

**ABNORMAL PERSONS OR EMBEDDED INDIVIDUALS?:  
TRACING THE DEVELOPMENT OF INFORMED  
CONSENT REGULATIONS FOR ABORTION**

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## INTRODUCTION

A consent to an abortion is not voluntary and informed, unless, in addition to any other information that must be disclosed under the common law doctrine, the physician provides that pregnant woman with the following information:

- (1) A statement in writing providing the following information:  
 . . .  
 (b) *That the abortion will terminate the life of a whole, separate, unique, living human being;*  
 (c) *That the pregnant woman has an existing relationship with that unborn human being . . . ;*  
 (d) That by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated;  
 (e) A description of all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including:  
 (i) *Depression and related psychological distress;*  
 (ii) *Increased risk of suicide ideation and suicide; . . . .*<sup>1</sup>

Abortion regulations that require the woman's "informed consent" have become a common means for states to influence and restrict women's decisions to terminate their pregnancies. Yet the notion of informed consent, as originally developed in health care jurisprudence, bears little resemblance to the current invocation of the doctrine in the abortion context. Informed consent restrictions in abortion have been criticized as biased, paternalistic, and coercive, as well as divergent from the principles of autonomy and self-determination on which the original doctrine of informed consent was based.<sup>2</sup>

<sup>1</sup> S.D. CODIFIED LAWS § 34-23A-10.1 (2009) (emphasis added). On remand, ruling on the constitutionality of this statute, the South Dakota District Court held, *inter alia*, that provision (b) ("biological disclosure") was constitutional, but that provisions (c) and (d) ("relationship disclosures") and (e)(ii) ("suicide disclosure") were unconstitutional. *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 650 F. Supp. 2d 972, 976–79, 982–83 (D.S.D. 2009).

<sup>2</sup> See generally Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 225 (2009) (arguing that "the denial of pregnant women's capacity to make abortion decisions unjustifiably diverges from the law's treatment of patient decision-making in both the private law doctrine of informed consent and in public law constitutional cases governing medical decision-making."); Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1701 (2008) (discussing how the form of gender paternalism evident in *Carhart* attempts to remedy harm to women by

The purpose of this Article is to chart how the doctrine of informed consent entered into and helped shape the abortion discourse. Moving historically from seduction law, to labor law, to the origins of informed consent in healthcare, to the debates over the decriminalization of abortion, and into the present, this Article will illustrate how the development of an alternate system of legal treatment for women fostered and perpetuated the assumptions that make informed consent restrictions on reproductive choices legally and socially acceptable today.

This Article posits that an underlying conception of women as not solely status-defined, but not quite autonomous or rational, has led to women being “shifted” from treatment as first-track, classical liberal theory individuals to second-track, “abnormal” persons, depending on the needs of society as determined by those in positions of power (typically a white, male, propertied elite).<sup>3</sup> Because of this track-shifting, certain assumptions about wo-

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controlling them, in contrast to the focus on decisional autonomy in *Casey*); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 265 (1992) (situating abortion-restrictive legislation in the social and historical context of discourses about women’s roles and women’s bodies); Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193, 1196 (2010) (discussing the Supreme Court’s reasoning that increased restrictions on abortion are needed to protect women from the psychological harm of their own decisions); see also B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 279–80 (2007) (exploring contradictions arising from two separate lines of constitutional doctrine involving medical treatment, using as examples abortion and medical marijuana); Linda P. McKenzie, *Federally Mandated Informed Consent: Has Government Gone Too Far?* 20 J.L. & HEALTH 267, 269 (2006–07) (discussing the legal and ethical implications of the mandated provision of specific information in medical treatment decisions); Kathy Seward Northern, *Procreative Torts: Enhancing the Common-Law Protection for Reproductive Autonomy*, 1998 U. ILL. L. REV. 489, 491 (1998) (advocating for the use of tort law to protect women’s procreative autonomy); Amanda McMurray Roe, *Not-So-Informed Consent: Using the Doctor-Patient Relationship to Promote State-Supported Outcomes*, 60 CASE W. RES. L. REV. 205, 207–08 (2009) (arguing that statutes mandating the provision of medically dubious information for moral ends undermine the integrity of informed consent). For institutional assessments of the accuracy of informed consent materials, see Chinuè Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, GUTTMACHER POL’Y REV., Fall 2006, at 6; Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, GUTTMACHER POL’Y REV., Fall 2007, at 6.

<sup>3</sup> At other points, I will refer to this division of power as the gender/power hierarchy. See, e.g., CAROLE PATEMAN, *THE SEXUAL CONTRACT* 3 (1988) (observing that “civil society is patriarchal”); Carol Horton, *Liberal Equality and the Civic Subject: Identity and Citizenship in Reconstruction America*, in *THE LIBERAL TRADITION IN AMERICAN POLITICS* 115, 124 (David F. Ericson & Louisa Bertch Green eds., 1999) (“[T]he universal subject had always been unproblematically male; women, it was widely assumed, were not, by their very nature, really individuals.”); Catharine MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1281–84 (1991) (“No woman had a voice in the design of the legal institutions that rule the social order under which women, as well as men, live. . . . An account of sex inequality under law in the United States must begin with what white men have done and not done because they have created the problem and benefited from it, controlled access to addressing it, and stacked the deck against its solution.”); Carol Nackenoff, *Gendered Citizenship: Alternative Narratives of Political Incorporation in the United States, 1875–1925*, in *THE LIBERAL TRADITION IN AMERI-*

men based on their historic second-track status—namely, that the public has an interest in their reproductive functions, that women have a natural predisposition toward motherhood, and that the female mind is inherently mentally unstable—accompanied women even when the law treated them as first-track, liberal theory individuals. The current perversion of informed consent doctrine in the abortion context, which is focused on the mental health effects of abortion rather than the right to bodily autonomy or self-determination,<sup>4</sup> is the result of a framework that has developed from entrenched conceptions of women both as mothers and as mentally unstable.

Part I of this Article will discuss the two-track system of treatment for normal individuals versus abnormal persons, building off of the work of Martha Minow and Carole Pateman. First, it will provide an example of women's transferable legal treatment by comparing seduction law and labor law. It will explore how women's transferability was used by Progressive activists to promote the idea that all persons were capable of rational autonomy but often embedded in a social context that prevented their exercise of this autonomy—what I am calling the concept of the *embedded individual*. Progressive application of the theory of embedded individuality in labor law led to a sharp shift in legal treatment of women laborers. Although this benefitted worker protection regulation as a whole, it also helped foster a separate system of legal treatment for women premised on their childbearing capacity. Part II will discuss the central role of track-transferability in the early development of the concept of informed consent in health care, and the doctrine's gradual incorporation of the embedded individual approach. Part III will explore how prevailing assumptions about women's inherent mothering nature and mental instability influenced the promotion of pre-abortion counseling during the period of abortion's decriminalization in the late 1960s to early 1970s, and how this was fused with informed consent doctrine as a means of ensuring that the woman's decision about whether to continue her pregnancy was both "rational" and "autonomous." Part IV will illustrate how continued belief in the connection between mental health and reproduction, assumptions about women's mothering nature, and the supposed public interest in progeny have created a legal framework in which a perversion of the embedded individual approach of the original informed consent doctrine has been mobilized to promote and justify a second-track, status-based treatment of women in the abortion context. Finally, this Article will discuss problems with a pro-choice legal strategy based on motherhood that come to the forefront in light of the foregoing historical exploration. It will suggest that if *motherhood* is to be reclaimed by the women's movement, it must be

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CAN POLITICS, *supra*, at 137, 140 (“[N]on-citizens have been understood to be non-white, non-male, non-adult, non-agents,” who “require[ ] guidance, restraint, and sometimes protection.”).

<sup>4</sup> See *infra* Part IV.

done carefully, in a way that not only respects women as rational, autonomous individuals, but also recognizes their power.

## I. HISTORY AND THEORY: TWO TRACKS OF TREATMENT, FROM SEDUCTION TO LABOR LAW

### A. *Theoretical Background: Normal Individuals and Abnormal Persons*

The individual of traditional liberal theory<sup>5</sup> is the epitome of rationality and autonomy, a “hard and unyielding individual” with “boundless, empty freedom,”<sup>6</sup> who exists “without any relationships with others.”<sup>7</sup> According to early liberal theorists like John Locke,<sup>8</sup> Thomas Hobbes,<sup>9</sup> and Jean-Jacques Rousseau,<sup>10</sup> a citizenry composed of such individuals created the social contract, on which Western notions of liberty and the state-individual relationship are founded.<sup>11</sup> Not all persons subject to civil government were citizen-individuals, however. Married women, children, slaves, servants, the insane, and other dispossessed persons, whose status defined them as infer-

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<sup>5</sup> The intellectual foundations of liberalism, whose origins are attributed to Enlightenment thinkers such as John Locke, center on a conception of “free and equal individuals, competing with each other in a market to protect and further their interests,” under a social contract guaranteeing protection of rights in exchange for obedience to the state. CAROLE PATEMAN, *THE PROBLEM OF POLITICAL OBLIGATION: A CRITIQUE OF LIBERAL THEORY* 164 (1985).

<sup>6</sup> JESSIE TAFT, *THE WOMAN MOVEMENT FROM THE POINT OF VIEW OF SOCIAL CONSCIOUSNESS* 52 (1915). This book, Dr. Taft’s Ph.D. dissertation in Philosophy at the University of Chicago in 1913, challenged the individual of classical liberal theory and formed part of the foundation for modern feminism by claiming that the “freedom that was supposed to reside in the individual is seen to be realized only through society.” NACKENOFF, *supra* note 3, at 154–55 (quoting TAFT, *supra*, at 51).

<sup>7</sup> PATEMAN, *supra* note 3, at 55.

<sup>8</sup> JOHN LOCKE, *TWO TREATISES OF GOVERNMENT* 168–69 (Thomas I. Cook ed., Hafner Press 1970) (1690) (“Men being, as has been said, by nature, all free, equal, and independent, no one can be put out of this estate and subjected to the political power of another without his own consent. The only way whereby any one divests himself of his natural liberty, and puts on the bonds of civil society, is by agreeing with other men to join and unite into a community, for the comfortable, safe and peaceable living one amongst the other, in a secure enjoyment of their properties and a greater security against any, that are not of it.”).

<sup>9</sup> THOMAS HOBBS, *LEVIATHAN* 87 (A. R. Waller ed., Cambridge University Press 1904) (1651) (discussing the Second Law of Nature: “That a man be willing, when others are so too, as farre-forth, as for Peace, and defence of himselfe he shall think it necessary, to lay down this right to all things; and be contented with so much liberty against other men, as he would allow other men against himselfe.”) (emphasis omitted).

