Who Decides?: Informed Consent Doctrine Applied to Denial of Reproductive Health Care Information at Crisis Pregnancy Centers

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ABSTRACT: Crisis pregnancy centers are largely religiously affiliated organizations that advertise pregnancy support but often do not provide full and accurate information about abortion or contraception. Often attacked for false advertising and operating without medical licenses, crisis pregnancy centers recently have begun converting to medical centers with medical staff on site. Since medical providers owe additional duties to their patients, crisis pregnancy centers operated by medical staff must follow additional procedures, such as providing informed consent. Informed consent doctrine is based on the idea of autonomous decision-making and requires medical providers to accurately inform patients of their viable medical options. Even though crisis pregnancy centers often fail to inform people about critical reproductive health care, people who visit crisis pregnancy centers still would have difficulty bringing a claim of informed consent against these centers. Applying informed consent doctrine to crisis pregnancy centers highlights the discrepancy between the philosophical purpose of informed consent and the doctrine in practice today. Courts should loosen the causation and injury requirements for informed consent doctrine, at least in reproductive health care cases. Making this change would be the first step in holding crisis pregnancy centers accountable and could help courts more accurately apply reproductive-specific tort claims generally.

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[T]he doctrine of informed consent, if it is to enhance patients' participation in decision-making, must confront the question: Who decides?[1]

I. INTRODUCTION

At Informed Choices Medical Clinic in Iowa City, Iowa, a person can consult on general reproductive health care with a medical provider.[2] However, the consultation will generally exclude full and complete information about abortion procedures or contraception.[3] This clinic is not unique; over 2,500

1. Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 142 (1977) [hereinafter Katz, *A Fairy Tale*].

2. *Our Services*, INFORMED CHOICES MED. CLINICS [hereinafter *Our Services*, INFORMED CHOICES], https://www.informedchoicesclinic.com/services [https://perma.cc/PUL7-S3SF].

3. *Id.*; *see also* Amy G. Bryant & Erika E. Levi, *Abortion Misinformation from Crisis Pregnancy Centers in North Carolina*, 86 CONTRACEPTION 752, 754 (2012) (analyzing North Carolina crisis pregnancy centers and finding that "[w]hether in-person, over the phone or through their Web sites, the centers presented here often overstated or gave false information about the physical and psychological risks of abortion"); Melanie Zurek & Jenny O'Donnell, *Abortion Referral-Making in the United States: Findings and Recommendations from the Abortion Referrals Learning Community*, 100 CONTRACEPTION 360, 361 (2019) (analyzing recent abortion referral studies, not limited to just crisis pregnancy centers, and finding that "a third or more of [providers who responded to a survey] typically report[] that they do not refer for abortion and as many as 1 in 6 report[] active dissuasion"); Andrea Swartzendruber, Riley J. Steiner & Anna Newton-Levinson, *Contraceptive*

centers that claim to be specifically dedicated to reproductive health across the United States fail to provide information about basic reproductive health care procedures.[4] These centers, often called crisis pregnancy centers,[5] are generally nonprofit religious organizations whose mission is to convince people[6] to carry their pregnancies to term.[7] While the practices at these centers impact any person who visits a crisis pregnancy center, they disproportionately impact low-income women, women of color, and LGBTQIA+ and non-gender conforming people.[8] Crisis pregnancy centers outnumber

Information on Pregnancy Resource Center Websites: A Statewide Content Analysis, 98 CONTRACEPTION 158, 158 (2018) (analyzing crisis pregnancy center websites in Georgia and finding that they "emphasized contraceptive failure and minimized effectiveness . . . [with] a high degree of inaccurate and misleading information about contraceptives").

4. *See* Ramiro Ferrando, *While Abortion Clinics Diminish, Crisis Pregnancy Centers Flourish*, MIDWEST CTR. FOR INVESTIGATIVE REPORTING (Feb. 19, 2019), https://investigatemidwest.org/2019/02/19/while-abortion-clinics-diminish-crisis-pregnancy-centers-flourish [https://perma.cc/TW96-F5UF] (showing in a chart the discrepancy between abortion clinics and crisis pregnancy centers, with many states having much higher ratios of crisis pregnancy centers and very few abortion clinics); *see also Identify CPCs*, CRISIS PREGNANCY CTR. MAP, https://crisispregnancycentermap.com/?view=map [https://perma.cc/ZP39-7WM2] (identifying crisis pregnancy center locations in the United States). The author is unaware of any study that analyses all medical providers, across hospitals, medical centers, and clinics, to determine the ratio of providers who provide information about both abortion and contraception to providers who do not, so the true extent of the lack of care is unknown.

5. The term "crisis pregnancy center" will be used throughout for consistency, since most scholarly articles use this term, although some crisis pregnancy centers consider themselves "pregnancy resource centers." *See* CARE NET, THE TRUTH ABOUT "CRISIS PREGNANCY CENTERS" 2 (2019) [hereinafter CARE NET, CRISIS PREGNANCY CENTERS], https://www.carenet.org/hubfs/Downloads/The_Truth_About_Crisis_Pregnancy_Centers.pdf?hsCtaTracking=a06cb313-a1fe45c0-813a-236ab3c8fbfe%7C19a83cca-5f9e-4352-8c70-bb7f26222f7c [https://perma.cc/G7ZA-L54Y].

6. This Note attempts to be gender inclusive of anyone who is impacted by reproductive health care decisions related to childbirth. *See* Sharon Muza, *Series: Welcoming All Families - Using Gender-Neutral Language in Birth Classes*, LAMAZE INT'L (Nov. 13, 2018), https://www.lamaze.org/Connecting-the-Dots/series-welcoming-all-families-using-gender-neutral-language-in-birth-classes [https://perma.cc/6KAA-BC6Y].

7. *See About NIFLA*, NAT'L INST. OF FAM. & LIFE ADVOCS. [hereinafter *About NIFLA*], https://nifla.org/about-nifla [https://perma.cc/89BX-XDHA] ("The National Institute of Family and Life Advocates (NIFLA) exists to protect life-affirming pregnancy centers that empower abortion-vulnerable women and families to choose life for their unborn children."); *Option Line*, HEARTBEAT INT'L [hereinafter *Option Line*, HEARTBEAT], https://www.heartbeatinternational.org/our-work/option-line [https://perma.cc/EC5F-HJGY] ("We [rescue] those who are reached through our life-support network of pregnancy centers providing true reproductive health care, ministry, education, and social services where lives are saved and changed.").

8. *See* Meaghan Winter, *The Stealth Attack on Abortion Access*, N.Y. TIMES (Nov. 12, 2015), https://www.nytimes.com/2015/11/12/opinion/the-stealth-attack-on-abortionaccess.html?partner=rss&emc=rss&_r=1 [https://perma.cc/K27H-DC3F]; Hilary Weaver, *Crisis Pregnancy Centers Are Hurting Women of Color*, SUPERMAJORITY NEWS (Jan. 8, 2020), https://supermajority.com/2020/01/crisis-pregnancy-centers-are-hurting-women-of-color [https://perma.cc/8U75-SA8T]; *see* Heidi Moseson et al., *Abortion Experiences and Preferences of Transgender, Nonbinary, and Gender-Expansive People in the United States*, 224 AM. J. OBSTETRICS & GYNECOLOGY 376.e1, 376.e3–.e6 (2021); *see* Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*,

abortion clinics three-to-one (or more), and many people live in a county without access to all reproductive medical services.[9]

When operated by non-medical providers, crisis pregnancy centers have been criticized for misleading people into believing they were seeing qualified medical professionals.[10] Now these clinics are increasingly converting to medical centers.[11] Crisis pregnancy centers operated by medical providers have increased responsibility, including a duty to obtain informed consent from patients. Informed consent is a doctrine that holds medical providers liable for a failure to fully inform patients about their medical options.[12]

People unaware of the limited scope of medical options at crisis pregnancy centers cannot "make an informed decision about [their] own care."[13] Crisis pregnancy centers' failure to provide full and accurate information about these services when operated by a medical provider should be liable for failure to meet informed consent standards. The Journal of Ethics for the American Medical Association has published scholarship that admits "[t]he counseling

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124 YALE L.J. 2516, 2572–74 (2015) (discussing the issue with health care refusals and the impact on the LGBT community). The additional issues of access to reproductive health care that these populations face is outside the scope of this Note.

9. *See* Ferrando, *supra* note 4 (providing data that there were 2537 crisis pregnancy centers to 780 abortion clinics in the United States in 2019); *Data Center*, GUTTMACHER INST., https://data.guttmacher.org/states/table?state=US&dataset=data&topics=58+59 [https://perma.cc/W3YR-8YST]. According to the Guttmacher Institute, in 2017, 38 percent of women aged 15–44 lived in a county without any known abortion provider and 89 percent of counties in the United States do not have a known abortion provider. *Id.*

10. *See* LISA MCINTIRE, NARAL PRO-CHOICE AM., CRISIS PREGNANCY CENTERS LIE: THE INSIDIOUS THREAT TO REPRODUCTIVE FREEDOM 2–4 (2015), https://www.prochoiceamerica.org/wp-content/uploads/2017/04/cpc-report-2015.pdf [https://perma.cc/G7XZ-2ZKB]; *see also* NARAL PRO-CHOICE AM., THE TRUTH ABOUT CRISIS PREGNANCY CENTERS 1 (2017) [hereinafter NARAL, THE TRUTH ABOUT CRISIS PREGNANCY CENTERS], https://www.prochoiceamerica.org/wp-content/uploads/2016/12/6.-The-Truth-About-Crisis-Pregnancy-Centers.pdf [https://perma.cc/6HWB-ZJLD] ("Many CPCs intentionally misinform and mislead women seeking pregnancy-related information."); *So-Called "Crisis Pregnancy Centers,"* PLANNED PARENTHOOD (Aug. 2007), https://www.plannedparenthood.org/about-us/our-leadership/clergy-advocacy-board/our-values/crisis-pregnancy-centers [https://perma.cc/S79H-EAL5] (noting that the Planned Parenthood Federation of America Clergy Advocacy Board (CAB) "strongly oppose[s] so-called 'crisis pregnancy centers' (CPCs) because of the biased and often inaccurate and misleading information they provide to women seeking honest information about birth control and abortion").

11. Sandy Christiansen, *Medical Q&A: "Can We Just Do Ultrasounds Without Becoming a Medical Clinic?"*, CARE NET [hereinafter Christiansen, *Medical Q&A*], www.care-net.org/center-insights-blog/medical-qanda-ultrasounds [https://perma.cc/5KSF-78U6] (explaining that "pregnancy centers are frequently the target of attacks and accusations of being 'fake clinics,'" and therefore they want to convert to medical centers); *Are We a Medical Clinic?*, HEARTBEAT INT'L [hereinafter *Are We a Medical Clinic?*, HEARTBEAT], https://www.heartbeatinternational.org/are-we-a-medical-clinic [https://perma.cc/6MEE-HHLB]; *Medical Clinic Conversion*, NAT'L INST. OF FAM. & LIFE ADVOCS. [hereinafter *Medical Clinic Conversion*, NIFLA], https://nifla.org/medical-clinic-conversion [https://perma.cc/A6ZH-KJRQ].

