the 23 states with detailed requirements, a woman seeking an abortion is specifically informed that her decision must be voluntary and that her consent may not be the result of coercion (col. 2). In these eight states, and indeed in all of the 23 states with detailed requirements, state law requires that consent for any medical procedure be voluntary.

Abortion Procedures

All 23 states require that the woman be given information about the specific abortion procedure she is about to undergo (col. 3). But in 18 of the states, the written materials include descriptions of the range of common abortion procedures (col. 4). By mandating information about a range of abortion procedures performed at various points in gestation, the materials include information nongermane to individual women. (Although the process of making a decision may take longer for some women than others, nearly

nine in 10 women who have an abortion do so in the first trimester, making descriptions of abortion procedures performed later in pregnancy irrelevant to most women.)

That said, when describing these abortion procedures, the written materials in 14 of the 18 states are along the lines of what would generally be provided patients in advance of surgery. For example, the Minnesota materials describe a vacuum aspiration abortion as one in which "the opening of the cervix is gradually stretched with a series of dilators. The thickest dilator used is about the width of a fountain pen. A tube is inserted into the uterus and is attached to a suction system that will remove the fetus, placenta and membranes from the woman's uterus."

Four states—Idaho, Oklahoma, South Dakota and Texas—take a different tack. Each uses graphic, inflammatory language to describe later abortion procedures similar to that used in Justice Kennedy's majority opinion in *Carhart.* Notably, these requirements were all adopted prior to that decision.

Fetal Development

Of the 23 states, all but Idaho require that a woman considering abortion be told the approximate gestational age of the fetus she is carrying (col. 5). In all but one state, however, the written materials given the woman include information on fetal development throughout pregnancy (col. 6). (Only Michigan tailors the information, at least on its Web site, so that a woman receives just the information relevant to her pregnancy.) Typically, this information includes pictures at two-week increments. With nearly 90% of all abortions occurring at or before 12 weeks, information on the development of a fetus after that point is generally not germane to most patients.

In many of the states, the written materials include detailed descriptions of fetal development. All the states include at least some essentially objective information, such as the size or weight of a fetus at various stages. But in their descriptions of the fetus, many states use loaded language in an apparently deliberate attempt to "personify" the fetus. For example, the North Dakota materials note that fetus is "a Latin word meaning young one or offspring." The materials also say that at 10 weeks' gestation, the fetus "now has a distinct human appearance" and that "eyelids are formed." At 14 weeks, according to the materials, the fetus "is able to swallow" and "sleeps and awakens."

Since 1996, some states have looked to the provision of information about ultrasound as yet another way to attempt to personify the fetus. Viewing an ultrasound image, according to Rep. Greg Delleney (R), lead sponsor of legislation in South Carolina this year, would enable the woman to "determine for herself whether she is carrying an unborn child deserving of protection or whether it's just an inconvenient, unnecessary part of her body." Thirteen states have a requirement related to ultrasound. (Ten of these are among the 23 states with detailed consent requirements, Indiana has an otherwise customary informed consent law, and Arizona and Florida have a requirement in the context of their abortion clinic regulations.) In six of the 13 states (col. 7), women are told how to obtain an ultrasound should they want to obtain one. In two of these six states (Georgia and Michigan), as well as in Arkansas and Idaho, providers must give the woman the opportunity to view the image whenever an ultrasound is performed prior to an abortion.

The informed consent policies in three states affirmatively require ultrasound provision, a requirement that can add $50–$200 to the cost. In Alabama, Louisiana and Mississippi, the law requires providers to perform an ultrasound prior to all abortions, even though the procedure is generally not considered medically necessary before a first-trimester abortion. (In addition, the abortion clinic regulations in Arizona and Florida require ultrasounds whenever an abortion is performed after the first trimester.)

Health Risks

A basic requirement of the informed consent process is that patients be given information about the potential risks of a procedure they are considering. Central to that mandate is that the information that patients are given is accurate.

Against that backdrop, it is useful to measure the content of the state abortion counseling requirements against the current state of medical knowledge.

Future fertility. According to a 2000–2001 Guttmacher Institute survey, about half of women having an abortion plan to have children in the future, and another one in five are unsure of their intentions. Any negative effect of abortion on women's future fertility, therefore, is critical. The overwhelming scientific consensus, however, is that vacuum aspiration—the most common first-trimester procedure—poses virtually no long-term risk of infertility, ectopic pregnancy, spontaneous abortion or congenital malformation. (Repeat early abortion, in and of itself, seems to pose little or no risk, although the literature is less extensive.) Some studies suggest that second-trimester abortion using dilation and evacuation may pose some increased risk of complication in future pregnancies; however, medical advances appear to have reduced the likelihood of these complications.