<sup>10</sup> JEAN-JACQUES ROUSSEAU, *THE SOCIAL CONTRACT* 24–25 (Cosimo, Inc. 2008) (1762) (discussing the act of forming the Social Contract: “At once, in place of the individual personality of each contracting party, this act of association creates a moral and collective body, composed of as many members as the assembly contains voters, and receiving from this act its unity, its common identity, its life and its will. The public person, so formed by the union of all other persons, formerly took the name of *city*, and now takes that of *Republic* or *body politic* . . .”).

<sup>11</sup> See MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW* 124 (1990); PATEMAN, *supra* note 3, at 55–56, 60.

ior to and dependent on a (usually male) guardian figure, were exempt from the social contract and from the ability to contract in general.<sup>12</sup> Because of their subordinate status, they were not privy to the same rights of liberty and self-determination as white, male, empowered individuals. Instead, they were conceptualized as incapable of autonomy or rationality, justifying their social subordination.<sup>13</sup>

Martha Minow, drawing on classical legal theorists' distinction between "normal" and "abnormal" persons, posits the existence of a second track of legal treatment for non-individual, status-defined persons.<sup>14</sup> The first track reflects a respect for liberal principles like autonomy and rationality.<sup>15</sup> It views relationships between individuals as governed by contract, and presumes that contract is a manifestation of the free and equal will of the parties.<sup>16</sup> The second track presumes dependence and irrationality, and views persons as legally inseparable from their status relationships with first-track individuals.<sup>17</sup> As modern contract theory developed in legal thought, however, a conception of women as purely abnormal exposed the fundamental contradiction in women's absence from classical social contract theory: women's ability to enter into some contracts, notably the marriage contract, presupposed a degree of rationality and autonomy for women that a purely "abnormal" status would deny them.<sup>18</sup> As Janet Halley illustrates, this tension in the conceptualization of marriage was apparent to legal schol-

<sup>12</sup> MINOW, *supra* note 11, at 124; PATEMAN, *supra* note 3, at 54; Janet Halley, *What is Family Law?: A Genealogy, Part I*, 23 *YALE J.L. & HUMAN.* 1 (2011) (citing 3 THEOPHILUS PARSONS, *THE LAW OF CONTRACTS* (1853) & WILLIAM BLACKSTONE, *COMMENTARIES ON THE LAWS OF ENGLAND* (1765)).

<sup>13</sup> PATEMAN, *supra* note 3, at 52–53.

<sup>14</sup> MINOW, *supra* note 11, at 126 ("The competent can advance claims based on principles of autonomy; the incompetent are subject to restraints that enforce relationships of dependence. These 'two tracks' of legal treatment reflect the traditional Western idea that responsibility follows only from voluntary, knowing, and intelligent choice."); see also DUNCAN KENNEDY, *THE RISE AND FALL OF CLASSICAL LEGAL THOUGHT* 185 (2006) (discussing the emergence under classical legal thought of "a specialized law of persons, and of a new category of status, that grouped together and explained the peculiar character of rules incompatible with the new [classical legal] vision of the nature of 'real' contracts").

<sup>15</sup> See MINOW, *supra* note 11, at 126.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* See also PATEMAN, *supra* note 3, at 10 (discussing one definition of status as ascription—"human beings are born into certain social positions by virtue of their ascribed characteristics, such as sex, colour, age and so on"—the definition primarily employed in this Article).

<sup>18</sup> PATEMAN, *supra* note 3, at 6, 54 (observing that "[i]f women have been forcibly subjugated by men, or if they naturally lack the capacities of 'individuals,' they also lack the standing and capacities necessary to enter into the original contract," yet they must enter the marriage contract); MacKinnon, *supra* note 3, at 1282 ("Yet the applicability of these reigning conceptions [of Hobbes, Locke, and Rousseau] of equality, consent, and human need to at least half the population went unquestioned as women—including those owned neither in marriage nor in slavery—were deemed in theory to be participants in the social compact, while most women in life were not allowed to sign a contract.").

ars in the mid-1800s, who attempted to address it by viewing marriage as an amalgam of status and contract.<sup>19</sup>

The nineteenth century saw many formerly status-defined groups shifted (at least ostensibly) from second- to first-track treatment. The transition of the abnormal-track servant to the first-track laborer provided an example to other abnormal groups, including women, of how this transference could be accomplished.<sup>20</sup> The master-servant relation was originally considered a form of status.<sup>21</sup> However, as Robert Steinfeld illustrates, in the years following the American Revolution, labor became disengaged from the “family government” model of household relations.<sup>22</sup> Whereas from the eighteenth to early nineteenth century, servants, indentured servants, and slaves were conceptualized as being under the control and protection of the master of the house, in the early nineteenth century laborers began to insist on their individual autonomy and free will.<sup>23</sup> Henry Sumner Maine recognized this shift as part of a larger move from status to contract.<sup>24</sup> Part of the reason for this reconceptualization was an attempt by the white working class to distinguish themselves from black slaves; it was also a reaction to the perceived status-based hierarchies of England, to which the freedom and liberty rhetoric of the new United States of America was distinctly opposed.<sup>25</sup> The employment contract became a symbol of this freedom of self-determination.<sup>26</sup> By the late nineteenth century, the conception of the laborer as independent, autonomous, and capable of contracting freely was firmly entrenched in the employment context.<sup>27</sup>

The establishment of a view of employment as contractual meant that, when women began to enter the workforce in the late nineteenth century, women laborers were also considered parties able to contract. This conflicted with the dominant conception of women as abnormal persons and

<sup>19</sup> Halley, *supra* note 12, at 5; *see also* PATEMAN, *supra* note 3, at 112 (“If women are purely objects of exchange . . . then they cannot take part in contract—but their inability to participate creates a major problem for contract doctrine.”).

<sup>20</sup> *See* Halley, *supra* note 12, at 15.

<sup>21</sup> ROBERT STEINFELD, *THE INVENTION OF FREE LABOR: THE EMPLOYMENT RELATION IN ENGLISH AND AMERICAN LAW AND CULTURE, 1350–1870*, at 56 (2002).

<sup>22</sup> *Id.* at 56, 126.

<sup>23</sup> *Id.* at 126–27; *see also* KENNEDY, *supra* note 14, at 206 (“[I]f employment was a status, it was also, according to the dichotomy that dominated Classical legal thought, ‘feudal, regressive, paternalistic,’ and so demeaning to the laborer. To say that ‘laborer’ was a special status was to say that workers lacked full legal capacity . . .”).

<sup>24</sup> HENRY SUMNER MAINE, *ANCIENT LAW* 170 (Transaction Publishers 3d ed. 2002) (1866).

<sup>25</sup> STEINFELD, *supra* note 21, at 127.

<sup>26</sup> AMY DRU STANLEY, *FROM BONDAGE TO CONTRACT: WAGE LABOR, MARRIAGE, AND THE MARKET IN THE AGE OF SLAVE EMANCIPATION* 35 (1998); *see also* JULIE NOVKOV, *CONSTITUTING WORKERS, PROTECTING WOMEN: GENDER, LAW, AND LABOR IN THE PROGRESSIVE ERA AND NEW DEAL YEARS* 58 (2001) (“One who exercised liberty of contract was no longer merely a ‘not slave’ but instead was an affirmatively free agent with the masculine authority to control the direction of his life.”).

<sup>27</sup> PAMELA HAAG, *CONSENT: SEXUAL RIGHTS AND THE TRANSFORMATION OF AMERICAN LIBERALISM* 25 (1999); NOVKOV, *supra* note 26, at 52.

thus generally unable to contract.<sup>28</sup> To maintain the legitimacy of women's participation in contractual relationships, in the late nineteenth and into the twentieth century, the legal system developed a separate, flexible treatment of women which viewed them as somewhat rational and autonomous—sufficiently so to form contracts, but not so much that their liberty of contract could not be overridden. Some degree of flexibility regarding women's economic individuality had already been legally recognized with regards to the contractual capacity of married women.<sup>29</sup> Although Blackstone's *Commentaries* presented married women as having given up whatever contractual ability they had upon marriage, a strict application of this view to nineteenth-century economic reality was unfeasible.<sup>30</sup> Married women were seen as legally capable of independent economic activity in certain circumstances—for instance, when the husband was away for long periods, or when isolating a woman's property protected it from her husband's creditors.<sup>31</sup> Yet, although some nineteenth-century legal scholars like Tapping Reeve believed that “the commercial intricacies of marital property” required recognizing women's ability to contract, they still considered limitations on women's contractual powers to exist because of their subordinate, weaker status.<sup>32</sup>

These entrenched assumptions about women's abnormal status, which painted them as physically and mentally weak and incapable of self-governance, prevented women from being recognized as completely independent (or to adopt Minow's framework, from being located on track one).<sup>33</sup> Despite this, in cases like marriage and employment, courts viewed women as sufficiently rational and autonomous to form a contract in order to preserve the fiction of liberal contract theory, which upheld necessary social institutions like the family and capitalism.<sup>34</sup> This conception of women as semi-rational and semi-autonomous allowed the legal system to attribute decision-making capacity to women and respect their legal contracts when necessary for certain ends, like economic stability. This phenomenon, which I am calling *track transference* or *track shifting*, will be explored more thoroughly in the next Section.

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<sup>28</sup> The exception was the *feme sole*, a woman who was of age but not yet married, whom Maine recognized as, like the worker, having the ability to contract. MAINE, *supra* note 24, at 157. Janet Halley explores the attempts of legal scholars to explain marriage as contract- or status-based while avoiding the implications for women's individual liberty that a view of marriage as pure contract would carry. Halley, *supra* note 12, at 10. I suggest that this same unease accompanied the entrance of women into the public labor force.

<sup>29</sup> Norma Basch, *Invisible Women: The Legal Fiction of Marital Unity in Nineteenth-Century America*, 5 FEMINIST STUD. 346, 351 (1979); Halley, *supra* note 12, at 5.

<sup>30</sup> Basch, *supra* note 29, at 350–51.

<sup>31</sup> *Id.* at 349, 352.

<sup>32</sup> *Id.* at 352 (referencing TAPPING REEVE, THE LAW OF BARON AND FEMME (1816)).

<sup>33</sup> NOVKOV, *supra* note 26, at 74; PATEMAN, *supra* note 3, at 96.

<sup>34</sup> PATEMAN, *supra* note 3, at 54–55.