12. 3 BARRY A. LINDAHL, MODERN TORT LAW: LIABILITY AND LITIGATION § 24:41 (2d ed., 2020).

13. Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J.L. & MED. 85, 100 (2016).

provided on abortion and contraception by [crisis pregnancy centers] falls outside accepted medical standards and guidelines for providing evidence-based information and treatment options."[14] Similarly, "[t]he Society for Adolescent Health and Medicine and the North American Society for Pediatric and Adolescent Gynecology . . . [a]ssert that crisis pregnancy centers pose risk by failing to adhere to prevailing medical standards of sexual and reproductive health care and informed consent."[15]

People wishing to sue crisis pregnancy centers under informed consent doctrine, however, would face issues bringing a claim.[16] This Note demonstrates the disconnect between informed consent in theory and in practice when applied to crisis pregnancy centers.[17] Because of this disconnect, this Note proposes rethinking the causation and injury elements of informed consent doctrine in reproductive rights cases.[18] Part II discusses how the medical community views abortion and contraception as essential reproductive health care. Part III details the practices at crisis pregnancy centers and their recent push to convert to medical centers with licensed providers. Part IV discusses the underlying ethics of informed consent, the history in the courts, and the current elements to bring an informed consent claim. Part V looks at two elements—causation and injury—and the issues with applying these elements to crisis pregnancy centers. It also explains some recent scholars' solutions to these issues. Part VI proposes changing these two problematic elements of informed consent specifically for reproductive rights cases. By rethinking the standards of informed consent in reproductive rights cases, the doctrine can better fit its philosophical roots.

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14. Amy G. Bryant & Jonas J. Swartz, *Why Crisis Pregnancy Centers Are Legal but Unethical*, 20 AMA J. ETHICS 269, 271 (2018).

15. Andrea Swartzendruber et al., *Crisis Pregnancy Centers in the United States: Lack of Adherence to Medical and Ethical Practice Standards; A Joint Position Statement of the Society for Adolescent Health and Medicine and the North American Society for Pediatric and Adolescent Gynecology*, 32 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 563, 563 (2019).

16. For additional information, see generally Bryant & Swartz, *supra* note 14 (detailing some of the reasons crisis pregnancy centers have not been held liable for violating informed consent). Outside of informed consent, people attempting to sue crisis pregnancy centers face additional hurdles, like contractual limitations and conscience protection laws. *See* Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CALIF. L. REV. 1255, 1255–56 (2020) [hereinafter Sawicki, *Conscience Defense*] (providing "the first empirical study of state conscience laws . . . for medical providers who refuse to participate in [the provision of] reproductive health services, including abortion, sterilization, contraception, and emergency contraception," focusing on the "impact on patients' right to a tort law remedy"). Discussion of these additional issues is outside the scope of this Note.

17. *See infra* Part V.

18. *See infra* Part VI. Other possible claims against crisis pregnancy centers or informed consent statutes, such as First Amendment or consumer protection issues, are outside the scope of this Note.

II. AN INTRODUCTION TO REPRODUCTIVE HEALTH CARE

Abortion and contraception are basic reproductive procedures, although this information has been put into doubt by crisis pregnancy centers.[19] According to The National Academies of Sciences, Engineering, and Medicine, all currently available methods of abortion are safe and effective.[20] It also found "having an abortion does not increase a woman's risk of secondary infertility, pregnancy-related hypertensive disorders, abnormal placentation (after a D&E abortion), preterm birth, . . . breast cancer," or mental health disorders such as depression, anxiety, and PTSD.[21] The reasons people obtain abortions vary from wishing to terminate pregnancies that resulted from rape, incest, or abusive relationships, to socioeconomic reasons like being unable to afford another baby.[22] If complications occur during the pregnancy, abortion can often be a safer medical option.[23] According to the Guttmacher Institute, "about one in four (24%) women will have an abortion by age 45."[24]

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19. *See infra* Part III. The legal right to an abortion, however, has been in the news recently. The Supreme Court granted certiorari to decide whether an abortion ban at 15 weeks is unconstitutional, putting into question whether they will overturn *Roe v. Wade*. *See* Dobbs v. Jackson Women's Health Org., 945 F.3d 265 (5th Cir. 2019), *cert. granted*, 141 S. Ct. 2619 (U.S. May 17, 2021) (No. 19-1392); *see also Dobbs v. Jackson Women's Health Organization*, OYEZ, https://www.oyez.org/cases/2021/19-1392 [https://perma.cc/AT7Z-TUQD] (describing the issue to be decided). However, 15 states and Washington, D.C. have state laws protecting abortion in the event *Roe v. Wade* is overturned. *Abortion Policy in the Absence of* Roe, GUTTMACHER INST. (Nov. 1, 2021), https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe?gclid=EAIaIQobChMI8_Khk7SL8wIVEyM4Ch3_xwDkEAAYAiAAEgJFffD_BwE [https://perma.cc/HB2X-EXQ9] (showing 14 states and Washington, D.C. have some protections in place, but missing Minnesota); Women of State of Minn. *ex rel.* Doe v. Gomez, 542 N.W.2d 17, 27 (Minn. 1995) (holding Minnesota has a state constitutional protection for abortion). In the event the Supreme Court overturns *Roe v. Wade* or similarly puts into question the legal right to an abortion, this Note will continue to apply to contraception everywhere, to abortion in those 15 states and Washington, D.C. which have protections in place, and to abortion in the other states to extent that can still be obtained.

20. NAT'L. ACADS. OF SCIS., ENG'G., & MED., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 11 (2018).

21. *Id.* at 9.

22. Sophia Chae, Sheila Desai, Marjorie Crowell & Gilda Sedgh, *Reasons Why Women Have Induced Abortions: A Synthesis of Findings from 14 Countries*, 96 CONTRACEPTION 233, 238 (2017).

23. *See* DONNA L. HOYERT, NAT'L. CTR. FOR HEALTH STAT., MATERNAL MORTALITY RATES IN THE UNITED STATES, 2019, at 3 (2021), https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/E-Stat-Maternal-Mortality-Rates-H.pdf [https://perma.cc/QW3W-UQ7L] (citing 20.1 total maternal deaths per 100,000 live births in 2019, with even higher maternal death rates for people of color). Abortion is generally less risky than live birth. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 215–16 (2012) ("The risk of death associated with childbirth is approximately 14 times higher than that with abortion.").

24. *Induced Abortion in the United States*, GUTTMACHER INST. (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states?gclid=CjwKCAiAgc-ABhA7EiwAjev-jxmi_kC3083_puFl7L7hJaRSLwfu6ybS5ogc4reO54rXq_8dHMtNfBoCJygQAvD_BwE [https://perma.cc/UWT8-475].

Similarly, contraception plays a large role in reproductive health care. "The average American woman spends five years pregnant (or trying to be) and thirty years trying not to get pregnant by avoiding sex or using birth control."[25] Indeed, almost every person with the physical ability to become pregnant and who has been sexually active has relied on some form of contraception.[26] In addition, physicians prescribe contraception for a number of other reasons, ranging from menstrual regulation and pain to treatment of medical conditions like dysmenorrhea and endometriosis.[27] According to the Guttmacher Institute, more than half of contraception pill users rely on the medication for reasons outside of pregnancy prevention at least in part.[28]

Providing accurate and nonbiased information about abortion and contraception is critical given the prevalence, efficacy, and safety of these medical options. The American Medical Association has established ethical codes that request providers "[p]resent relevant information accurately and sensitively . . . includ[ing] . . . [t]he burdens, risks, and expected benefits of all options."[29] The American College of Obstetricians and Gynecologists published guidance affirming that access to abortion and contraception are necessary medical options.[30] In addition, the Center for Disease Control ("CDC") considers "[v]oluntary informed choice of contraceptive methods . . . an essential guiding principle" when determining the appropriate contraception

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25. Dov Fox, Essay, *Reproductive Negligence*, 117 COLUM. L. REV. 149, 177 (2017).

26. *The Broad Benefits of Contraceptive Use in the United States*, GUTTMACHER INST. (Apr. 2020), https://www.guttmacher.org/fact-sheet/broad-benefits-contraceptive-use-united-states [https://perma.cc/C6EE-AJ9D]; THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, ACCESS TO CONTRACEPTION 2 (2015) [hereinafter ACCESS TO CONTRACEPTION], https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf [https://perma.cc/EJ4Q-MN5L] ("Ninety-nine percent of U.S. women who have been sexually active report having used some form of contraception.").

27. *Many American Women Use Birth Control Pills for Noncontraceptive Reasons*, GUTTMACHER INST. (Nov. 15, 2011), https://www.guttmacher.org/news-release/2011/many-american-women-use-birth-control-pills-noncontraceptive-reasons [https://perma.cc/54HT-VRMV] (detailing other uses of contraception); Pelin Batur, *Female Contraception*, CLEVELAND CLINIC CTR. FOR CONTINUING EDUC. (Dec. 2016), https://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/womens-health/female-contraception [https://perma.cc/X2LR-A2EH] (describing the contraceptive and noncontraceptive medical benefits for oral contraceptives); *see also* Eva Williams, *5 Reasons Why You Might Want to Use Birth Control Even if You've Never Had Sex*, HER CAMPUS (Jan. 6, 2020), https://www.hercampus.com/wellness/5-reasons-why-you-might-want-use-birth-control-even-if-youve-never-had-sex [https://perma.cc/7JNR-C5E9] (discussing reasons why women might use contraception outside of birth control uses).

28. GUTTMACHER INST., *supra* note 27.

29. *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/informed-consent [https://perma.cc/5GJR-Y9QD].

30. ACOG Committee on Health Care for Underserved Women, Committee Opinion, *Increasing Access to Abortion*, 136 OBSTETRICS & GYNECOLOGY 1075, e107 (2020), https://www.acog.org//media/project/acog/acogorg/clinical/files/committeeopinion/articles/2020/12/increasing-access-to-abortion.pdf [https://perma.cc/4D9G-5CJZ]; ACCESS TO CONTRACEPTION, *supra* note 26, at 2.

method and when counseling on reproductive health care.[31] Given the demand for and necessity of these services, people should be entitled to full and correct information when consulting a medical provider in a setting specifically designated for reproductive health care services.