Most of the 23 states' laws and materials accurately reflect this scientific consensus (col. 9). In South Dakota, however infertility is included without any qualification on the list of potential risks of abortion. For their part, the Texas materials state flatly that abortion-related complications "may make it difficult or impossible to become pregnant in the future or to carry a pregnancy to term."

Breast cancer. Antiabortion activists continue to assert as fact that having an abortion leads to an increased risk of developing breast cancer later in life. For many years, whether or not this was true was an open question; however, after convening the world's leading experts to assess all of the extant studies, the National Cancer Institute (NCI) issued a categorical statement in early 2003: "Induced abortion is not associated with an increase in breast cancer risk." NCI categorized the determination as "well-established," its highest rating. A similar investigation conducted in 2004 by a panel convened by the British government came to the same conclusion.

Nonetheless, the written materials in six states inaccurately assert that the data are inconclusive and that a link may exist between having an abortion and developing breast cancer (col. 12). It is distressing that two of these states are Mississippi and Texas, in which state law specifically requires that women be given "medically accurate" information verbally concerning abortion and breast cancer.

Psychological impact. Abortion opponents also claim that having an abortion increases a woman's chances of experiencing a barrage of negative mental health outcomes later in life. The notion that having an abortion is psychologically riskier for a woman than delivering and parenting a child she did not intend to have or placing a baby for adoption is not supported by the evidence. The most methodologically sound research conducted over the past two decades does not find a causal relationship between abortion and severe negative mental health outcomes. In fact, according to a study published in the *Archives of General Psychiatry* in 2000, the best indicator for a woman's mental health after an abortion is her mental health before the abortion. A review of the mental health literature by the American Psychological Association in 1989, as summarized in the Guttmacher Institute's May 2006 report, *Abortion in Women's Lives,* found that women generally feel the most distress before an abortion; after an abortion, women frequently report feeling "relief or happiness" (related article, Summer 2006, page 8).

In 12 of the 19 states in which the topic is addressed in the states' written abortion-counseling materials, women seeking an abortion are told that a woman may feel a range of emotions after the abortion, from sadness to relief (col. 13). The materials in the remaining seven states focus mostly on the likelihood of negative feelings after an abortion (col. 14). In four states—South Dakota, Texas, Utah and West Virginia—the materials go so far as to assert either that a woman may experience suicidal thoughts or that she will suffer from "postabortion traumatic stress syndrome," a disorder recognized by neither the American Psychological Association nor the American Psychiatric Association.

Fetal Pain

Abortion opponents increasingly are advocating that some or even all women considering abortion be given information about the ability of a fetus to feel pain—information that is generally irrelevant to their situation and, in most cases, is not supported by scientific research. A recent review of the literature published in the *Journal of the American Medical Association* concluded that the necessary physical structures to perceive pain develop between 23 and 30 weeks' gestation. However, the review also concluded that the limited data available suggest that a fetus is unlikely to have the ability to transmit and interpret sensory information until at least 29 weeks' gestation.

Currently, some or all women considering abortion in eight states are provided information about the ability of a fetus to feel pain (col. 15). In three of these states (Arkansas, Minnesota and Oklahoma), women who are having the procedure at or after 20 weeks' gestation must be given the information verbally. (Nationally, about 1% of all women having abortions do so at 21 weeks or later.) But in all eight states, the legislature mandates that the information be included in the written materials given to all women seeking an abortion, regardless of gestational age.

None of the state-developed materials comport with the current medical literature. Those in Alaska and Minnesota say that experts differ over whether a fetus can feel pain at 20 weeks' gestation. In Arkansas, Georgia and Oklahoma, they say that at 20 weeks' gestation, "the unborn child has the physical structures necessary to experience pain." The Texas materials first assert that some experts believe the capacity for pain is not developed until 20 weeks, but then conclude that whether the fetus can feel pain as early as 12 weeks is "unknown." In South Dakota, meanwhile, the materials simply state that an "unborn child may feel physical pain" without any reference to gestational age. (The written materials to implement Louisiana's mandate, enacted in July, have not yet been developed.)

Alternatives

Along with information about abortion, women in all 23 states receive information, either orally or in writing, about childbirth. In all of these states, women are told about the medical risks of pregnancy and childbirth, often including discussion of the likelihood and consequences of such topics as diabetes, high blood pressure, infection and premature labor. In nine states, the information also includes material on postpartum depression.