*B. Track Transferability: Abnormally Seduced and Rationally Employed*

When belief in women's complete autonomy and rationality threatened existing power structures, particularly in cases of sexual relations between white women and "socially inappropriate men,"<sup>35</sup> women's autonomy (called "consent") was downplayed, and conflicts were framed as between men over the right to access certain women.<sup>36</sup> Conversely, when the maintenance of the social order required that women were seen as contract-capable, women were treated as rational, autonomous individuals.<sup>37</sup> Although many examples exist, this paper will highlight women's treatment in seduction law versus labor law to exemplify this transferability.<sup>38</sup>

The right of certain men to access certain women is a central motivating factor for treating women as abnormal, and thus incapable of making their own rational, autonomous decisions. Carole Pateman calls this fraternal order of access to women the "sexual contract."<sup>39</sup> Seduction law provides a clear case of transferability for the sake of upholding the fraternal sexual contract, and also establishes the right of access to women and women's sexual/reproductive services as a matter of public concern. Seduction law of the nineteenth and early twentieth centuries provided a cause of action for a husband or father against a woman's seducer, based on common law liability for theft of a servant.<sup>40</sup> Victorian ideology's conception of white women as

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<sup>35</sup> Socially inappropriate men included non-white or lower-class men, or men who did not have proper relations with the women concerned, such as those who engaged in sexual relations with women who were either not married or married to someone else (and thus under the province of the father or husband). See, e.g., HAAG, *supra* note 27, at 148 (discussing the trial of three non-white men in Ala Moana, Hawaii for raping a white woman; the trial was framed as "an exercise in determining the extent of men's rights as citizens over women. . . . [T]he right of a white man to govern his own women and protect them from assailants envisioned as nonwhite.") (emphasis omitted).

<sup>36</sup> PATEMAN, *supra* note 3, at 113 (discussing the importance of maintaining the marriage institution as a means of ensuring the fraternal order of access to women).

<sup>37</sup> See *supra* Part I.A; NOVKOV, *supra* note 26, at 61.

<sup>38</sup> For a detailed inquiry into different areas of illegal or illicit activity where women were either recognized as first-track and thus having consented, or second-track and thus having been coerced, see generally HAAG, *supra* note 27. See also MARY E. ODEM, *DELINQUENT DAUGHTERS: PROTECTING AND POLICING ADOLESCENT FEMALE SEXUALITY IN THE UNITED STATES, 1885–1920* (1995) (discussing policies of sexual regulation principally targeting working-class teenage girls in response to moral reform campaigns in the late nineteenth and early twentieth centuries).

<sup>39</sup> PATEMAN, *supra* note 3, at 102–03, 109–10. In Pateman's retelling of the story of the genesis of civil society, men "make a sexual contract. They establish a law which confirms masculine sex-right and ensures that there is an orderly access by each man to a woman. . . . The original contract that creates civil society . . . implicitly incorporates the sexual contract." *Id.* at 109–10.

<sup>40</sup> Jane E. Larson, "Women Understand So Little, They Call My Good Nature 'Deceit'": A Feminist Rethinking of Seduction, 93 COLUM. L. REV. 374, 380, 382 (1993) (exploring the history of seduction law and suggesting the reconception of seduction as the tort of "sexual fraud," providing an avenue for the woman to obtain damages in cases of "intentional, harmful misrepresentation made for the purpose of gaining [her] consent to sexual relations"—a woman-empowering, non-consent-driven alternative to rape prosecution).

predisposed towards chastity but, by virtue of their natural irrationality, easily coerced, negated the possibility that chaste women could agree to illicit intercourse without overwhelming male persuasion.<sup>41</sup> This located women squarely on the “abnormal status” track—they were neither rational nor autonomous, and so were not responsible for illicit intercourse; their active agreement to the relation was irrelevant. Rather, the action lay against the seducer for depriving the husband or father of his socially- and legally-recognized right of access to the woman.<sup>42</sup> By viewing women as incapable of autonomy in this situation, white male citizen individuals could levy the law against unacceptable partners in the name of protecting women, which really meant protecting certain men’s right of access to certain women.<sup>43</sup> Furthermore, seduction was framed as a crime against “public purity,” thereby locating the woman’s sexual and reproductive conduct within the sphere of public oversight.<sup>44</sup> Seduction law was thus an example of maintaining women’s status as subordinate both to a particular man and to the review of society.

Alternatively, when the court considered the “seduced” woman to be unchaste or a prostitute, she was viewed as a first-track, liberal theory individual.<sup>45</sup> Her capacity “to strike self-interested, albeit perhaps immoral, ‘bargains’” was recognized, and she had no recourse under the law of seduction but was instead condemned for her decision to act immorally.<sup>46</sup> This is an example of track-shifting for social purposes. Viewing prostitutes and unchaste women as responsible for their conduct and holding them liable served to disincentivize women from liaisons with socially inappropriate men. Additionally, as Pateman points out, prostitution was tacitly seen as a “necessary evil,”<sup>47</sup> as well as “an integral part of patriarchal capitalism.”<sup>48</sup> Unchaste women and prostitutes were not under the province/protection of any particular man, and so under the sexual contract they were available for

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<sup>41</sup> *Id.* at 388. As illustrated by the statement of the victim in one 1845 seduction case that “he [the seducer] compelled me to consent,” consent and coercion were not seen as diametrically opposed, the way they are in contemporary rape law. HAAG, *supra* note 27, at 7–9. See also ELAINE SHOWALTER, *THE FEMALE MALADY: WOMEN, MADNESS AND ENGLISH CULTURE, 1830–1980* (1987) (discussing the historical interplay between social conceptions of women, deviance, and insanity).

<sup>42</sup> HAAG, *supra* note 27, at 4–5.

<sup>43</sup> PATEMAN, *supra* note 3, at 93–94.

<sup>44</sup> HAAG, *supra* note 27, at 12. This theme will recur in the abortion context, as detailed in Parts III and IV *infra*.

<sup>45</sup> HAAG, *supra* note 27, at 26.

<sup>46</sup> *Id.* at 26, 34.

<sup>47</sup> PATEMAN, *supra* note 3, at 190 (“Prostitution was seen . . . as a necessary evil that protected young women from rape and shielded marriage and the family from the ravages of men’s sexual appetites . . .”); Larson, *supra* note 40, at 390 n.64 (“Although Victorian culture prized the ideal of female modesty and male restraint, it tolerated in practice a double standard under which men routinely engaged in illicit sexual activity with little social penalty.”).

<sup>48</sup> PATEMAN, *supra* note 3, at 189 (“Prostitutes are readily available at all levels of the market for any man who can afford one and they are frequently provided as part of business, political and diplomatic transactions.”).

access by all men.<sup>49</sup> Viewing unchaste women and prostitutes as first-track liberal individuals made the women liable for their conduct instead of the men, thus preserving the social-sexual contract of certain men's right to access certain women.

Similarly, in cases where belief in women's rationality and autonomy was necessary to uphold the liberal capitalist regime based on freedom of contract,<sup>50</sup> women were situated on the first track. *Ritchie v. People*<sup>51</sup> provides an example of an early labor case where women were shifted to the first track for the purposes of promoting manufacturing interests and striking down restrictive labor legislation.<sup>52</sup> The case challenged an eight-hour working limit for women in factories.<sup>53</sup> Noting that the Illinois constitution guaranteed equal rights to men and women, the court stated:

[I]nasmuch as sex is no bar, under the constitution and the law, to the endowment of woman with the fundamental and inalienable rights of liberty and property which include the right to make her own contracts, the mere fact of sex will not justify the legislature in putting forth the police power of the State for the purpose of limiting her exercise of those rights . . . .<sup>54</sup>

The court attributed the same capacity for legal contracting to male and female employees.<sup>55</sup> Although such gender-blind enforcement of rights in the-

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<sup>49</sup> This is a logical inference of Pateman's theory of the fraternal sexual contract, which makes certain women available for access by only certain men. It is also apparent in the dichotomous Victorian view of women as either virgins or whores. See generally HAAG, *supra* note 27.

<sup>50</sup> In classical legal thought at the turn of the nineteenth century, contract law, as the expression of individualism and the will theory, was central to the promotion of a laissez-faire economic order. The purpose of law was to allow individuals to give expression to their wills through contract. See, e.g., P.S. ATIYAH, *THE RISE AND FALL OF FREEDOM OF CONTRACT* 402–03, 405 (1979) (discussing the principle contractarian features of the free market, and stating that the “equation of general principles of contract law with the free market economy led to an emphasis on the framework within which individuals bargained with each other, and a retreat from interest in substantive justice or fairness. The model of contract theory which implicitly underlay the classical law of contract . . . was thus the model of the market.”); KENNEDY, *supra* note 14, at 159–60 (quoting *Parsons on Contracts*: “The Law of Contracts, in its widest extent, may be regarded as including nearly all the law which regulates the relations of human life . . . . [Implied contracts] form the web and woof of actual life.”); NOVKOV, *supra* note 26, at 78, 90.

<sup>51</sup> 40 N.E. 454 (Ill. 1895).

<sup>52</sup> NOVKOV, *supra* note 26, at 60–61. For other early labor cases treating women as contract-capable, see, for example, *Commonwealth v. Hamilton Mfg. Co.*, 120 Mass. 383, 385 (1876) (holding that a law limiting the number of hours a woman may work per day in a manufacturing establishment did not infringe on her right to work as many hours as she chose in another establishment); *In re Mary Maguire*, 57 Cal. 604, 607 (1881) (finding an ordinance prohibiting women from serving in bars unconstitutional, and stating that legislative power “shall never, by direct or indirect action, incapacitate any person on account of sex from entering upon or pursuing any lawful business, vocation, or profession”).

<sup>53</sup> *Ritchie*, 40 N.E. at 454.

<sup>54</sup> *Id.* at 458–59.

<sup>55</sup> NOVKOV, *supra* note 26, at 61.

ory reflected the principle of equality promoted by the nascent suffragist movement,<sup>56</sup> women were recognized as liberal individuals not because their rights were truly seen as inalienable but because it was in the interest of the laissez-faire freedom of contract regime and the state's promotion of industry to do so. By holding that women, like men, were capable of and entitled to form contracts, courts like that in *Ritchie* situated women on the first track. In this sense, women laborers were similar to prostitutes in that their work in the public sphere was necessary to the functioning of the public order—here, the capitalist industrial order. As in early marital property concerns,<sup>57</sup> this interest superseded women's status as abnormal persons, bypassing the status-imposed conception of women as irrational and dependent that would otherwise have situated them on the second track.