III. CRISIS PREGNANCY CENTERS' LACK OF INFORMATION ABOUT HEALTH CARE OPTIONS AND RECENT CONVERSIONS TO MEDICAL CENTERS

Crisis pregnancy centers are usually religious organizations that offer pregnancy support but specifically do not offer or refer any abortion services and may not offer contraceptives.[32] Crisis pregnancy centers do, however, offer pregnancy tests, ultrasounds, and pregnancy support, such as classes or consultations on adoption and parenting, oftentimes for free,[33] which can help people access some basic reproductive services.[34] Over the last few years, however, the ratio of crisis pregnancy centers to abortion clinics has grown larger, limiting access to health care services and information about abortion and contraception.[35] In 2018, there were 2,537 crisis pregnancy centers compared to 780 abortion clinics, and the number of crisis pregnancy centers is likely even higher today.[36]

The largest three crisis pregnancy center organizations—Care Net, the National Institute of Family and Life Advocates, and Heartbeat International —do not hide the fact that they promote pro-life values, which affects the health care they provide.[37] In order to become one of Care Net's 1,100 centers, a facility must affirm it has Christian beliefs and will not offer

31. *Contraception*, CDC (Aug. 13, 2020), https://www.cdc.gov/reproductivehealth/contraception/index.htm [https://perma.cc/PUR5-QEHA].

32. *See What Is a Pregnancy Center*, CARE NET [hereinafter *Pregnancy Center*, CARE NET], https://www.care-net.org/what-is-a-pregnancy-center [https://perma.cc/9QAG-D4VX]; *About NIFLA*, *supra* note 7; *Our Passion*, HEARTBEAT INT'L [hereinafter *Our Passion*, HEARTBEAT], https://www.heartbeatinternational.org/about/our-passion [https://perma.cc/CVX4-3KAH]; CARE NET, STATEMENT OF FAITH 1, https://cdn2.hubspot.net/hub/367552/file-2184386775-pdf/Statement-of-Faith-2-08-C.pdf?t=1484769440142 [https://perma.cc/SA3S-7XNJ].

33. *Pregnancy Center*, CARE NET, *supra* note 32; *About NIFLA*, *supra* note 7; *Our Passion*, HEARTBEAT, *supra* note 32; *Services*, BIRTHRIGHT INT'L [hereinafter *Services*, BIRTHRIGHT], https://birthright.org/services/?tab=3 [https://perma.cc/H2FZ-UTR8].

34. *See* Anna North, *What "Crisis Pregnancy Centers" Really Do*, VOX (Mar. 2, 2020, 7:10 AM), https://www.vox.com/2020/3/2/21146011/crisis-pregnancy-center-resource-abortion-title-x [https://perma.cc/7K8Z-DKKS] (noting that while crisis pregnancy centers provide free resources for pregnant people, they also require people to attend a series of religiously affiliated classes, which people found "unpleasant or upsetting"). *See generally* CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5 (discussing the benefits of crisis pregnancy centers and their impact on the people who visit them).

35. *See* Ferrando, *supra* note 4.

36. *Id.*; *but see Worldwide Directory of Pregnancy Help*, HEARTBEAT INT'L, https://www.heartbeatinternational.org/worldwide-directory (last visited Sept. 27, 2021) (finding roughly 4000 centers as of September 2021 in the United States on Heartbeat International's directory).

37. *See* sources cited *supra* note 32.

abortions or even birth control to single women, and will instruct married women to see their pastor if they ask about birth control options.[38] Another organization, Heartbeat International, has a similar mission: "to [r]each and [r]escue as many lives as possible, around the world, through an effective network of life-affirming pregnancy help . . . consistent with Biblical principles and with orthodox Christian (Catholic, Protestant, and Orthodox) ethical principles."[39] A third organization, the National Institute of Family and Life Advocates, is not openly religious; however, the organization does promote pro-life values "by offering medical services, such as ultrasound[s], a powerful medical tool [that] is utilized [to] empower[] mothers to choose life."[40] Together these organizations control most of the crisis pregnancy centers in the United States.[41] Outside of these three larger organizations, many other centers operate independently.[42] Because of the lack of empirical research on crisis pregnancy centers, the practices of medical providers at these individually affiliated centers can be hard to trace. [43]

Many of these centers do not provide information about abortion, and when they do, they typically intend to dissuade the pregnant person from receiving an abortion and move them toward pro-life choices.[44] Care Net claims to provide "practical support for those choosing non-violent options."[45] Some crisis pregnancy center sites discuss abortion reversal, which involves

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38. CARE NET, PREGNANCY CENTER STANDARDS OF AFFILIATION 1 (2019) [hereinafter CARE NET, STANDARDS], https://cdn2.hubspot.net/hubfs/367552/Standards%20of%20Affiliation%202019.pdf [https://perma.cc/62RQ-9JCH] (noting that, to be affiliated with Care Net, a "pregnancy center [must] not perform or refer for abortion[,] . . . [must] provide[] a written disclaimer to this effect to clients requesting services," and must "not recommend, provide, or refer single people for contraceptives. (Married women and men seeking contraceptive information should be urged to seek counsel, along with their spouses, from their pastor and/or physician.)").

39. *Option Line*, HEARTBEAT, *supra* note 7.

40. *The Life Choice Project (TLC)*, NAT'L INST. OF FAM. & LIFE ADVOCS. [hereinafter *TLC*, NIFLA], https://membership.nifla.org/the-life-choice-project.asp [https://perma.cc/VV3Q-HXK9].

41. NARAL, THE TRUTH ABOUT CRISIS PREGNANCY CENTERS, *supra* note 10, at 1–2.

42. *See* CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5, at 10.

43. This Note will focus primarily on the practices documented on the sites of the three largest organizations: NIFLA, Care Net, and Heartbeat International.

44. *See, e.g.*, *TLC*, NIFLA, *supra* note 40 ("When pregnancy centers convert to medical clinic status, they experience many benefits including an increase in total number of patients seen, an increase in the number of abortion-minded patients seen, and a dramatic increase in the percentage of clients seen who choose life."); CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5, at 19 (finding Care Net has "saved" 748,784 lives and "8 out of 10 women who are considering abortion when they visit a Care Net Pregnancy Center choose life for their unborn children" (emphasis omitted)); *The ICU Ministry Model*, ICU MOBILE, https://www.icumobile.org/what-we-provide-you [https://perma.cc/7NY5L6MK] ("The mobile medical platform is neutral branded and medical looking. By having this independent brand, we break down the barriers that may prevent even one abortion-minded woman from coming on board to learn about her life-affirming options." (emphasis omitted)). This Note relies on the information publicly available through websites to evaluate the practices at crisis pregnancy centers because little empirical research has been done.

45. *Pregnancy Center*, CARE NET, *supra* note 32.

taking a drug to reverse the effects of medical abortion,[46] but do not provide information about the efficacy and safety of abortion in the first place.[47] For instance, on Informed Choices' website, the only information listed for abortion are related to risks, side effects, and "[f]inding [s]pirtual and [e]motional [p]eace."[48] The site does not provide information on how to receive an abortion, or give context to the risks.[49] However, on Informed Choices' adoption site, adoption is noted as "a wonderful option if you . . . [w]ant your child to be loved and cared for."[50] Overall, women are encouraged to contact Informed Choices and come in so they can receive "personal solutions."[51] Similarly, on another website, the center claims to provide information about pregnancy and childbirth, but does not mention abortion at all.[52] Abortion information at crisis pregnancy centers is either missing entirely or biased.

While these organizations are most often criticized for their deceptive stance on abortion,[53] many also provide misleading information,[54] or no

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46. George Delgado et al., *A Case Series Detailing the Successful Reversal of the Effects of Mifepristone Using Progesterone*, 33 ISSUES L. & MED. 21, 29 (2018).

47. Christa Brown, *Chemical Abortion and Reversal: How Your Center Can Help*, HEARTBEAT INT'L, https://www.heartbeatinternational.org/chemical-abortion-and-reversal-how-your-center-can-help [https://perma.cc/7XWC-8N9P]; *Abortion Pill Rescue Network*, HEARTBEAT INT'L, https://www.heartbeatinternational.org/our-work/apr [https://perma.cc/ZK3Y-7N2N]; *Considering Abortion*, OPTION LINE, https://optionline.org/options/abortion-overview [https://perma.cc/ZVL5-SDM9] (communicating that people should come in to an Option Line center to make sure they are pregnant and get an ultrasound); *Abortion Safety Checklist*, OPTION LINE, https://optionline.org/options/abortion-overview/abortion-safety-checklist [https://perma.cc/WFK4-B369] (highlighting risks and complications of abortion and stating "that it's OK to change your mind"). *But see* Mary Gatter, Kelly Cleland & Deborah L. Nucatola, *Efficacy and Safety of Medical Abortion Using Mifepristone and Buccal Misoprostol Through 63 Days*, 91 CONTRACEPTION 269, 271 (2015) (finding the efficacy of medical abortion to be 97.7 percent); *supra* note 21 and accompanying text.

48. *Our Services*, INFORMED CHOICES, *supra* note 2.

49. *Abortion*, INFORMED CHOICES MED. CLINICS [hereinafter *Abortion*, INFORMED CHOICES], https://www.informedchoicesclinic.com/information/abortion [https://perma.cc/6ED9-HAEH].

50. *Adoption*, INFORMED CHOICES MED. CLINICS, https://www.informedchoicesclinic.com/information/adoption [https://perma.cc/2N9S-THJX].

51. *Abortion*, INFORMED CHOICES, *supra* note 49.

52. *Services*, BIRTHRIGHT, *supra* note 33.

53. *See generally* NARAL, THE TRUTH ABOUT CRISIS PREGNANCY CENTERS, *supra* note 10 (detailing the tactics used at crisis pregnancy centers); Last Week Tonight, *Crisis Pregnancy Centers: Last Week Tonight with John Oliver (HBO)*, YOUTUBE (Apr. 9, 2018), https://www.youtube.com/watch?v=4NNpkv3Us1I [https://perma.cc/RPY3-FFYQ] (describing the practices of crisis pregnancy centers and why they are often deceptive to people); 12TH & DELAWARE (Home Box Office 2010) (following a crisis pregnancy center and an abortion center across the street from one another, as well as the operations of the crisis pregnancy center). *Contra* CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5, at 2.