In all the states with written materials except Michigan, information about the availability of services relating to alternatives to abortion is included (col.16). Much of this information is in line with the accepted notion of providing patients information on their options, and includes contact information for a range of support services for pregnant and parenting women, including adoption services, financial assistance, child care, health services and prenatal care. The referral information can be as brief as referring the woman to a toll-free hotline or as detailed as a list of specific organizations.

However, in these same states, the materials refer women to antiabortion "crisis pregnancy centers" (col. 17) that deceptively claim to provide women facing an unintended pregnancy with a wide range of support services, including abortion counseling, information on adoption, parenting classes, and assistance with baby clothes and other supplies. Two separate 2006 reports—released by Rep. Henry Waxman (D-CA) and the National Abortion Federation—found that these centers frequently fall short of their claims, often by providing false or misleading information aimed at dissuading pregnant women from seeking an abortion. Significantly, only the materials in Georgia and Wisconsin acknowledge that the centers do not provide services related to abortion.

Looking Ahead

Although the concept of informed consent has a firm foundation in law, it is, as the President's Commission concluded, "essentially an ethical imperative." Unfortunately, the abortion counseling provided by states, both orally and in writing, falls short of these fundamental ethical principles. These violations of the ethical precepts vary.

By containing incomplete or inaccurate information, the materials in many states are what Tom Beauchamp, professor of philosophy and senior research scholar at Georgetown University's Kennedy Institute of Ethics, and James Childress, professor of ethics and director of the Institute for Practical Ethics and Public Life at the University of Virginia, would consider "informational manipulation"—an attempt to use information to influence a patient's choice. "Many forms of informational manipulation," they wrote in their seminal 2001 textbook, *Principles of Biomedical Ethics,* "are incompatible with autonomous decision-making. For example, deception that involves lying, withholding information and misleading exaggeration to lead persons to believe what is false are all inconsistent with autonomous choice."

Materials that inaccurately portray the health risks of abortion, such as those that exaggerate the risks of breast cancer, psychological harm or damage to a woman's ability to have a future healthy pregnancy, inappropriately seek to steer a woman's decision. Materials that contain lurid descriptions of abortion procedures or that use language clearly aimed at personifying the fetus have this same goal as well.

Similarly, many of the state-developed materials contain information that is not relevant to an individual woman and unrelated to her ability to make an informed decision in her individual circumstances. "Professionals should recognize, and lawyers and courts should perhaps be reminded," cautioned the President's Commission, "that patients' interests are not well served by detailed technical expositions of facts that are germane neither to patients' understanding of their situations nor to any decisions that must be made. Such recitations are not legally required, nor should they be."

Most frequently, the materials run afoul of this basic element of informed consent by crafting a one-size-fits-all message to be delivered to every woman, regardless of when in gestation she is contemplating an abortion. With nearly all abortions occurring in the first trimester, information on either fetal development or abortion procedures performed later in gestation are clearly irrelevant under most circumstances. Even more disturbing, perhaps, are recent requirements that women obtaining abortions even very early in pregnancy be given information about fetal pain, notwithstanding that the fetus is unlikely to have the capacity to perceive pain until well into the third trimester.

Given the Court's actions in *Carhart* and the tacit invitation in Justice Kennedy's majority opinion, it is overwhelmingly likely that preabortion counseling requirements will be a subject of continuing, perhaps intensifying, debate when the state legislatures convene again in January. Already, some state legislatures appear eager to take up the challenge; proposals to mandate the provision of inaccurate information on fetal pain or to require a woman to view an ultrasound image in an acknowledged attempt to personify the fetus were proliferating even before the Court's decision.

One key question is how far the Court, having already shown a growing antipathy toward abortion, may be willing to diverge from the principles of informed consent in considering any new state laws that come before it. With the Court having signaled its willingness to accept requirements aimed at influencing rather than informing a woman's decision, as well as those premised on data that have not been fully vetted by or are outside of the scientific consensus, the signs are ominous indeed.

A prior, key question, of course, is how many of these proposals might be blocked in the first place. With the Court unlikely to be a backstop against even particularly egregious requirements, the stakes in the outcome of these debates are huge—for reproductive rights advocates, for those who care deeply about the principles of informed consent that have long been the foundation of the ethical practice of medicine, and, most importantly, for women coping with unplanned pregnancies whose well-being may depend on the successful efforts of both.

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