In determining when women are track-shifted, then, the question becomes one of balancing the benefit to those atop the gender/power hierarchy<sup>58</sup> in recognizing women as individuals versus the threat of disruption to the gender/power hierarchy implicit in such recognition. I posit that one of the key factors acting as a fulcrum in this balance is control of women's sexuality. In seduction law, the action lies in the seducer's taking control of the woman's sexuality without public sanction; the woman is second-tracked and the man is reprimanded. On the other hand, (tacit) public sanction has granted male customers control of the prostitute's sexuality; the woman is first-tracked, so *she* is reprimanded, and the man is absolved of responsibility. In labor law, however, control of women's sexuality was (at first)<sup>59</sup> not an issue and so a conceptualization of women as first-track individuals posed no threat. However, as we will see below, once control of sexuality is introduced into the labor context, through the element of reproduction, women's abnormality and lack of autonomy once again come to the fore.

### *C. An Alternative to a Two-Track System: The Embedded Individual Approach*

Progressive-era legal activists, concerned about poor labor conditions and the poverty of the working class, questioned the courts' traditional view of labor contracts as expressions of free and equal will.<sup>60</sup> They drew on the philosophy of activists like Jane Addams and Frederick Douglass, who saw the independence of white male citizen individuals as "synonymous with powerlessness and abandonment" for disempowered persons like the work-

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<sup>56</sup> See generally Reva B. Siegel, *She the People: The Nineteenth Amendment, Sex Equality, Federalism, and the Family*, 115 HARV. L. REV. 947, 972 n.68 (2002) (discussing the suffragists' early claim of equal voting rights under the "privileges and immunities" clause of the Fourteenth Amendment).

<sup>57</sup> See *supra* Part I.A.

<sup>58</sup> See *supra* note 3 (defining this term).

<sup>59</sup> See *infra* Part I.C.

<sup>60</sup> Nackenoff, *supra* note 3, at 140–43; see also *supra* note 50.

ing class, former slaves, immigrants, and women—those who worked in manufacturing jobs and were most exploited by capitalism and industrialization.<sup>61</sup> Progressive thought viewed such “abnormal” persons not as outside the traditional liberal definition of the individual, but as rational persons embedded in unequal and coercive environments that prevented them from acting in their best interests.<sup>62</sup> I am calling this view of all people as capable of rational autonomy but embedded in restrictive circumstances the *embedded individual* approach. Disempowered people, as contextually-embedded individuals, required state assistance to rectify the situational inequality that inhibited their rational autonomy. Unlike traditional liberal theory, the embedded individual approach viewed the state not as “an enemy of human liberty,” but as “a potential guarantor of social rights.”<sup>63</sup> The protective legislation Progressive activists promoted was intended to adjust for contextual, socio-legal inequality by providing mandatory protective barriers, such as limited-hour working days, to augment the bargaining power of disempowered individuals.<sup>64</sup>

Courts were unwilling to subscribe to a shift in the fundamental liberal definition of the individual, however. Rather than acknowledge the contextual inequality of bargaining power between employers and laborers that threatened the freedom of contract fiction, courts like that in *Ritchie*<sup>65</sup> in-

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<sup>61</sup> Nackenoff, *supra* note 3, at 143 (discussing Frederick Douglass’s view that citizenship and rights are dependent on society and government).

<sup>62</sup> *Id.*; see also Horton, *supra* note 3, at 123 (discussing how contextual inequality prevented the realization of the liberal individual: “Universalist assumptions of economic rationality undergirded policy formation and institution building in a way that furthered the rapid legitimation of basic liberal principles, such as freedom of contract, within an entrenched system of economic hierarchy and inequality.”); Gayle McQueen, *A “Guiding Principle” of Liberalism in the Thought of Frederick Douglass and W. E. B. DuBois*, in *THE LIBERAL TRADITION IN AMERICAN POLITICS*, *supra* note 3, at 99, 107 (exploring Frederick Douglass’s theory that “self-realization is attainable (and rights realizable) only when all members of society respect each other’s self-ownership”). Martha Minow discusses the impact of structural inequality on the two-track system of legal treatment in terms of rights discourse:

When reformers seek to apply the language of rights, taking the rhetoric of equality and freedom literally, they encounter the dilemma that rights crafted for the norm reiterate the differences of those at the margin, and special rights crafted for those at the margin risk perpetuating the negative effects of difference.

MINOW, *supra* note 11, at 224.

<sup>63</sup> Nackenoff, *supra* note 3, at 162 (internal quotation marks omitted) (citing Kathryn Kish Sklar, *The Historical Foundations of Women’s Power in the Creation of the American Welfare State, 1830–1930*, in *MOTHERS OF A NEW WORLD: MATERNALIST POLITICS AND THE ORIGINS OF WELFARE STATES* 43, 68 (Seth Koven & Sonya Michel eds., 1993)).

<sup>64</sup> *Id.* at 146, 153, 160. In legal scholarship, this critique of classical legal thought’s reliance on *laissez-faire* principles of equal and unregulated bargaining was exemplified by the work of Robert Hale, who emphasized that workers’ wages were not the result of “free” negotiation but dependent “on the relative power of coercion” that employers and employees could exercise against each other, a coercion that was the result of inequitable legal entitlements. Robert L. Hale, *Coercion and Distribution in a Supposedly Noncoercive State*, 38 *POL. SCI. Q.* 470, 478 (1923).

<sup>65</sup> *Ritchie v. People*, 40 N.E. 454 (Ill. 1895).

sisted on viewing all parties to labor contracts, including women, as classic liberal individuals.<sup>66</sup> Labor restrictions were struck down as unconstitutional exercises of state police power over individual liberty to contract.<sup>67</sup> The conflict between police power and individual liberty was infamously (albeit temporarily) resolved in favor of the latter by the Supreme Court in *Lochner v. New York*.<sup>68</sup> As *Lochner* noted, the one exception to the incursion of police power on individual liberty was in the case of public health.<sup>69</sup>

The *Ritchie* court had also recognized the state's legitimate exercise of police power on behalf of public health. However, finding that the restriction on women's working hours was not justified by health but by sex alone, the court stated that sex-based protective legislation was unconstitutional "unless the courts are able to see, that there is some fair, just and reasonable connection between such limitation and the public health, safety or welfare proposed to be secured by it."<sup>70</sup> Here the court provided a clue. It hinted that in order for protective legislation for women to be upheld, Progressive litigators would have to establish the connection between public health and the sex of the workers.

#### D. *Conflating Situation and Status: Track Transference as a Tool of Social Welfare*

Progressive activists like Louis Brandeis and Josephine Goldmark realized that they could utilize status-based assumptions about women, as well as effects of situational equality like their weakness in bargaining situations, to support a public health justification for sex-specific protective legislation.<sup>71</sup> They emphasized the state's interest in women's reproductive func-

<sup>66</sup> See NOVKOV, *supra* note 26, at 90.

<sup>67</sup> *Id.* at 55.

<sup>68</sup> 198 U.S. 45, 61 (1905) (holding that the right to contract for employment is part of the liberty protected by the Fourteenth Amendment, and the state police power to regulate for the protection of public health and safety cannot override the right to contract "unless there be some fair ground, reasonable in and of itself, to say that there is material danger to the public health"); see also NOVKOV, *supra* note 26, at 92-93.

<sup>69</sup> 198 U.S. at 57, 62 (finding the connection between working-hour restrictions of bakers and public health to be "too shadowy and thin"). The trump-card quality of legitimate exercises of police power in the name of public health, however, was solidified by the Supreme Court in *Jacobson v. Massachusetts*, 197 U.S. 11, 26-28 (1905), decided in the same term as *Lochner*, which upheld compulsory vaccination as a proper exercise of police power for the benefit of public health.

<sup>70</sup> *Ritchie*, 40 N.E. at 459.

<sup>71</sup> The *embedded individual* view accords with Brandeis's philosophy that "the final end of the State was to make men free to develop their faculties," which was later apparent in his time on the Supreme Court. See *Whitney v. California*, 274 U.S. 357, 375 (1927); see also Vincent Blasi, *The First Amendment and the Ideal of Civic Courage: The Brandeis Opinion in Whitney v. California*, 29 WM. & MARY L. REV. 653, 668 (1988). For a history of Josephine Goldmark's involvement with progressive labor legislation, see Clement E. Vose, *The National Consumers' League and the Brandeis Brief*, 1 MIDWEST J. POL. SCI. 267 (1957).

tions as important to public health.<sup>72</sup> In so doing, they prompted the transfer of women from treatment as pure first-track individuals to treatment informed by their status as abnormal persons. This reasoning was central to their famous brief for the state, popularly known as the Brandeis Brief, in *Muller v. Oregon*.<sup>73</sup> The case challenged Oregon's ten-hour working day restriction for women laborers who were employed in laundries, and was the first time the Supreme Court found women-protective labor legislation constitutional.<sup>74</sup>

The Brandeis Brief articulates both the Progressive conception of the woman as an individual embedded in an unequal social context, as well as traditional assumptions about women's weakness compared to men. It argues:

It may be vehemently asserted that woman stands on the same plane with man, that she is *sui juris*, and that her sacred and inalienable right to enter into such contracts must remain inviolate; but such arguments are gilded sophistry; it is a matter of common knowledge that there is in this connection a clear distinction between the sexes, in opportunity, strength and capacity. There are fewer avenues of employment open to women than to men and competition for entrance thereto is keener, and, because of a physical difference, she is not able to endure the hours of work that a man is fitted for.<sup>75</sup>

The Brief presents unequal bargaining as the product of both context and nature; women are given fewer opportunities than men, but they are also weaker physically and in "capacity," i.e. mental power and ability.<sup>76</sup> Drawing heavily on scientific "evidence," the Brief lists extensive studies of the effect of overwork on "[c]hildbirth and [f]emale [f]unctions," noting a connection between long hours and sterility, infant mortality, and "puny, sickly, partly developed children," among other health and reproductive consequences.<sup>77</sup> It asks:

[K]nowing the duty she owes to the home and the family and that she is the mother of the citizens of a coming generation, can we say that a law restricting the number of hours in which she may

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<sup>72</sup> This was an extension of the belief that the state could regulate reproduction on behalf of public morals and the maintenance of the dominant social order. See Seigel, *Reasoning From the Body*, *supra* note 2, at 264–65.

<sup>73</sup> Brief for the State of Oregon, *Muller v. Oregon*, 208 U.S. 412 (1908) (No. 107), 1908 WL 27605 [hereinafter Brandeis Brief].

<sup>74</sup> *Muller v. Oregon*, 208 U.S. 412, 423 (1908). The statute at issue mandated "[t]hat no female (shall) be employed in any mechanical establishment, or factory, or laundry in this state more than ten hours during any one day." *Id.* at 416.