54. *See, e.g.*, *Emergency Contraception*, OPTION LINE, https://optionline.org/emergency-contraception [https://perma.cc/FU23-ZUML] ("There is no way to predict or control which way the morning-after pill might work in your circumstances. For this reason, many women feel uncomfortable taking emergency contraception."). *But see Emergency Contraception*, CDC, (Nov. 2, 2018), https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/emergency.html [https://perma.cc/

information at all, about contraception.[55] The organizations cite religious and medical reasons for not doing so.[56] Heartbeat International sees contraception as an "easy fix" to the larger problem of premarital sex.[57] By not providing contraception, the centers promote abstinence before marriage because "[p]utting an unmarried woman or girl on the pill says to her that [these centers] are doubtful that she can or will make the healthiest choice for her body, mind, and spirit."[58] Therefore, Heartbeat's centers believe that failing to provide information about contraception is the best policy because contraception merely purports to "'solve' a problem by breaking a working part of a woman's body."[59] A recent study conducted with crisis pregnancy center websites in Georgia found that only 31 percent of websites presented any information about contraception, and when they did, the content was focused on emergency contraception and their risks and side effects.[60] The study also found the sites that did mention contraception "overemphasized and misstated the risks and side effects" and included "scientifically inaccurate information."[61] The only site found to promote contraception use was actually citing from Plan B user instructions.[62]

While more studies need to be done, current research shows that many crisis pregnancy centers are failing to provide full and accurate information about contraception. Crisis pregnancy centers were criticized for operating as "fake clinics," because nonmedical staff performed ultrasounds and discussed pregnancy options.[63] In response, the largest organizations have begun what they have called "conversion" of their centers into clinics with health providers.[64] On Heartbeat International's site, it recommends that ultrasounds

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PUM2-7WL5] ("UPA and levonorgestrel ECPs [are highly effective] when taken within 3 days after unprotected sexual intercourse . . . .").

55. *See, e.g.*, *Our Commitment*, HEARTBEAT INT'L, https://www.heartbeatinternational.org/about/our-commitment [https://perma.cc/YVF9-MKFD] ("Heartbeat affiliates encourage chastity as a positive lifestyle choice."); CARE NET, STANDARDS, *supra* note 38, at 1 ("The pregnancy center does not recommend, provide, or refer single [women] for contraceptives.").

56. *See, e.g.*, CARE NET, STANDARDS, *supra* note 38, at 1; Jennifer Wright, *How Providing Alternatives to Contraceptives Makes Us More Credible*, HEARTBEAT INT'L, https://www.heartbeatservices.org/how-providing-alternatives-to-contraceptives-makes-us-more-credible [https://perma.cc/RKC2-EHG8].

57. Wright, *supra* note 56.

58. *FAQs: Provision of Contraceptives by PHOs*, HEARTBEAT INT'L, https://www.heartbeatservices.org/faqs-provision-of-contraceptives-by-phos [https://perma.cc/WH88-NZFB].

59. Wright, *supra* note 56.

60. Andrea Swartzendruber, Riley J. Steiner & Anna Newton-Levinson, *Contraceptive Information on Pregnancy Resource Center Websites: A Statewide Content Analysis*, 98 CONTRACEPTION 158, 159–61 (2018).

61. *Id.* at 161.

62. *Id.* at 159.

63. *See supra* note 53.

64. Sandy Christiansen, *Medical Conversion Step 1: Strategic Planning*, CARE NET, https://www.care-net.org/center-insights-blog/medical-conversion-step-1-strategic-planning [https://perma.cc/Y39W-B6F9]; *Medical Clinic Conversion*, NIFLA, *supra* note 11; *see also Are We a Medical*

are "performed by properly trained personnel . . . under appropriate medical licensure."[65] The National Institute of Family and Life Advocates has a similar message that clinics should have a licensed medical professional operate ultrasound machines.[66] Centers that do provide ultrasounds, however, limit them to confirming viability of the pregnancy.[67]

Crisis pregnancy centers who are affiliated with one of these larger organizations will face pressure to convert to medical centers soon, if they have not already.[68] If they do convert, though, medical providers must ensure that the patient is making a decision with informed consent.[69] Previously, criticism of crisis pregnancy centers focused on the lack of medical providers.[70] With clinics transitioning to using medical providers to offer their services, clinics have increased responsibility to their patients. This Note argues that crisis pregnancy centers have failed to meet this responsibility with informed consent.

Clinic?, HEARTBEAT, *supra* note 11 (discussing that the administering of ultrasounds and pregnancy tests should be completed by medical providers).

65. *Are We a Medical Clinic?*, HEARTBEAT, *supra* note 11 (emphasis omitted); *see also TLC*, NIFLA, *supra* note 40 ("With the use of ultrasound, clinics can confirm pregnancy and establish its viability immediately. A non-medical pregnancy center cannot provide such a diagnosis since doing so would be practicing medicine."); Christiansen, *Medical Q&A*, *supra* note 11 ("[T]he use of ultrasound energy is considered the practice of medicine and must be done for clear medical indications and be performed by trained and licensed medical providers." (emphasis omitted)). While the three large collections of crisis pregnancy centers appear to be requiring their centers to have medical staff perform ultrasounds, many centers are unaffiliated with any parent organization and may not be following this protocol.

66. *TLC*, NIFLA, *supra* note 40 ("[B]efore your center can provide medical services, such as the ultrasound, you must be licensed as a medical clinic and have a licensed physician serve as Medical Director and oversee the provision of ultrasound services.").

67. CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5, at 3 (offering a "[l]imited diagnostic ultrasound for [the] confirmation of a viable pregnancy"); *TLC*, NIFLA, *supra* note 40 (offering "limited obstetric ultrasound[s]"); *2017 Ultrasound Training at Pregnancy Help Institute a Huge Success*, HEARTBEAT INT'L, https://www.heartbeatinternational.org/2017-ultrasound training-at-phi-success [https://perma.cc/CF9B-932E] (offering "[l]imited OB Ultrasound training"); *see also Ultrasound Exams*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (JUNE 2020), https://www.acog.org/womens-health/faqs/ultrasound-exams [https://perma.cc/P76HVSGH] (follow hyperlink; then expand all sections) (distinguishing a limited ultrasound from a standard ultrasound). The American College of Obstetricians and Gynecologists states that "[a] limited ultrasound exam is done to answer a specific question [such as] check[ing] the fetus's position in the uterus [during labor]." *Id.* In contrast, "[a] standard ultrasound exam checks the fetus's physical development, screens for major congenital anomalies, and estimates gestational age." *Id.*

68. No research exists on how many crisis pregnancy centers have medical providers compared to those who do not. According to Care Net, in 2019 "[a]pproximately 60% of [their] centers [are currently] licensed to offer . . . medical services." CARE NET, CRISIS PREGNANCY CENTERS, *supra* note 5, at 3. These medical services include "[c]onsultation[,]. . . [l]imited diagnostic ultrasound[s] for confirmation of a viable pregnancy[, and] [t]esting for sexually transmitted infections and diseases." *Id.* Since this Note focuses on medical practice, it only considers crisis pregnancy centers that have medical staff.

69. *See* discussion *infra* Sections IV.B, IV.C.

70. *See supra* note 53.

IV. A PHILOSOPHICAL AND LEGAL HISTORY OF INFORMED CONSENT

Informed consent doctrine is founded in ethics, which is fundamental to understanding informed consent doctrine in the law.[71] And where law has struggled to "defin[e] or set[] requirements of informed consent," an ethical analysis can help frame the issues.[72] At its core, informed consent is about autonomous choice, not about professional disclosure standards.[73]

A. *PHILOSOPHICAL FOUNDATIONS: AUTONOMY AND BENEFICENCE*

Autonomy in medicine means both freedom "from controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding."[74] Informed consent is based on this idea of autonomy.[75] Disclosure of information is not enough. "[T]he patient [should be] free[] to choose among alternatives . . . [and] free from coercion, pressure, or undue influence."[76] The provider must consider who is making the decision when thinking about what medical options to provide.[77] Because autonomy is such a fundamental principle of informed consent, any limitations on this principle should be justified by an equally strong "competing moral principle," like beneficence.[78]

Beneficence is "a moral obligation to act for the others' benefit, helping them to further their important and legitimate interests, often by preventing or removing possible harms."[79] Beneficence is a key goal of health care,[80] and medical ethics incorporates the idea of beneficence "aimed at the promotion

71. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. & BIOMEDICAL & BEHAV. RSCH., SUMMING UP: FINAL REPORT ON STUDIES OF THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH 20 (1983) ("Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative.").

72. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 3 (1986).

73. *See id.* at 3, 7–14; John Kleinig, *The Nature of Consent*, *in* THE ETHICS OF CONSENT: THEORY AND PRACTICE 3, 8 (Franklin G. Miller & Alan Wertheimer eds., 2010).

74. THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, ETHICAL DECISION MAKING IN OBSTETRICS AND GYNECOLOGY 3 (2007) [hereinafter ETHICAL DECISION MAKING], https://www.acog.org/media/project/acog/acogorg/clinical/files/committeeopinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology.pdf [https://perma.cc/7UYB-P8KM].

75. *Id.*

76. *Id.* at 6.

77. *Id.* at 7.

78. FADEN & BEAUCHAMP, *supra* note 72, at 9.

79. Tom Beauchamp, *The Principle of Beneficence in Applied Ethics*, STAN. ENCYCLOPEDIA OF PHIL. (FEB. 11, 2019), https://plato.stanford.edu/entries/principle-beneficence [https://perma.cc/S6G4-LFQ4].

80. FADEN & BEAUCHAMP, *supra* note 72, at 9–10.

of health by cure or prevention of disease."[81] The Hippocratic Oath is based on beneficence, to "do no harm."[82]

When autonomy and beneficence are in harmony, both the provider and the patient meet at the same goal: the patient is able to freely choose their treatment and the medical provider is able to fulfill their duties in performing that treatment.[83] For instance, when a patient chooses autonomously to have a cesarean section to deliver the child, the patient's wishes and the doctor's oath to promote life align. Medical decisions become more complicated when autonomy and beneficence are in tension.[84] In some cases, to whom beneficence is owed can become a disputed issue, and the provider must consider "[w]hose interest[] count[s], and whose count[s] the most."[85] The interests of others might impede the patient's autonomy and therefore the patient's ability to make an informed decision.[86]

Take two scenarios specific to crisis pregnancy centers. In one scenario a pregnant person wishes to obtain an abortion because they cannot afford to give birth and raise a child. The person's interest in terminating the pregnancy potentially conflicts with beneficence, the provider's desire "to do no harm."[87] Depending on the provider's view of abortion and the fetus, the provider could face competing issues of beneficence, between what could be considered harm to the fetus in terminating the pregnancy, or harm to the pregnant person in continuing the pregnancy.[88] In a second scenario, a person wishes to obtain birth control to prevent pregnancy. Their desire for autonomy to choose when they get pregnant could be in tension with the medical provider's idea of beneficence, if the provider sees contraception as "breaking a working part of a woman's body."[89]

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81. *Id.* at 10.

82. *Greek Medicine*, NAT'L INSTS. OF HEALTH: NAT'L LIBR. OF MED. (Feb. 7, 2012), https://www.nlm.nih.gov/hmd/greek/greek_oath.html [https://perma.cc/9KRT-VDSV].

83. *See* FADEN & BEAUCHAMP, *supra* note 72, at 9–11; THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE 3 (2007) [hereinafter LIMITS OF CONSCIENTIOUS REFUSAL], https://www.acog.org//media/project/acog/acogorg/clinical/files/committee-opinion/articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine.pdf [http://perma.cc/U29U-CF8V] ("Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge.").

84. *See* FADEN & BEAUCHAMP, *supra* note 72, at 9–11.

85. *Id.* at 11; *see also* Beauchamp, *supra* note 79 ("A health professional's conception of both harm to and benefit for a patient can differ sharply from that of the patient . . . . Different patients take different views about what constitutes a harm and a benefit, and when each view is reasonable it is morally unacceptable to maintain that the notions of medical benefit and harm are independent of the patient's judgment."); ETHICAL DECISION MAKING, *supra* note 74, at 5 (discussing the difficulties in balancing the interests between beneficence and autonomy in reproductive contexts).

86. *See* FADEN & BEAUCHAMP, supra note 72, at 10–11.

87. *See supra* note 82 and accompanying text.

88. *See supra* note 84 and accompanying text.

89. Wright, *supra* note 56.

Some medical associations in the scientific community have weighed in on this balancing of interests and found that the provider should focus primarily on the person who is making the decision about their body. For instance, the American College of Obstetricians and Gynecologists recently published a committee opinion recognizing a pregnant person's decision should take precedence over those of the fetus.[90] This Note argues that the application of the law is currently insufficient with this conclusion.[91]

B. Legal Development of Informed Consent

Informed consent in court cases first developed from the more general theory of consent.[92] Consent is the larger idea that every arrangement that people enter into together should be based on mutual agreement and understanding.[93] General theories of consent in medicine started showing up in court cases in the early twentieth century, brought under battery claims.[94]

In one of the most famous cases, *Mohr v. Williams*, a patient consented to an operation on her right ear, but the doctor realized the left ear needed surgery instead and performed the operation on that ear.[95] Mohr sued on a battery theory that the doctor operated on the opposite ear without her consent.[96] The court held that "[c]onsent . . . must be either expressly or impliedly given before a surgeon may have the right to operate," just as other

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90. THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, INFORMED CONSENT AND SHARED DECISION MAKING IN OBSTETRICS AND GYNECOLOGY e39 (2021) ("A patient who is pregnant is fully capable of making medical care decisions during pregnancy and during labor and delivery, even if those decisions are in disagreement with obstetrician-gynecologists or family members, involve withdrawal of life-sustaining treatment, or may adversely affect the health of the fetus."); *see also* LIMITS OF CONSCIENTIOUS REFUSAL , *supra* note 83, at 3 ("But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. . . . For situations in which [the interest of the pregnant woman and the fetus] diverge, the pregnant woman's autonomous decisions should be respected.").

91. *See infra* Parts V, VI.

92. *See* Tom L. Beauchamp, *Autonomy and Consent*, *in* THE ETHICS OF CONSENT: THEORY AND PRACTICE 55, 55–56 (Franklin G. Miller & Alan Wertheimer eds., 2010).

93. *See* David Johnston, *A History of Consent in Western Thought*, *in* THE ETHICS OF CONSENT: THEORY AND PRACTICE 25, 45–53 (Franklin G. Miller & Alan Wertheimer eds., 2010) (discussing the history of consent from the Bible and various philosophers such as Hobbes, Smith, Kant, Mill, and Plato).

94. *See, e.g.*, Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (finding "a surgeon who performs an operation without his patient's consent commits an assault"), *abrogated by* Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957); Mohr v. Williams, 104 N.W. 12, 15–16 (Minn. 1905) (discussing a battery charge for an ear surgery), *overruled in part by* Genzel v. Halvorson, 80 N.W.2d 854, 859 (Minn. 1957); Pratt v. Davis, 79 N.E. 562, 565 (Ill. 1906) (discussing consent before surgery).

95. *Mohr*, 104 N.W. at 13.

96. *Id.*

professions require mutual agreement between the parties.[97] The consent of the patient was not without limits, though; the physician was given reasonable latitude because any rule should not "unreasonably interfere with the exercise of [the physician's] discretion, or" whatever is reasonably necessary in an emergency.[98] Ultimately the court held that the physician committed battery and assault, even though the patient who received surgery on the damaged ear did not suffer any physical injury, and the physician was not negligent.[99] The lack of consent to operate on the left ear alone was sufficient for the court to find an injury.[100]

Informed consent as a legal right developed from the general theory of consent beginning in the late 1950s and early 1960s.[101] The phrase originated from a brief "by the lawyers for the American College of Surgeons" in *Salgo v. Leland Stanford Jr. Univ. Bd. Trs.*[102] In *Salgo*, a patient was left permanently paralyzed in his lower extremities after a medical procedure.[103] One of the theories the court found persuasive was a duty to disclose.[104] "Proceeding from the law of battery, the courts reasoned that significant protection of patients' right to decide their medical fate required not merely perfunctory assent but a truly 'informed consent,' based on an adequate understanding of the medical and surgical options available to them."[105] The court in *Salgo* held that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[106]

The physician again had discretion to determine how much to disclose, but the court was unclear where to draw the line.[107] On one hand, the physician must explain every risk, "no matter how remote," even if it would alarm the patient, but on the other hand the physician was allowed "a certain amount of discretion . . . consistent with the full disclosure of facts necessary to an informed consent."[108] The court remanded to instruct the jury on the

97. *Id.* at 15.

98. *Id.*

99. *Id.* at 15–16.

100. *Id.* at 16.

101. FADEN & BEAUCHAMP, supra at 72, at 88, 125.

102. Jay Katz, *Reflections on Informed Consent: 40 Years After Its Birth*, 186 J. AM. COLL. SURGEONS 466, 467 (1998) [hereinafter Katz, *Reflections on Informed Consent*] ("For years I wondered where the doctrine had come from. . . . Justice Bray had adopted the entire paragraph on informed consent verbatim from the brief submitted by the lawyers for the American College of Surgeons.").

103. Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 317 P.2d 170, 174–75 (Cal. Dist. Ct. App. 1957).

104. *Id.* at 181.

105. Katz, *A Fairy Tale, supra* note 1, at 148.

106. *Salgo*, 317 P.2d at 181.

107. *See id.*; *see also* Katz, *Reflections on Informed Consent, supra* note 102, at 467 (discussing how the court was confused between "discretion and full disclosure").

108. *Salgo*, 317 P.2d at 181.

physician's discretion.[109] While *Salgo* continued to rely on a battery claim, later courts grounded this idea of informed consent in negligence.[110]

Shortly after *Salgo*, the Kansas Supreme Court decided *Natanson v. Kline*, which became a model for a provider-centered standard for informed consent.[111] The court found that if a physician failed to disclose to the patient the risks of a procedure, the physician would be breaching their duty, applying a negligence theory.[112] The court further found the standard of duty should be the requirement that the physician disclose all information "in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances."[113] This standard for informed consent thus fit with the tradition of vesting decision-making authority with doctors, dating back to the Hippocratic Oath.[114]

Perhaps the most famous informed consent case came a few years after *Natanson*, where the notion of informed consent shifted from the physician's obligation for disclosure to the patient's need for autonomy.[115] In *Canterbury v. Spence*, the court found that the provider-centered standard of disclosure was "at odds with the patient's prerogative to decide[,] . . . [which] is at the very foundation of the duty to disclose."[116] Instead, the court announced the standard should be focused on the patient since "the patient's right of self-decision shapes the boundaries of the duty to reveal."[117] The *Canterbury* court identified a patient-centered standard for informed consent—what an objectively "reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego [sic] the proposed therapy."[118] The court based this standard in the concept of autonomy—"that '[e]very human being of adult years and sound mind has a right to determine

109. *Id.* ("The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent.").

110. FADEN & BEAUCHAMP, *supra* note 72, at 129; *see also* Nadia N. Sawicki, *Modernized Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821, 822–23 ("It was not until the early 1960s that most medical and legal professionals began to recognize that malpractice liability could attach to a physician's failure to properly inform her patient of the risks and benefits of proposed clinical treatment.").

111. *See* Natanson v. Kline, 354 P.2d 670, 673 (Kan. 1960) (holding that, by failing to inform a patient of risks in a treatment, the provider failed in their duty of care).

112. *Id.* at 671.

113. *Id.* at 673.

114. Katz, *Reflections on Informed Consent*, *supra* note 102, at 468–69.

115. *See generally* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) (establishing the patient-centered standard for informed consent); FADEN & BEAUCHAMP, *supra* note 72, at 133–38.

116. *Canterbury*, 464 F.2d at 786.

117. *Id.*

118. *Id.* at 787 (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970)).

what shall be done with his own body.'"[119] This shift to patient autonomy was an important step in connecting the legal theory of informed consent to the philosophical history of the doctrine. Cases today have not always been as faithful to patient autonomy concerns, especially in reproductive health care cases.[120]

C. *Informed Consent Cause of Action Today*

The law continues to translate these early ideas of morality into legal remedies and courts have built off these early cases. However, the legal interpretations have slowly strayed from the original concepts of patient autonomy.[121] Today, informed consent is a type of tort limited to health care situations.[122] It is now based in negligence, rather than battery.[123] Battery claims in medicine can generally only be brought when the patient did not consent at all, whereas informed consent claims can be brought if a patient consents but was not fully informed.[124] The main elements of informed consent are:

> (1) the physician has a duty to give information to the patient (under the appropriate standard of disclosure), which is part of the professional duty of due care; (2) the physician breaches the duty; (3) there is an injury to the patient that makes the patient worse off (in financially measurable terms) than if the procedure had not been performed; (4) the injury is the materialization of an undisclosed outcome or possible outcome (risk); and (5) had the plaintiff been informed of the outcome or risk, he or she (or a reasonable person) would not have consented. Underlying (5) is the crucial premise that the injury was caused by the nondisclosure.[125]

119. *Id.* at 780 (alteration in original) (quoting Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)); *see also* FADEN & BEAUCHAMP, *supra* note 72, at 135 ("Self-determination thus provided the *Canterbury* court with its primary justification for protecting a patient's right of decision.").

120. *See infra* Part V.

121. FADEN & BEAUCHAMP, *supra* note 72, at 25.

122. *See id.* at 29; Mary Laska Malone, Note, *Informed Consent and Hospital Consent Forms: Paper Chasing in a Video World*, 61 U. DET. J. URB. L. 105, 106 (1983).