<sup>75</sup> Brandeis Brief, *supra* note 73, at 11.

<sup>76</sup> 2 OXFORD ENGLISH DICTIONARY 857–58 (2d ed. 1989).

<sup>77</sup> Brandeis Brief, *supra* note 73, at 36–37, 51.

labor, in certain classes of hard work, is not a law involving the safety, the morals, nor the welfare of the public?<sup>78</sup>

This reasoning combines the scientific rationale for women's weakness and assumptions about women's traditional status role as mother with a Progressive understanding of the contextual hurdles women face. All the while the Brief takes for granted the capability of women to enter into legal contracts—a thought that would have been radical for early social contract theorists like Locke and Rousseau.<sup>79</sup>

Indicating its place in a larger agenda, however, the Brief also emphasizes dangers of working long hours that are not sex-specific, such as the encouragement of moral vice, increased risk of accidents, and development of specific health problems, such as pelvic disorders, caused by long hours of standing.<sup>80</sup> This helped Progressive activists set the stage for recognizing power imbalances in the labor context that would eventually influence the development of greater protective legislation, including restrictions for male laborers.<sup>81</sup>

Yet even as the Brief upheld a conception of women as sufficiently autonomous and rational to contract, by employing status-based assumptions about women's physical and mental weakness and natural role as mothers, Goldmark and Brandeis reinscribed<sup>82</sup> a system of legal treatment for women that justified protective intervention by the state.<sup>83</sup> The Supreme Court's acceptance of this argument solidified a view of women as sub-rational and semi-autonomous.<sup>84</sup> Tellingly, in adopting Brandeis's justification for protective legislation, the *Muller* court focused almost exclusively on a woman's "physical structure and performance of maternal functions," rather than the situational inequality that prevented her from bargaining on equal

<sup>78</sup> *Id.* at 19.

<sup>79</sup> See *supra* Part I.A.

<sup>80</sup> Brandeis Brief, *supra* note 73, at 28, 44–45.

<sup>81</sup> For a study of how women-specific labor legislation promoted labor regulation reform for all laborers, see NOVKOV, *supra* note 26, at 185 ("[T]he courts were using arguments about workers' experiences in the labor market that had initially applied only to women to uphold protective measures for all workers."). See also *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379, 391 (1937) ("[T]he liberty safeguarded is liberty in a social organization which requires the protection of law against the evils which menace the health, safety, morals and welfare of the people. Liberty under the Constitution is thus necessarily subject to the restraints of due process, and regulation which is reasonable in relation to its subject and is adopted in the interests of the community is due process.").

<sup>82</sup> The Oxford English Dictionary defines *inscribe* as "To write, mark, or delineate (words, a name, characters, etc.) in or on something; esp. so as to be conspicuous or durable . . ." and "To delineate or trace (a figure or line) within a figure, so that some particular points of it lie in the boundary or periphery of that figure." 7 OXFORD ENGLISH DICTIONARY 1015 (2d ed. 1989). *Reinscribe* is defined as "to inscribe again." 13 OXFORD ENGLISH DICTIONARY 539 (2d ed. 1989). I use reinscribe in the sense of reiterating and re-emphasizing women's position in a certain social order.

<sup>83</sup> NOVKOV, *supra* note 26, at 139.

<sup>84</sup> *Muller v. Oregon*, 208 U.S. 412, 422–23 (1908).

footing with a male employer.<sup>85</sup> Women's primary status as mothers rather than workers and the public's interest in progeny justified the state's exercise of police power to intervene in their ability to contract: "as healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race."<sup>86</sup> As in seduction law,<sup>87</sup> the Court positions women's bodies as property, the disposition of which is a matter of public importance; however, instead of allocating the property interest in women's bodies between competing male claimants, here it belongs to the public at large.<sup>88</sup> Although the Court did not transfer women entirely back to second-track treatment, it instead viewed the woman as "properly placed in a class by herself"<sup>89</sup> and "needing especial care that her rights may be preserved."<sup>90</sup> This aligns with the theory of women as somewhat rational and somewhat autonomous, but not sufficiently so as to merit first-track individual treatment when the exercise of their independence could threaten dominant social structures; rather, women are transferrable between tracks based on the needs of the gender/power hierarchy.<sup>91</sup> The Court noted:

Even though all restrictions on political, personal, and contractual rights were taken away, and she stood, so far as statutes are concerned, upon an absolutely equal plane with [her brother] . . . her physical structure and a proper discharge of her maternal functions—having in view not merely her own health, but the well-being of the race—justify legislation to protect her from the greed as well as the passion of man.<sup>92</sup>

Importantly, the Court equated women's health with maternal health, implying that protecting women's health was only important insofar as women were mothers.<sup>93</sup> The rights that need preserving by the state include not just the right to contract, but the "right" to "proper[ly] discharge . . . maternal functions."<sup>94</sup> According to the Court, control of women's sexuality—in this case, their reproductive functions—was important to the survival of the race.<sup>95</sup> The public had an interest in safeguarding the health of national progeny, which necessitated ensuring state control over women's reproduc-

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<sup>85</sup> *Id.* at 421.

<sup>86</sup> *Id.*

<sup>87</sup> *See supra* Part I.B.

<sup>88</sup> *See Muller*, 208 U.S. at 421.

<sup>89</sup> *Id.* at 422.

<sup>90</sup> *Id.* at 421.

<sup>91</sup> *See supra* Part I.B.

<sup>92</sup> *Muller*, 208 U.S. at 422.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.* The diminishment and weakening of the Anglo-American citizenry against rising tides of non-Anglo immigrants was a central concern behind such changes to the legal architecture as, *inter alia*, the criminalization of abortion, the establishment of protective labor laws for women, and the criminalization of mail-order marriages during the late

tive functions. As in seduction law, control of women's bodies merited the transfer of women from treatment as first-track autonomous individuals to second-track, status-defined persons. This collapsing of women into their predetermined role as mothers, and making performance of that role a matter for public concern that is subject to oversight by the state, are themes that will recur in the abortion context, as will be explored in Parts III and IV.

The reasoning of the Brandeis Brief was widely accepted by state courts across the country.<sup>96</sup> When Brandeis presented this argument again in *Ritchie v. Wayman* ("*Ritchie II*"),<sup>97</sup> the Illinois Supreme Court proved no exception. Citing *Muller*, Judge Learned Hand opined:

It is known to all men (and what we know as men we cannot profess to be ignorant of as judges) that woman's physical structure and the performance of maternal functions place her at a great disadvantage in the battle of life . . . as weakly and sickly women cannot be the mothers of vigorous children, it is of the greatest importance to the public that the State take such measures as may be necessary to protect its women from the consequences induced by long, continuous manual labor in those occupations which tend to break them down physically . . . . [L]egislation which limits the number of hours which women shall be permitted to work . . . would fall clearly within the police power of the State.<sup>98</sup>

As *Ritchie II* and *Muller* illustrate, although women were granted sufficient autonomy and rationality to contract in the workplace, they could not be permitted to contract in such a way that would deprive the state of healthy progeny. The state thus claimed a right of access to women's bodies, just as men claimed access as a property right in seduction law. Women were free to make labor contracts as long as they did not overstep the state-imposed restriction that the ultimate and most important use of their physical functions was for reproduction. Permitting intervention to enforce this restriction via the state's interest in public health (reproduction) communicated and cemented the conception of women as not quite autonomous or rational individuals, and the "proper discharge of [their] maternal functions" as a matter of public concern.<sup>99</sup>

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nineteenth and early twentieth centuries. See HAAG, *supra* note 27, at 102; NOVKOV, *supra* note 26, at 153; Siegel, *Reasoning from the Body*, *supra* note 2, at 279.

<sup>96</sup> NOVKOV, *supra* note 26, at 140 (listing state courts that upheld protective labor legislation for women post-*Muller*).

<sup>97</sup> 91 N.E. 695 (Ill. 1910).

<sup>98</sup> *Id.* at 697.

<sup>99</sup> *Muller*, 208 U.S. at 422.

## II. FROM DEPENDENCY TO SELF-DETERMINATION: THE EMERGENCE OF INFORMED CONSENT

The doctrine of informed consent emerged in the midst of the debate over state interest in public health versus individual liberty. The principle that a doctor must obtain a patient's consent to operate was legally recognized as early as 1767, when an English court held that doctors could not perform unauthorized surgery on patients.<sup>100</sup> However, it was not considered the basis for a legal claim until the 1880s, when courts began recognizing causes of action for battery against physicians who had gone beyond the nature and scope of their patient's authorization.<sup>101</sup> The doctrine of informed consent as based on a respect for the patient's self-determination, however, was only articulated by courts in the early twentieth century, and it was inspired by the same principles of individual autonomy as *Lochner*.

### A. *First-Tracking Second Track Persons: Pratt v. Davis and Informed Consent*

The seminal informed consent cases established the right of patients to elect their own medical treatment after informed consultation with their doctors.<sup>102</sup> These early cases employed language that evoked the same Fourteenth Amendment liberty principles as *Lochner* and other freedom of contract cases. They stressed self-determination, autonomy, and bodily integrity, and referred to the physician-patient relationship as a form of contract.<sup>103</sup>

Decided the year after *Lochner*, *Pratt v. Davis* held that a doctor could not operate on a mentally-competent patient without her informed consent.<sup>104</sup> The Illinois state courts that heard *Pratt* viewed it in light of liberal princi-

<sup>100</sup> RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 116–17 (1986) (discussing *Slater v. Baker & Stapleton*, (1767) 95 Eng. Rep. 860 (K.B.)).

<sup>101</sup> *Id.* at 117; see also *State v. Housekeeper*, 16 A. 382 (Md. 1889), discussed in detail *infra* note 104.

<sup>102</sup> See, e.g., *Mohr v. Williams*, 104 N.W. 12, 12 (Minn. 1905) (unauthorized operation on female plaintiff's right instead of left ear); *Pratt v. Davis*, 79 N.E. 562, 564 (Ill. 1906) (unauthorized removal of patient's uterus and ovaries); *Rolater v. Strain*, 137 P. 96, 96 (Okla. 1913) (unauthorized removal of bone from female patient's toe during operation); *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 94 (N.Y. 1914) (unauthorized operation to remove tumor from female patient's stomach).

<sup>103</sup> *Mohr*, 104 N.W. at 15; *Rolater*, 137 P. at 98; *Housekeeper*, 16 A. at 384; *Carstens v. Hanselman*, 28 N.W. 159, 159 (Mich. 1886); see also Robert E. Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189, 191 (1961) (noting that the physician-patient relationship "is essentially contractual in nature").