123. LINDAHL, *supra* note 12, § 24:42.

124. DAVID W. LOUISELL & HAROLD WILLIAMS, MEDICAL MALPRACTICE § 8.06[2] (2021) ("Thus, most courts today reserve the assault and battery theory for cases in which the patient has not consented to the procedure actually performed, while using negligence as the basis for claims that the provider obtained the patient's consent without making a proper disclosure." (footnote omitted)). Pennsylvania, however, bases informed consent claims in battery. *See* Isaac v. Jameson Mem'l Hosp., 932 A.2d 924, 929 (Pa. Super. Ct. 2007) ("A claim of a lack of informed consent sounds in the intentional tort of battery because an operation performed without the patient's consent is deemed to be the equivalent to a technical assault." (citing Smith v. Yohe, 194 A.2d 167, 174 (Pa. 1963))).

125. FADEN & BEAUCHAMP, *supra* note 72, at 29 (emphasis omitted); *see, e.g.*, Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 360 (Iowa 1987).

Informed consent doctrine applies to two areas of modern medical practice, treatment and research, but the law has focused mostly on the former.[126]

To prove the first two elements, the plaintiff must first determine what standard of duty is applicable in their jurisdiction.[127] The states are evenly divided between a physician-centered and patient-centered standard.[128] The physician-centered standard is what "a reasonably prudent practitioner in the same field of practice or specialty" would disclose to the patient.[129] The remaining states have adopted a patient-centered standard, as proposed in *Canterbury v. Spence*.[130] This standard means a health care provider must disclose all *material facts*, which includes all information that "a reasonably prudent person in the position of the patient . . . would attach significance to . . . [in] deciding whether or not to submit to the proposed treatment."[131] This approach, unlike the reasonable physician method, "vests the final decision-making authority in patients."[132] A material fact may include a failure to disclose important information about the procedure or treatment but also could include the physician's professional experience and qualifications.[133]

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126. FADEN & BEAUCHAMP, *supra* note 72, at 3. This Note will focus only on treatment which aligns with crisis pregnancy centers and their practices.

127. *See* Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 430 (2006).

128. *Id.* at 430, 493–501; *compare* Korman v. Mallin, 858 P.2d 1145, 1149 (Alaska 1993) ("The focus [of the materiality risk test] is on whether a reasonable person in the patient's position would attach significance to the specific risk. This determination does not require expert testimony." (quoting Hondroulis v. Schuhmacher, 553 So. 2d 398, 412 (La. 1988))), *with* Fuller v. Starnes, 597 S.W.2d 88, 90 (Ark. 1980) (holding "that the physician's duty to disclose risks is measured by the customary practice of physicians in the community in which he practices or in a similar community").

129. Tashman v. Gibbs, 556 S.E.2d 772, 777 (Va. 2002).

130. *See, e.g.*, *Pauscher*, 408 N.W.2d at 360; *Hondroulis*, 553 So. 2d at 412 (finding "an objective standard of causation: whether a reasonable patient in the plaintiff's position would have consented to the treatment or procedure had the material information and risks been disclosed"); Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972).

131. WASH. REV. CODE § 7.70.050 (2) (2021).

132. Wendy Chavkin & Farah Diaz-Tello, *When Courts Fail: Physicians' Legal and Ethical Duty to Uphold Informed Consent*, 1 COLUM. MED. REV. 6, 6 (2017).

133. *See* Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 83 (N.J. 2002) (holding that, while a doctor does not have a duty to disclose "personal credentials and experience[,] . . . a serious misrepresentation concerning the quality or extent of a physician's professional experience" might be material); Johnson v. Kokemoor, 545 N.W.2d 495, 505 (Wis. 1996) (finding a reasonable patient would have wanted to know about the surgeon's lack of experience performing a particular surgery); Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990) (en banc) ("[A] physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment . . . ."). *But see* Ditto v. McCurdy, 947 P.2d 952, 958 (Haw. 1997) ("We decline to hold that a physician has a duty to affirmatively disclose his or her qualifications or the lack thereof to a patient."); Duttry v. Patterson, 771 A.2d 1255, 1259 (Pa. 2001) (finding "that information personal to the physician . . . is irrelevant to the doctrine of informed consent").

Sometimes no treatment at all is a reasonable alternative, and a failure to disclose that option may also be a breach of the duty element.[134]

Both standards present difficulties for plaintiffs. Under a physician-centered standard, a plaintiff will usually need to provide an expert witness to establish the standard of care,[135] but under a patient-centered standard, proving the plaintiff would have chosen a different treatment can be difficult.[136] Under either standard, a plaintiff will likely need an expert witness to establish the risk was material, meaning the risk was sufficient to warrant disclosure.[137] The standard in each jurisdiction is established through case law or, more often, through general informed consent statutes.[138] However, informed consent statutes and cases are sometimes vague, making it difficult to determine which standard applies.[139] Many states also have specific statutes regulating informed consent for certain procedures,[140] including abortion.[141]

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134. *See* Wecker v. Amend, 918 P.2d 658, 662 (Kan. Ct. App. 1996) (holding that if "a plaintiff presents evidence that doing nothing—or merely watching a medical condition to see if it goes away on its own—is a medically acceptable alternative, [then] . . . a physician has a duty to advise a patient of the option of choosing no treatment at all"). Note, however, that a failure to diagnose at all is usually considered medical malpractice and not informed consent. *See* Gomez v. Sauerwein, 331 P.3d 19, 23 (Wash. 2014) (en banc).

135. *See* Culbertson v. Mernitz, 602 N.E.2d 98, 104 (Ind. 1992); Potter v. Kern Wisner, 823 P.2d 1339, 1347 (Ariz. Ct. App. 1991); Willis v. Bender, 596 F.3d 1244, 1255 (10th Cir. 2010).

136. *See, e.g.*, Backlund v. Univ. of Wash., 975 P.2d 950, 959 (Wash. 1999) (en banc) (finding that, under a patient-centered standard, a reasonable person in the plaintiff's position would still have opted for the treatment performed even if informed of all alternatives); *Howard*, 800 A.2d at 79 (finding under patient-centered standard that "[i]f the plaintiff would have consented to the proposed treatment even with full disclosure, the burden of proving causation is not met").

137. *See, e.g.*, Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 360 (Iowa 1987) (finding that, on remand, the plaintiff will need to provide "expert testimony relating to the nature of the risk and the likelihood of its occurrence, in order for the jury to determine, from the standpoint of the reasonable patient, whether the risk is in fact a material one").

138. *See* King & Moulton, *supra* note 127, at 493–501 (providing a list of the informed consent statutes and cases in every state and additional notes).

139. *See, e.g.*, OR. REV. STAT. § 677.097 (2019) (vague informed consent statute); Gerety v. Demers, 589 P.2d 180, 195 (N.M. 1978) ("We adopt an 'objective' standard, based on the knowledge or skill of an ordinary patient or physician, as being the most reasonable theory for both parties involved."); Kinikin v. Heupel, 305 N.W.2d 589, 595 (Minn. 1981) (combining the patient- and provider-centered standards).

140. *See, e.g.*, NEB. REV. STAT. § 38-2059 (2020) (acupuncture); OR. REV. STAT. § 192.535 (2019) (obtaining DNA samples); N.Y. COMP. CODES R. & REGS. tit. 10, § 52-11.3 (2021) (organ donations).

141. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 171.012 (West 2021) (providing a comprehensive list of the requirements to receive informed consent before performing an abortion, including having a sonogram and certifying that the woman understands she is "required by law to hear an explanation of the sonogram images" unless she was raped and subsequently reported it to the police, is an emancipated minor, or the fetus has a medical condition). *But see* Cynthia R. Daniels, Janna Ferguson, Grace Howard & Amanda Roberti, *Informed or Misinformed Consent? Abortion Policy in the United States*, 41 J. HEALTH POL., POL'Y & L. 181, 194 (2016) (listing state statutes with abortion informed consent laws and the percentage of medically inaccurate statements).

After establishing that the provider failed to follow the appropriate standard of disclosure, the plaintiff must go on to prove causality.[142] Across essentially all jurisdictions, causation is based on an objective standard of a reasonable patient.[143] The plaintiff needs to show they would have chosen a different treatment if they had been provided the withheld information, known as "decision-causation."[144] They also need to show that the treatment caused some provable injury, known as "injury-causation."[145]

Lastly, jurisdictions are split on whether plaintiffs need to prove some physical injury or a more general injury, either emotional or physical.[146] In a Louisiana Supreme Court case, *Lugenbuhl v. Dowling*, the court allowed the plaintiff damages on an injury "to plaintiff's dignity, privacy and emotional well-being."[147] Even though the plaintiff did not have physical injuries, the "damages [were] for deprivation of self-determination, insult to personal integrity, invasion of privacy, anxiety, worry and mental distress."[148] Similarly, Iowa has expanded the idea of injury by allowing cases "where an undisclosed risk did not materialize and cause physical harm to the patient."[149]

Other jurisdictions have held that physical harm is necessary.[150] The Mississippi Supreme Court has held that the plaintiff needs to show some type of "worsened condition" with an expert witness.[151] In addition, the Eleventh Circuit

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142. Pauscher v. Iowa Methodist Med. Ctr., 408 N.W.2d 355, 360 (Iowa 1987); FADEN & BEAUCHAMP, *supra* note 72, at 28–29.

143. Evelyn M. Tenenbaum, *Revitalizing Informed Consent and Protecting Patient Autonomy: An Appeal to Abandon Objective Causation*, 64 OKLA. L. REV. 697, 713–17 (2012) (surveying all state statutes).

144. *Id.* at 710–11; FADEN & BEAUCHAMP, *supra* note 72, at 29; *see also* Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 613 ("If the doctor unreasonably withheld information about the risks of a recommended course of action, the doctor was liable for the harm caused by the course of action if the patient otherwise would have declined to proceed.").

145. Tenenbaum, *supra* note 143, at 711.

146. *See* Andersen v. Khanna, 913 N.W.2d 526, 544–48 (Iowa 2018) (detailing the history of cases and damages in informed consent).

147. Lugenbuhl v. Dowling, 96-1575, p. 14 (La. 10/10/97); 701 So. 2d 447, 455; *see also* McQuitty v. Spangler, 976 A.2d 1020, 1039 (Md. 2009) ("We hold today that [physical invasion] is not a requirement to sustain an informed consent claim."); Black v. Comer, 38 So. 3d 16, 27 –28 (Ala. 2009) (allowing compensatory damages for both mental anguish and physical injury).

148. *Lugenbuhl*, 96-1575 at p. 14, 701 So. 2d at 455 (referencing Dobbs' *Law of Remedies* for damages for dignitary torts).

149. *Andersen*, 913 N.W.2d at 546 (comparing jurisdictions that require a materialization of harm with the minority of jurisdictions that do not, and holding that Iowa does not require a materialization of a physical harm).

150. *See* Erin Sheley, *Rethinking Injury: The Case of Informed Consent*, 2015 BYU L. REV. 63, 67 ("[T]he current law ignores patients whose physical injuries are not readily apparent" and instead "base[s] [the injury element] on an excessively narrow idea of physical harm, which has negative consequences for tort law.").