<sup>104</sup> *Pratt*, 79 N.E. at 565. In tracing the path of informed consent, an important case in establishing a woman's right to make independent medical decisions was *Housekeeper*, 16 A. at 382. This was a criminal suit for the death of Matilda Janney allegedly caused by the negligent or wrongful removal of the patient's breast, instead of just the tumor in the breast. Although not a direct precursor to liability in tort for operating without consent, this case established a valuable precedent for treating women patients as semi-autonomous actors in the health context. Finding that evidence existed that the wife

ples of autonomy and individualism.<sup>105</sup> These principles had been given such legal clout via *Lochner's* interpretation of the Fourteenth Amendment that, for the *Pratt* court, they overrode status-based considerations that previously could have posed a serious obstacle to the case's success.<sup>106</sup> The court's reasoning echoed *Ritchie I* and other pre-*Muller* labor cases that expanded the conception of the rational actor to include persons who had previously been thought to lack decision-making capacity—not just women, but presumptive mental incompetents as well.<sup>107</sup>

The plaintiff of *Pratt*, Parmelia Davis, suffered from epilepsy.<sup>108</sup> In 1896, she and her husband visited Dr. Pratt's sanitarium, where Dr. Pratt undertook to cure Parmelia by mutilation and amputation of her genital and reproductive organs.<sup>109</sup> Parmelia's husband agreed to the first "trifling" surgery,<sup>110</sup> in which Dr. Pratt intended "to loosen the head of the clitoris, to dilate and curette and operate for the laceration of the cervix of the uterus, and to put the rectum in repair,"<sup>111</sup> and apparently Parmelia consented as well.<sup>112</sup> However, as Parmelia's symptoms did not abate after this "surface" operation, Dr. Pratt requested that she be returned to the sanitarium, where, while her husband was out of town, he anaesthetized Parmelia and operated

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consented to the operation, and so the husband's lack of consent was irrelevant, the court held:

If she consented to the operation the doctors were justified in performing it, if after consultation they deemed it necessary for the preservation and prolongation of the patient's life. Surely the law does not authorize the husband to say to his wife: "You shall die of the cancer; you cannot be cured." . . . The husband had no power to withhold from his wife the medical assistance which her case might require.

*Id.* at 383–84. Although this does not grant the woman total autonomy in elective operations—her consent is subject to the doctor's assessment of her need for the treatment—it does remove her from complete dependence on her husband, in situations where the husband has refused to provide for her. This approach views women as semi-autonomous, allowing them to make decisions subject to the oversight of a competent man, either the husband or the doctor. It also implies that whatever interest the husband has in his wife as property (as seen in seduction law) is not so extensive that he can deny her the protection that their status relationship requires.

<sup>105</sup> *Pratt*, 79 N.E. at 564.

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* at 563.

<sup>109</sup> *Id.* From the mid-to-late 1800s until the early twentieth century, popular medical theories viewed disease as caused and exacerbated by expenditures of sexual energy. See SHOWALTER, *supra* note 41, at 55. The "sympathetic connection existing between the brain and the uterus" was thought to contribute to mental illnesses, from insanity and epilepsy to conditions more clearly linked to sexuality or reproduction. *Id.* at 55–56 (internal quotation marks omitted). See also John Studd, *Ovariectomy for menstrual madness and premenstrual syndrome—19th century history and lessons for current practice*, 22 J. GYNECOLOGICAL ENDOCRINOLOGY 411, 413 (2006) (providing a history of the removal of ovaries "in order to prevent insanity and moral decline"). Inmates in psychiatric hospitals were regularly subject to such operations. *Id.*

<sup>110</sup> 79 N.E. at 564.

<sup>111</sup> *Pratt v. Davis*, 118 Ill. App. 161, 169 (1905).

<sup>112</sup> 79 N.E. at 564.

on her again, this time removing her uterus and ovaries.<sup>113</sup> When Parmelia awoke and discovered what had happened, she and her husband sued Dr. Pratt for operating without her consent.<sup>114</sup>

Dr. Pratt's testimony indicates that he did not conceptualize his duty to his patient as including the responsibility to obtain her consent. On the contrary, he admitted to the court that he "deliberately and calmly deceived the woman"<sup>115</sup> in order to administer the operation "for [her] good."<sup>116</sup> This was in line with the "beneficence model" of the doctor-patient relationship, which held that the doctor's primary duty was to improve the patient's health.<sup>117</sup> Dr. Pratt also claimed that Parmelia's husband had agreed to both operations by agreeing to the first one.<sup>118</sup>

Despite her doubly abnormal status as a woman and a potential imbecile, both the Court of Appeals and the Illinois Supreme Court chose to view Parmelia as an autonomous individual. The Court of Appeals rejected the beneficence model of doctor-patient relations, embracing instead what has come to be called the "autonomy model,"<sup>119</sup> which held that a physician could not "violate without permission the bodily integrity of his patient."<sup>120</sup> The court further held that regardless of the "gentle restraint"<sup>121</sup> over his wife a husband normally possessed, a husband "could not, without his wife's acquiescence, control the integrity of her body."<sup>122</sup> In other words, despite their subordinate status, women were to be treated as autonomous individuals in the health care context.

The exception, the Illinois Supreme Court noted, was when the husband acted as guardian for a wife who was insane.<sup>123</sup> Much of the case, then, turned on whether Parmelia was sane enough at the time of the operation to give consent.<sup>124</sup> By the time the case reached the court, Parmelia had been committed to the Kankakee Insane Asylum, after having tried to commit suicide by jumping in front of a moving train.<sup>125</sup> However, the Court of Appeals determined that as epilepsy was a disease involving "a gradual breaking down of mental faculties," at the time of the operation Parmelia was of sound enough mind to have been able to give or withhold consent.<sup>126</sup>

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<sup>113</sup> *Id.* at 563.

<sup>114</sup> *Id.*

<sup>115</sup> *Pratt*, 118 Ill. App. at 170.

<sup>116</sup> *Id.* at 179.

<sup>117</sup> FADEN ET AL., *supra* note 100, at 59.

<sup>118</sup> 79 N.E. at 564.

<sup>119</sup> FADEN ET AL., *supra* note 100, at 59.

<sup>120</sup> *Pratt*, 118 Ill. App. at 166.

<sup>121</sup> *Id.* at 174.

<sup>122</sup> *Id.* at 177.

<sup>123</sup> 79 N.E. at 564.

<sup>124</sup> *Id.*; 118 Ill. App. at 177.

<sup>125</sup> 118 Ill. App. at 176-77. From the facts described in the appellate opinion, it is unclear when the suicide attempt happened in relation to the operations, indicating, interestingly, that the Appellate Court did not find the relationship between the events relevant. *Id.*

<sup>126</sup> *Id.* at 177.

This was corroborated by the testimony of witnesses and evidence of a letter Dr. Pratt had written to Parmelia pleading with her “to practice self-control, to learn to be kind and gentle, and . . . stop her nonsense,” i.e. drop the suit, in which he had addressed her as a rational individual.<sup>127</sup> The Court of Appeals held that it was unnecessary to inquire whether the husband had given his consent, since it was clear Parmelia, as a rational person, had not given hers.<sup>128</sup> The Supreme Court of Illinois, declining to address whether a husband could consent to surgery for his insane wife, found that Parmelia was not insane and that neither she nor her husband had given consent.<sup>129</sup>

Both courts use language imbued with the liberty and freedom of contract rhetoric of *Lochner* and *Ritchie I*. Like *Lochner*'s focus on “the general right of an individual to be free in his person,”<sup>130</sup> the Court of Appeals emphasizes that “the free citizen's first and greatest right, which underlies all others” is “the right to the inviolability of his person, in other words, his right to himself.”<sup>131</sup> The opinion of the Illinois Supreme Court proposes the principle of a baseline of respect for patient autonomy despite status considerations, holding, “where the patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition . . . it is manifest that his consent should be a prerequisite to a surgical operation.”<sup>132</sup> Parmelia, though a woman and an imbecile, was treated as a first-track, rational, autonomous individual, an example of a *Lochnerian*-inspired track-shifting from dependency to self-determination. This established a baseline assumption of respect for the self-determination of even historically abnormal persons in the health care context, which would prove to be the foundation of informed consent doctrine as it developed.<sup>133</sup>

Importantly, as in *Pratt*, the plaintiffs in many early informed consent cases were women.<sup>134</sup> The high incidence of female plaintiffs may indicate the physicians' assumptions that women's subordinate status permitted them to bypass their female patients' consent if their medical judgment so dictated. I suggest that there was something about the particular status of the plaintiffs as traditionally abnormal persons that made cases brought by women partic-

<sup>127</sup> *Id.* at 176.

<sup>128</sup> *Id.* at 180.

<sup>129</sup> *Pratt*, 79 N.E. at 565.

<sup>130</sup> 198 U.S. 45, 58 (1905).

<sup>131</sup> *Pratt*, 118 Ill. App. at 166.

<sup>132</sup> *Pratt*, 79 N.E. at 564.

<sup>133</sup> The rhetoric of other early cases was similarly *Lochnerian*. See *Mohr v. Williams*, 104 N.W. 12, 14–15 (Minn. 1905) (“The patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal one.”) (internal quotation marks omitted); *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 129 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”); *Rolater v. Strain*, 137 P. 96, 97 (Okla. 1913) (quoting *Pratt and Mohr*).

<sup>134</sup> See *supra* note 102 (listing the gender of the plaintiffs in early informed consent cases).

ularly attractive to the courts. These cases provided a means of solidifying the vision of the rational, autonomous individual—an individual whose will was paramount and effectuated through legal expression in contractual arrangements. As exemplified by *Lochner* and other challenges to labor regulation, during this period the liberty to contract—and because of contract’s importance to the market economy, the principle of laissez-faire itself<sup>135</sup>—was “under attack” by Progressive forces.<sup>136</sup> By viewing the doctor-patient relationship as a contractual arrangement,<sup>137</sup> courts could reinscribe both the centrality of contract to the social order and the perception of the contracting parties as autonomous, rational, and independent (and thus protected from state oversight by the Fourteenth Amendment), on which the contractual regime depended. Women’s transferability between first- and second- track treatment provided the perfect vehicle for the solidification of the Lochnerian vision of the individual and the centrality of contract. It enabled the courts to show that contract was so important that even traditionally status-defined persons could not have their liberty to contract overridden by the state.<sup>138</sup>

### B. Ambiguity Re-Introduced: The Infiltration of Status Assumptions

In spite of the work of *Pratt* and other early informed consent cases to locate women on the first track in the health care context, assumptions about women’s status roles as mother and bearer of national progeny infiltrated courts’ assessment of lack-of-consent claims. As when concerns about women’s sexuality were brought into labor law, assumptions about women’s sexuality in the health care context similarly derailed the treatment of women as first-track individuals. Courts whose conceptions of women were colored by these assumptions often saw a woman’s claim as operative only if

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<sup>135</sup> See ATIYAH, *supra* note 50; KENNEDY, *supra* note 14, at 159–60; *supra* Part I.B.