151. Jamison v. Kilgore, 903 So. 2d 45, 48 (Miss. 2005) (quoting Palmer v. Biloxi Reg'l Med. Ctr., Inc., 564 So. 2d 1346, 1364 (Miss. 1990)). *See* Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972); Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 79–80 (N.J. 2002).

recently confronted this issue in a clinical research informed consent case, where Alabama law was unclear if a physical injury was required.[152] When the Alabama Supreme Court refused to answer the certified question, the court found that a physical injury is required under Alabama informed consent doctrine because it sounds in negligence.[153] If the plaintiff meets all these elements of informed consent, they can receive damages to the extent the procedure caused harm, "whether or not the medical diagnosis and/or treatment was negligent."[154]

V. Issues Holding Crisis Pregnancy Centers Liable as Medical Providers Under Informed Consent

Crisis pregnancy centers currently do not provide full and accurate information about contraception or abortion, yet are staffed by medical providers.[155] For people who go to crisis pregnancy centers and do not receive information about their health care, the law does not provide a clear claim against these centers, as this Section will discuss. In addition, the centers have defenses they could bring against these claims, including contractual limitations and conscience protection arguments.[156] Between current tort law and these defenses, holding crisis pregnancy centers liable is difficult.[157] This Note focuses

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152. Looney v. Moore, 861 F.3d 1303, 1309 (11th Cir. 2017) ("Alabama law, however, does not expressly tell us whether such an informed consent claim is subject to the same requirements as a malpractice or negligence claim, nor does it speak to what the elements of such a claim would be if the claim finds no home in the malpractice/negligence camp.").

153. Looney v. Moore, 886 F.3d 1058, 1064–65, 1069 (11th Cir. 2018) ("Defendants' position is consistent with the majority of other courts that have addressed this issue, which hold that informed consent claims sound in negligence and thus require an actual injury.").

154. Gomez v. Sauerwein, 331 P.3d 19, 28 (Wash. 2014) (en banc); *Howard*, 800 A.2d, at 85 ("[P]laintiff may be compensated for that injury . . . irrespective of whether defendant deviated from the standard of care in performing the surgical procedure."); *Andersen*, 913 N.W.2d at 545 ("Under neither [the negligence nor battery approach to informed consent] is the plaintiff required to prove negligence in conducting the operation. . . . The wrong done is not a negligent operation but a failure to respect the patient's right of choice." (alteration and omission in original) (quoting Dan B. Dobbs, Paul T. Hayden & Ellen M. Bublick, The Law of Torts § 308 (2d ed. 2011))).

155. *See supra* Part III.

156. A crisis pregnancy center is fully within their rights to contractually limit ultrasounds, which many centers do. *See supra* note 67 and accompanying text; *see also* Sawicki, *Conscience Defense*, *supra* note 16, at 1263–68 (describing the extent of conscience protection laws in the context of reproductive health care). A discussion of these additional defenses is outside the scope of this Note.

157. For instance, in a recent U.S. Supreme Court decision regarding crisis pregnancy centers, the majority found that crisis pregnancy centers do not provide medical procedures, even when they have medical providers operating ultrasounds. Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361, 2369–73 (2018). In response, Justice Breyer in the dissent wrote a simple "Really?" *Id.* at 2386 (Breyer, J., dissenting) ("The majority contends that the disclosure here is unrelated to a "medical procedure," unlike that in *Casey*, and so the State has no reason to inform a woman about alternatives to childbirth (or, presumably, the health risks of childbirth). Really? No one doubts that choosing an abortion is a medical procedure that involves certain health risks." (citation omitted)).

on the nexus of the issue with informed consent claims against crisis pregnancy centers—the heightened requirements for causation and injury.

A. *Establishing Causality*

In a claim against a crisis pregnancy center, a person would have to show that they would have chosen a different option—an abortion or contraception—if they had known more.[158] They also need to show that the lack of information led to some harm.[159] These usually need to be proven through an objective standard, what a reasonable person would have done.[160] Both causation elements present difficulties in the context of reproductive decision-making.

Even with general medical diagnosis, predicting what someone would have done given different information is complex.[161] Adding an objective person standard to this analysis makes proving decision-causation impossible for a plaintiff. No answer exists for what a reasonable person would have done facing a pregnancy decision because the very nature of the decision is personal.

In response, some scholars have proposed reestablishing a subjective standard rather than an objective one, where only what the individual would have decided is considered.[162] Several problems arise with subjective proof in reproductive health care though. First, proof turns "on the rather shaky reed of the plaintiff's hindsight testimony," and therefore its evidentiary value is low.[163] Second, in many cases, the person will likely have given birth and then is placed in the emotionally fraught place of saying they would have received an abortion.[164] Lastly and most importantly, decision-causation does not add empirical value to the informed consent claim. Evidence to prove decision-causation is not necessary to prove that the provider denied information which created dignitary injury.[165] Regardless of the ultimate decision the person reaches, the denial of information removed the individual's ability to make a decision, and placed it with the provider who wanted a particular

158. *See supra* note 144 and accompanying text.

159. *See supra* note 145 and accompanying text.

160. *See supra* note 144 and accompanying text.

161. Sofia Yakren, *"Wrongful Birth" Claims and the Paradox of Parenting a Child with a Disability*, 87 FORDHAM L. REV. 583, 602–03 (2018) (discussing the harshness of the "all-or-nothing perspective" of what a mother would have done).

162. Alan Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 110–13 (1977); *see also* Eve R. Green Koopersmith, *Informed Consent: The Problem of Causation*, 3 MED. & L. 231, 234 (1984) (summarizing the general debate between subjective and objective causation in informed consent). *See generally* Tenenbaum, *supra* 143 (arguing for subjective causation in informed consent).

163. Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 251 (1985).

164. Yakren, *supra* note 161, at 602–03.

165. Shultz, *supra* note 163, at 251.

outcome. The decision becomes the provider's rather than the patient's, which is the ultimate harm.[166]

In response to the causation issue, Leonard Riskin suggests a hybrid tort between battery and negligence that would loosen the causation requirements while retaining the connotations of negligence.[167] Unlike negligence, which currently applies to informed consent, battery does not have causation requirements.[168] Courts are hesitant to use battery in informed consent, however, because it implies a "hostile intent" or a "clearly evil" action by the provider, and battery also creates issues with proving a physical contact.[169] Relaxing the causation elements requires the patient to show "that the physician failed to disclose a risk or aspect of the treatment[,] . . . the physician performed the treatment[,] and . . . the patient was injured as a result of the materialization of the undisclosed risk."[170] Riskin's theory essentially removes decision-causation while retaining injury-causation, within the framework of a new tort.

The injury-causation element in the reproductive health care space generates additional proximate cause issues, especially if a physical injury is required.[171] For example, if the person only consulted with or at most received an ultrasound from the provider, tying that procedure to later childbirth is difficult. A single consultation with a provider early in the pregnancy is hard to connect causally to the resulting childbirth, as birthing people often need several types of providers and many consultations in the process.[172] In addition, people generally have some knowledge of abortions or contraception but are seeking a particularized knowledge from a medical provider.[173] Showing that a moment of missed information from a crisis pregnancy center caused a later outcome becomes a thought experiment rather than reality.

166. See *supra* Sections IV.A, IV.B.

167. Leonard L. Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 601–02.

168. 6 AM. JUR. 2D *Assault and Battery* § 85 (2021); Twerski & Cohen, *supra* note 144, at 617–18 ("First, the nondisclosure must have caused the patient to agree to a procedure which otherwise would have been declined (decision causation); second, the procedure must have caused the patient's harm (injury causation). The second link is difficult; the first link, however, is hopelessly complex." (footnotes omitted)).

169. Riskin, *supra* note 167, at 600. Note, however, that if crisis pregnancy centers fail to provide any information about certain procedures, or willfully withhold information, a battery claim could stand. In fact, one scholar even wrote that people would be better suited to simply bring battery claims against crisis pregnancy centers. Teneille R. Brown, *Crisis at the Pregnancy Center: Regulating Pseudo-Clinics and Reclaiming Informed Consent*, 30 YALE J.L. & FEMINISM 221, 248–63 (2018).

170. Riskin, *supra* note 167, at 602–03.

171. Koopersmith, *supra* note 162, at 233.

172. *See Prenatal Care and Tests*, OFF. ON WOMEN'S HEALTH (Jan. 30, 2019), https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests [https://perma.cc/BAY7-3N8Q].

173. Bryant & Swartz, *supra* note 14, at 270; *see also* Sawicki, *Conscience Defense*, *supra* note 16, at 1295 (discussing the range of harms when a provider denies a patient treatment, ranging from little harm if the patient "is still able to access that service elsewhere" to severe harm if "the patient has not been informed that the service is medically appropriate and available elsewhere").

However, allowing a broader definition of injury would ease proof requirements for injury-causation.

B. Demonstrating a Physical Injury

Many jurisdictions agree that damages for informed consent are tied to the failure to provide adequate information, and not from any negligence related to the procedure.[174] This is a key distinction between informed consent and medical malpractice, which only applies in cases of physical harm.[175] However, some courts have still insisted on a physical injury even for an informed consent claim, since both medical malpractice and informed consent are grounded in negligence.[176] Physical injury can be difficult for plaintiffs in informed consent claims generally, but even more so in reproductive health care.[177]

Plaintiffs in reproductive contexts have difficulty proving a harm, outside of dignitary harms already suffered. Denial of reproductive health care information means that the person was not able to make a fully informed decision. At crisis pregnancy centers, which are designed to lead the person to have a baby, the ultimate result from lack of information will be a child. Equating a resulting child as the harm, however, does not sit well with judges or society in general.[178] This narrow view of harm, focusing on an actual result or physical outcome, misses the point of informed consent doctrine. The injury is not the resulting child but the lack of information and deprivation of autonomous decision-making for the individual.[179] To require proof of something more is disingenuous to the informed consent doctrine. To

174. *See supra* note 154 and accompanying text.

175. Fox, *supra* note 25, at 153–54 ("Malpractice actions, for example, call for precisely these more tangible setbacks to the injured party's person or possessions. Tort law more generally declines to remedy even the negligent infliction of emotional distress without associated physical or economic harms." (footnote omitted)).

176. *See supra* note 153 and accompanying text.

177. *See supra* notes 150–53. Recent legislation could impact the types of harms experienced at crisis pregnancy centers as well. With states limiting the time when abortions can be accessed, crisis pregnancy centers that deprive people of information, and therefore prevent people from accessing health care during a limited window, can cause physical injury. *See* Whole Woman's Health v. Jackson, 141 S. Ct. 2494, 2498–99 (2021) (Sotomayor, J., dissenting). Douglas Nejaime & Reva B. Siegel argue that when denial of information becomes lack of access to medical options, injury has materialized to have direct consequences on people's access to health care. Nejaime & Siegel, *supra* note 8, at 2571 ("When patients are denied information about treatment options, they are denied the opportunity to seek services from an alternative provider."). In some cases, "[d]enial of access to termination of pregnancy in cases where continuation of pregnancy is dangerous may result in serious physical injury or even death." Sawicki, *Conscience Defense*, *supra* note 16, at 1296–97. In these particular cases, the lack of information denies health care access, which can create a physical injury in addition to a dignitary one.

178. Yakren, *supra* note 161, at 597–600; Shultz, *supra* note 163, at 266–67.

179. Yakren, *supra* note 161, at 622–23. In a similar vein, Sophia Yakren argues the "wrongful birth" tort should be renamed to "loss of reproductive choice" to "shift the blame from plaintiff-mothers to health-care professionals whose negligence has been obscured by concerns about the wrongful birth claim," to better capture the injury. *Id.* at 616, 623.

complicate the issue, courts have split on allowing harm related only to lack of information without a clear physical injury in informed consent cases.[180]

Several scholars have presented ways to define harms in the reproductive context. Pamela Laufer-Ukeles proposes expanding injury to recognize dignitary harms, similar to *Lugenbuhl.*[181] Expansion of injury would incentivize providers to ensure balanced medical treatment.[182] The result would be a focus on the patient's autonomy. Alan Meisel argues further that informed consent should be classified as a dignitary tort because of its similarities to battery and other dignitary torts.[183] This understanding would solidify the tort as dealing entirely with dignitary harms rather than physical ones.

Dov Fox argues instead for an entirely new tort which would recognize reproductive injuries as their own particular class.[184] He contends "[c]ourts routinely decline to grant remedies when reproductive professionals negligently deprive, impose, or confound procreation."[185] He describes specific types of reproductive harms including "impos[ing] unwanted pregnancy or parenting."[186] Fox's examples of this particular harm include "[i]nterference in the diagnosis of pregnancy, in the dispensation of birth control, and in the performance of abortion or sterilization."[187] While none of these specifically cover misinformation and denial of information about abortion and contraception at a crisis pregnancy center, this harm could be included. Lack of full information about reproductive options by medical professionals at dedicated pregnancy centers fits the larger harm of "impos[ing] unwanted pregnancy or parenting."[188] Fox believes the ultimate outcome for these reproductive torts should be defined as "the ability to determine the conditions

180. *See supra* notes 146–53 and accompanying text; Fox, *supra* note 25, at 153–54 ("The problem is that our legal system does not recognize a conception of injury that accommodates the disruption of reproductive plans apart from any unwanted touching, broken agreement, or damaged belongings."); *see also* Sawicki, *Conscience Defense*, *supra* note 16, at 1295–97 (discussing the range of harms when a provider denies a patient treatment, from minimal harm if the patient is able to access treatment somewhere else to severe harm if the patient has no knowledge about the treatment and is also unable to receive it somewhere).

181. Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy*, 37 AM. J.L. & MED. 567, 621 (2011); *see* Lugenbuhl v. Dowling, 96-1575, p. 14 (La. 10/10/97); 701 So. 2d 447, 455.

182. Laufer-Ukeles, *supra* note 181, at 622.

183. *See generally* 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) (arguing that informed consent should be classified as a dignitary tort).

184. *See generally* Fox, *supra* note 25 (arguing for a new reproductive negligence tort because many birth-related torts do not accurately fit under any current tort claims).

185. *Id.* at 154.

186. *Id.* at 153 (emphasis omitted).

187. *Id.* at 185; *see also id.* at 187 (providing further examples of reproductive injuries, such as "botched vasectomies, defective condoms, failed abortions, and unconsented embryo transfers").

188. *Id.* at 153 (emphasis omitted).

under which to procreate."[189] Reproductive decision-making has the power "to shape who people are, what they do, and how they want to be remembered."[190] Actions that prevent people from realizing these rights damage fundamental concepts of autonomy.[191] The crux of the injury Fox identifies is a dignitary one, focused on the loss of the right to make decisions about health care.

VI. RECONCEPTUALIZING INFORMED CONSENT CLAIMS IN REPRODUCTIVE HEALTH CASES

Without reconceptualizing informed consent claims in reproductive health care cases, harms like those experienced by people at crisis pregnancy centers will go unacknowledged. Informed consent law that requires stringent levels of causality and physical injury tied to the procedure misapplies informed consent doctrine, which was created to protect autonomous decision-making. This Section will discuss how the causation and injury elements not only miss important informed consent issues at crisis pregnancy centers but are also disingenuous to the philosophical standards of informed consent.

Because informed consent doctrine is mainly established through case law, change in this area will likely come slowly. However, courts should consider changing their informed consent requirements in two substantive ways when considering reproductive medical decisions.[192] First, courts should not require decision-causation, that the person would have made a different decision if they would have been fully informed. Second, the person should not have to prove a physical injury tied to the lack of information.

An individual proving that they would have made a different decision is difficult for them both psychologically[193] and procedurally,[194] especially in reproductive medical decisions. Childbirth and reproductive health care is significantly different from other types of medical procedures and therefore should require different treatment. Courts should remove decision-causation, since the element, using either subjective or objective standards, has little to no empirical value for an informed consent claim.[195] The issues with causation speak more to the flawed realities of informed consent legal standards than to the lived experiences of people at crisis pregnancy centers and the harms they face. Therefore, these barriers to proving causation should be modified.

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189. *Id.* at 155.

190. *Id.*

191. *Id.*

192. Whether these elements should be applied even more broadly beyond just reproductive rights is outside the scope of this Note.

193. *See* Twerski & Cohen, *supra* note 144, at 626 ("A number of factors make it difficult to predict how a person's decision would change as the amount of information provided to the person increases."); Yakren, *supra* note 161, at 602–03.

194. Tenenbaum, *supra* note 143, at 731.

195. *See supra* notes 163–66 and accompanying text.

Decision-causation in particular does nothing to promote the primary purpose of informed consent.[196]

Removing decision-causation for an informed consent claim would remove an unnecessary and unprovable element. However, courts do not need to consider creating a hybrid tort, as suggested by Riskin.[197] Injury-causation still applies and therefore the tort can still sound in negligence. Since injury-causation would still be required, this solution cannot stand on its own. Expanding what constitutes an injury is also required. Informed consent philosophical doctrine is based on the injury to bodily autonomy which might not result in a physical injury. Requiring a physical injury goes too far and transforms informed consent claims into a general medical malpractice claim. Courts should take note of jurisdictions beginning to move in this direction, like Iowa.[198] Non-physical harms, including harms to dignity and the ability to make autonomous decisions about one's life, must be recognized for the court to correctly apply informed consent doctrine. While defining the harm more broadly complicates damage calculations,[199] courts frequently make these types of calculations in other situations, like wrongful death and wrongful conviction cases.[200] The added complexity must be accepted to accurately capture the harm, just like in those other cases.[201]

By reconceptualizing the informed consent framework to better fit with the classical understanding of informed consent, a claim against a crisis pregnancy center becomes more possible. The tort would be less focused on the person's later decisions and the physicality of the harm, and more accurately focused on the infringement of the person's autonomy. The philosophy underlying informed consent would become more present in the legal claim, and the tort could better protect the rights of people in reproductive health care.

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196. Riskin, *supra* note 167, at 603 ("[T]he new cause of action is designed to project the patient's dignitary interest in deciding on the course of [their] medical treatment; this interest is invaded whether or not [they] can meet the causation requirement."). *See generally* Twerski & Cohen, *supra* note 144 (detailing the logical issues with placing weight on what patients would have decided, as well as the difficulty in predicting their behavior).

197. Riskin, *supra* note 167, at 601–03.

198. *See supra* note 149 and accompanying text.

199. *See* Lugenbuhl v. Dowling, 96-1575, p. 14–16 (La. 10/10/97); 701 So. 2d 447, 455–56 (discussing damages for dignitary torts).

200. Yakren, *supra* note 161, at 624 (citing Fox, *supra* note 25, at 224); *see also* William L. Prosser, *Privacy*, 48 CALIF. L. REV. 383, 389 (1960) (discussing privacy claims and damages available under them; this was one of the first articles to discuss damages for dignitary torts).

201. Harry Zavos, *Monetary Damages for Nonmonetary Losses: An Integrated Answer to the Problem of the Meaning, Function, and Calculation of Noneconomic Damages*, 43 LOY. L.A. L. REV. 193, 197 (2009) ("[N]oneconomic damages symbolically affirm that the plaintiff has been wrongfully deprived of something of value, even though that value cannot be expressed at its fair market equivalency."). Further discussion of damages calculations is outside the scope of this Note.

Scholars are acknowledging that reproductive health care is fundamentally unique, and therefore courts should treat it as such.[202] The common theme of these discussions by scholars and medical associations is the understanding that withholding reproductive medical information from people affects their ability to make decisions that forever shape their futures.[203] By looking at informed consent doctrine specifically applied to crisis pregnancy centers, the issues with informed consent doctrine become clear and these solutions fit into the larger dialogue of reform for reproductive health care torts.

VII. Conclusion

Crisis pregnancy centers have recently begun converting to medical centers operated by medical staff, and with these conversions come new practices and new potential causes of action.[204] Informed consent is the concept that without full disclosure of material information, patients cannot make autonomous decisions about their care.[205] In the context of reproductive health, this is especially important.[206] At crisis pregnancy centers, medical providers do not provide full and accurate information about abortion or contraception.[207] Under the current informed consent doctrine, however, holding these providers accountable for a failure to provide medical information is difficult.[208] Modifying both the causation and injury requirements in reproductive health care cases would realign informed consent elements with its philosophical roots.[209]

People should have autonomy to make health care decisions with full and accurate information about all safe and viable options. The person most impacted by the health care decision should be the one making that decision. In the case of reproductive health care at crisis pregnancy centers, the decision-makers are those withholding information instead of the person most affected by the decision, the patient. Modifying informed consent doctrine applied to reproductive health care would recognize the harm in denying people the ability to make decisions that forever impact their lives.

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202. *See supra* Part V.

203. *See* Yakren, *supra* note 161, at 622–23 (arguing for recognition of "deprivation of reproductive choice" instead of "wrongful birth" claims). *See generally* Meisel, *supra* note 183 (arguing that informed consent should be classified as a dignitary tort); Fox, *supra* note 25 (arguing for a recognition of reproductive injuries); Bryant & Swartz, *supra* note 14 (arguing that crisis pregnancy centers are failing to provide proper informed consent).

204. *See supra* Part III.

205. *See supra* Section IV.A.

206. *See supra* notes 29–31 and accompanying text.

207. *See supra* Part III.

208. *See supra* Part V.

209. *See supra* Part VI.