<sup>136</sup> NOVKOV, *supra* note 26, at 90.

<sup>137</sup> See *supra* note 104 for early informed consent cases recognizing the doctor-patient agreement as a contract. Interestingly, unlike its contemporary informed consent cases, although *Pratt* used the language of freedom of contract extensively, neither the Court of Appeals nor the Supreme Court made any express mention of a contract. The fact that *Pratt* was viewed as a tort claim instead of a breach of contract claim indicates that the courts may have considered status-based considerations to be a potential stumbling block to the promotion of Lochnerian individuality and the centrality of contract after all. As P.S. Atiyah points out, determining whether injuries “fell into the maw of tort law” or breach of contract was often a matter of judicial convenience. P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287, 291 (1986). By focusing on the patient’s right to due care by the doctor, *id.* at 293, and by equating due care with respect for a patient’s autonomy and self-determination *a la* contract, the court was able to skirt the issue of whether Parmelia had actually formed a valid contract with Dr. Pratt.

<sup>138</sup> The irony of this view was made apparent in 1923, when Hale proposed that court enforcement of laws, such as the law of property or contract, was itself a form of state oversight. Hale, *supra* note 64, at 471–72.

the injury caused by her lack of consent had impacted her reproductive ability.

In addition to *Pratt*, several other early-twentieth-century cases dealt with unauthorized operations on women's reproductive organs.<sup>139</sup> In these cases, the language of autonomy is minimized, and the operation's effect on the woman's ability to bear children is foregrounded. One case that found for the plaintiff stressed the importance of needing her consent before performing an operation that would cause the "destruction of any hope she might have of bearing children."<sup>140</sup> Another, finding for the defendants, involved two physicians who were supposed to remove an ectopic pregnancy.<sup>141</sup> Finding the pregnancy normal but noticing that the appendix was inflamed, they removed the patient's appendix instead.<sup>142</sup> The court remarked, "[t]his case is not one where a patient was rendered barren; on the contrary, her foetus was not disturbed and she achieved motherhood in a normal manner . . . [Now] she is forever relieved from the fear and danger of appendicitis."<sup>143</sup> The court also emphasized that the physicians considered the inflamed appendix a danger to the woman's pregnancy.<sup>144</sup> The juxtaposition between these two cases implies that one reason for the plaintiffs' success in such cases may have been that the deprivation of the possibility of motherhood was considered to be an injury worthy of legal redress, unlike operations on vestigial organs that did not impair a woman's mothering role, but in fact may have promoted it. Ironically, women were seen as autonomous when their autonomy furthered their ability to fulfill their status role—a theme that we will see reiterated in the abortion context.

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<sup>139</sup> See, e.g., *Hobbs v. Kizer*, 236 F. 681, 682 (8th Cir. 1916) (unauthorized abortion under guise of removing abscess in uterus; finding for plaintiff); *Tabor v. Scobee*, 254 S.W.2d 474, 475 (Ky. Ct. App. 1951) (removal of "diseased" Fallopian tubes during operation for appendicitis; finding for plaintiff); *Rothe v. Hull*, 180 S.W.2d 7, 12 (Mo. 1944) (removal of Fallopian tubes during operation for appendicitis; finding for the doctor because patient had given general authorization); *King v. Carney*, 204 P. 270, 271–72 (Okla. 1922) (removal of Fallopian tubes and ovaries during examination intended to discover cause of and cure sterility; remanded for evidence of removal being necessary for life or health).

<sup>140</sup> *Tabor*, 254 S.W.2d at 475.

<sup>141</sup> *Barnett v. Bacharch*, 34 A.2d 626, 627 (D.C. 1943).

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* at 628.

<sup>144</sup> The court noted:

What was the surgeon to do? Should he have left her on the operating table, her abdomen exposed, and gone in search of her husband to obtain express authority to remove the appendix? Should he have closed the incision on the inflamed appendix and subjected the patient, pregnant as she was, to the danger of a general spread of the poison in her system, or to the alternative danger and shock of a second, independent operation to remove the appendix? Or should he have done what his professional judgment dictated and proceed to remove the offending organ, regarded as it is as a mere appendage serving no useful physiological function and causing only trouble, suffering, and oftentimes death?

*Id.* at 627–28.

### C. *The Embedded Individual in Informed Consent*

As the doctrine of informed consent developed, it parted from the emphasis on pure autonomous individuality seen in *Pratt*<sup>145</sup> by embracing a vision more akin to the Progressive conceptualization of the embedded individual.<sup>146</sup> While early informed consent cases like *Pratt* undergirded the autonomy and liberty of second-track persons, subsequent cases used the doctrine to prevent first-track persons from being deprived of their autonomy and liberty when ill. One of the primary motivations for this development was the fear that first-track individuals could easily be downgraded to second-track persons in the newly industrialized health care context, absent legal protection to ensure that their right of self-determination was respected.

From the late 1950s into the 1970s, legal scholars saw the failure of physicians to obtain patients' informed consent to treatment as a product of the depersonalization of medicine.<sup>147</sup> The context of the large, impersonal hospital was viewed as infantilizing patients and making them especially vulnerable to exploitation.<sup>148</sup> Scholars emphasized that the shift from local family physicians to industrialized hospitals had created an "authoritarian" relationship between doctor and patient in which the patient was no longer

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<sup>145</sup> See *supra* Part II.A.

<sup>146</sup> See *supra* Part I.C.

<sup>147</sup> Failure to obtain consent was alternately viewed as an intentional tort (battery) that emphasized the failure to obtain consent as to a particular type of operation, or as a breach of the doctor's duty to the patient (negligence or malpractice), emphasizing the failure to relay sufficient information to make the patient's consent informed. Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1555-56 nn.64-65 (1970) [hereinafter *Restructuring Informed Consent*]. Courts have held that to be sufficient to inform, information given must disclose material risks. See *Salgo v. Leland Stanford Jr. Bd. Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957); *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. Super. Ct. 1971). Courts have split over which standard should govern materiality: that of a reasonable physician from the same field and region, or that of a reasonable or prudent patient, with materiality being that which might influence the patient to forego therapy. *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir. 1972); *Restructuring Informed Consent*, *supra* at 1559-60; Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. REV. 628, 637-40 (1970). State law has similarly varied in the scope of information required. Some states, like New York, apply a more relaxed standard, requiring only that the doctor provide information about "reasonably foreseeable risks and alternative treatments," while others like Georgia require "disclosure of the nature of the treatment, any of several specified risks, the likelihood of success, practical alternatives, and prognosis if treatment is declined." Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 916-17 (1994). Importantly, regardless of what type and scope of information is required, the actual content of the disclosure is determined by either the reasonable doctor or prudent patient standard, and not by the legislature.

<sup>148</sup> *Restructuring Informed Consent*, *supra* note 147, at 1537 ("The patient is expected to assume a child's role. He suffers from pain which he does not understand, and his anxieties are aroused. He is 'incapacitated,' excused from his normal functioning and, like a child, becomes dependent on others to take care of him.").

viewed as an individual but as a “disease in the body in the bed.”<sup>149</sup> These scholars saw informed consent law as a means of reconceptualizing the doctor-patient relationship as a “mutual partnership” predicated on equality, interdependence, mutual benefit, and empathy.<sup>150</sup> This reflects both the ideal free market contract, a mutually satisfactory bargain between individuals,<sup>151</sup> as well as the Progressive understanding of the individual’s exercise of autonomy as dependent on contextual circumstances, which I term *embedded individuality*.<sup>152</sup>

In addressing these concerns, courts viewed patients as rational individuals disadvantaged by the power asymmetry of the doctor-patient relationship and the context of illness, and aimed to correct this imbalance by compelling the doctor to transfer information to the patient.<sup>153</sup> *Canterbury v. Spence* incorporated much of this criticism of modern medical practice in its attempt to consolidate the core principles of informed consent.<sup>154</sup> Recognizing the context of inequality in which the doctor-patient relationship occurs, the court notes that “[t]he average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision,”<sup>155</sup> and that “[t]he patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire.”<sup>156</sup> The court identifies the multiple situational factors that create an environment in which the exercise of individual autonomy may be easily subject to coercive forces. It warns that “[t]he patient’s reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arm’s length [sic] transactions. His dependence upon the physician for infor-

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<sup>149</sup> *Id.* at 1533, 1549 n.44 (citing R. DUFF & A. HOLLINGSHEAD, *SICKNESS AND SOCIETY* 128 (1968)).

<sup>150</sup> *Id.* at 1572.

<sup>151</sup> *See supra* note 26.

<sup>152</sup> It also reflects the Progressive vision of “public health.” Carol Nackenoff explains how in Progressive thought pure individualism was impossible; cities and homes were “webbed together by a network of pipes and wires,” such that the health of all individuals depended on the health of the community. Nackenoff, *supra* note 3, at 142 (internal quotation marks omitted). The Supreme Court adopted this view in *Jacobson v. Massachusetts*, decided the same year as *Lochner*. 197 U.S. 11, 26, 37–38 (1905) (upholding the constitutional validity of a compulsory smallpox vaccination program). This illustrates the Court’s receptivity to allowing an exception to unbridled deference to the autonomous individual of liberal theory in the case of public health. In the labor context, as shown above, this permitted the restriction of women’s autonomy for the sake of public health (reproduction). *See supra* Part I.B.

<sup>153</sup> *See Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972) (“[T]he patient’s right of self-decision shapes the boundaries of the duty to reveal.”); *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) (as “law starts with the premise of thorough-going self-determination,” “each man is considered to be master of his own body”). *See also* *Salgo v. Leland Stanford Jr. Bd. Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957); *Gray v. Grunnagle*, 223 A.2d 663, 674 (Pa. 1966); *Cooper v. Roberts*, 286 A.2d 647, 650 (Pa. Super. Ct. 1971).

<sup>154</sup> *Canterbury*, 464 F.2d at 782.

<sup>155</sup> *Id.* at 780.

<sup>156</sup> *Id.* at 783 n.36.

mation affecting his well-being, in terms of contemplated treatment, is well-nigh abject.”<sup>157</sup> Although previous courts and legal scholars had called the physician-patient relationship “essentially contractual in nature,”<sup>158</sup> the *Canterbury* court views the relationship as more than simply contractual because of the status-like asymmetry between the two parties. Unlike in contract, where the parties are assumed to be equal and each has the responsibility to ensure that their rights are respected, here the responsibility is on the doctor to volunteer material information, not on the patient to ask for it.<sup>159</sup> The court emphasizes that “the patient’s right of self-decision” “can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.”<sup>160</sup> Obtaining the consent of the patient and ensuring that such consent is given only after the patient has been adequately informed of “all risks potentially affecting the [patient’s] decision”<sup>161</sup> acts as a bulwark of the patient’s liberty and prevents him from slipping into second-track status and treatment.

The court’s language with regard to patients in general and the plaintiff, Mr. Canterbury, in particular, indicates that maintenance of first-track treatment for dependent patients is a dominant concern. The plaintiff is a promising youth; although his mother is a “widow of slender financial means,” at the time of the operation he was working in Washington, D.C. as a clerk-typist for the FBI and was healthy aside from some troubles with back pain.<sup>162</sup> From the court’s description, Mr. Canterbury seems to have been the prototype of the “up-by-the-bootstraps” individual of American liberal ideology. He is not a traditional second-track person, yet by not informing him of the risks of the operation the physician treated him as such. The idea of the transferability of first-track individuals to second-track treatment threatened the position of first-track individuals in the power structure underlying liberal theory; courts used the doctrine of informed consent to stem this threat.

So concerned were they with second-track slippage that courts and legal scholars of this time emphasized that the patient’s right of self-determi-

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<sup>157</sup> *Id.* at 782.

<sup>158</sup> *Cooper*, 286 A.2d at 651 (citing Powell, *supra* note 103, at 191); *see also* Mohr v. Williams, 104 N.W. 12, 15 (Minn. 1905) (the patient “enters into a contract authorizing his physician to operate to the extent of the consent given, but no further”); Rolater v. Strain, 137 P. 96, 98 (Okla. 1913) (“[I]f the contract was made between the patient and surgeon . . . the patient had the right to insist upon a strict performance of it . . .”).

<sup>159</sup> *Canterbury*, 464 F.2d at 783 n.36 (“Duty to disclose is more than a call to speak merely on the patient’s request, or merely to answer the patient’s questions; it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision.”).

<sup>160</sup> *Id.* at 786.

<sup>161</sup> *Id.* at 787.

<sup>162</sup> *Id.* at 776–77.

nation included the right to make even irrational medical choices.<sup>163</sup> As a leading Torts textbook from 1968 explained:

The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community . . . Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones.<sup>164</sup>

This focus on the right of individuals to self-determination even when they act irrationally illustrates a fear of losing the liberty central to the definition of a first-track individual. Even when first-track individuals behave in a childish or dependent manner, they must not be treated as second-track persons.<sup>165</sup>

In making this argument, however, legal scholars were also forced to admit that even the first-track individual was not constantly, imperturbably rational. As a *Yale Law Journal* Note from 1970 observed:

The acquisition of fully informed and rational consent for every therapeutic intervention is an unobtainable goal. No man, let alone a worried and suffering patient, is completely rational. The

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<sup>163</sup> See, e.g., *Cooper*, 286 A.2d at 650 (“[T]he primary interest of Pennsylvania jurisprudence in regard to informed consent is that of having the patient informed of all the material facts from which he can make an intelligent choice as to his course of treatment, regardless of whether he in fact chooses rationally.”); *Restructuring Informed Consent*, *supra* note 147, at 1565–66.

<sup>164</sup> *Restructuring Informed Consent*, *supra* note 147, at 1565 n.98 (citing 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* § 17.1 n.15 (Supp. 1968)) (alteration in original).

<sup>165</sup> The borderline—where first-track individuals became so incompetent that a second-track overriding of their will was justified—was addressed through the concept of “therapeutic privilege.” *Id.* at 1567. This allowed the doctor to forego risk disclosure when it posed a significant “threat of detriment to the patient,” because the patient would “become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.” *Canterbury*, 464 F.2d at 789. Although recognizing this exception, the *Canterbury* court insisted that such physician discretion must be “carefully circumscribed.” *Id.* The court stresses:

The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity *for even the normal patient*, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

*Id.* (emphasis added) (internal citation omitted). In other words, echoing *Pratt*, the court understands the law to require that all patients be treated as presumptively stable and rational, and that the doctor's ability to override an unstable patient's right of self-determination is a rare exception.

human mind is limited in its capacity for rationality, and falls prey to many forms of internal and external pressures.<sup>166</sup>

In other words, no one is completely rational, yet everyone's autonomy must be respected. Informed consent doctrine thus worked to equalize persons on both tracks, admitting the possible irrationality of first-track individuals while, in order to maintain the powerful social position of those individuals, extending first-track treatment of respect for autonomy to all persons. However, if even first-track individuals were subordinate to contextual pressures, the logic behind a social categorization based on inherent rationality was undermined.<sup>167</sup> This acknowledgment of the fallibility of the ideal liberal individual introduced a question into the presumptive tracking of persons based on status.<sup>168</sup> Rather, the embrace of the embedded individual view in informed consent doctrine—a view in which all persons were capable of rational autonomy but hindered by contextual circumstances—created an alternative to the two-track system of treatment. This view was based not on the dichotomy of an independent Lochnerian individual versus a status-dependent, abnormal person, but on the recognition of the simultaneous individuality and social embeddedness of all people.

### III. INFORMED CONSENT IN THE ABORTION CONTEXT

This section will look at the principle of informed consent as it has been applied to the abortion context. From the late 1950s and into the early 1970s, a spectrum of social actors supported informed consent pre-abortion, from physicians and psychiatrists, to women's liberation activists, to anti-abortion and fetal life groups.<sup>169</sup> All drew on an embedded individual type conception of women as individuals capable of rationality but embedded in coercive contexts, which hindered their ability to make autonomous decisions. However, the interpretation and application of informed consent in the abortion context was also often colored by status-based conceptions of

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<sup>166</sup> *Restructuring Informed Consent*, *supra* note 147, at 1571 n.112.

<sup>167</sup> This view was also admitted in labor law when protective legislation was extended to male workers. NOVKOV, *supra* note 26, at 185. See also Duncan Kennedy, *Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 MD. L. REV. 563, 563 (1982) (arguing that “the notion that paternalist intervention can be justified only by the ‘incapacity’ of the person the decision maker is trying to protect is wrong”).

<sup>168</sup> All that could be left to justify first- or second-track categorization was thus gradations of rationality—first-track individuals were predominantly, though not always, rational, while second-track persons were more often irrational than not. The perpetuation of assumptions about second-track persons as inherently less rational was, therefore, instrumental to the maintenance of social power hierarchies, a theme reflected in the deployment of informed consent in the abortion context, as will be explored in Part III.

<sup>169</sup> See *infra* Part III.B–D; see also LINDA GREENHOUSE & REVA B. SIEGEL, *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 3–4* (2010) (discussing categories of social actors that generally began to support abortion reform during this time period).

women as less rational, inherently mothering, and subject to public oversight in their reproductive choices, justifying external intervention in the decision to abort.

### A. *The “Sympathetic Connection”: Early Medical Theories*

Under popular theories of medicine at the turn of the century, there was thought to be a “sympathetic connection” between the mind and the uterus, such that energy devoted to one necessarily depleted energy from the other.<sup>170</sup> Because of this, women were seen as “more vulnerable to insanity than men because the instability of their reproductive systems interfered with their sexual, emotional, and rational control.”<sup>171</sup> External actors, such as the state or concerned individuals like doctors, justified intervention with women’s sexual and reproductive decisions when such decisions were seen to be products of insanity.<sup>172</sup> Just as women were encouraged not to engage in strenuous thinking for fear it would harm their reproductive capacity, mental illness was likewise seen as resulting from an overactive libido or other reproductive or sexual issues.<sup>173</sup> This view linking reproduction to mental health assumed that women were naturally mothers and reinforced the idea that women’s psychological well-being was based on the fulfillment of their mothering nature.<sup>174</sup> Because it was antithetical to their natural role, abortion was seen as particularly traumatizing to women.<sup>175</sup> As Reva Siegel illustrates, this view contributed to the criminalization of abortion.<sup>176</sup>

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<sup>170</sup> SHOWALTER, *supra* note 41, at 56.

<sup>171</sup> *Id.* at 55.

<sup>172</sup> Reproductive and sexual choices that contained deviant elements were often considered symptoms of insanity. *Id.* at 78. Some such deviant choices included sex out of wedlock, HAAG, *supra* note 27, at 140–41 (discussing mandatory detention and psychiatric treatment for young women who had engaged in sexual relations outside of marriage); hypersexuality, SHOWALTER, *supra* note 41, at 77 (discussing a young woman who was considered insane because she “was sexually assertive in sending her visiting cards to men she liked”); and the desire for divorce, *id.* at 76 (discussing the use of clitoridectomy as a cure for women “whose madness consisted of their wish to take advantage of the new Divorce Act of 1857”).

<sup>173</sup> *Id.* at 124–25.

<sup>174</sup> For instance, scientific rationale was used to link women’s sanity to their reproductive ability:

Despite protests to the contrary, we know that women’s main role here on Earth is to conceive, deliver, and raise children . . . when this function is interfered with, we see all sorts of emotional disorders and certainly the climax of these disorders is reached at the menopause, when women recognize that they no longer can reproduce their kind . . . .

Richard Schwartz, *Psychiatry and the Abortion Laws: An Overview*, 9 COMPREHENSIVE PSYCHIATRY 99, 111 (1968) (citing Sidney Bolter, *The psychiatrist’s role in therapeutic abortion: The unwitting accomplice*, 119 AM. J. PSYCHIATRY 312, 316 (1962)).

<sup>175</sup> *Id.* (“[T]he woman who experiences an abortion, whether therapeutic or criminal, is traumatized by the act . . . .”). For an extensive discourse on judicial views of the link between abortion and trauma, see Suk, *supra* note 2.

<sup>176</sup> Siegel, *Reasoning from the Body*, *supra* note 2, at 350.

Abortion was criminalized in states across the country during the mid-nineteenth century.<sup>177</sup> The medical community promoted anti-abortion laws as a means of increasing the profession's legitimacy and taking control of the birth process away from midwives.<sup>178</sup> These doctor-advocates justified criminalizing abortion in the name of both the state's interest in the health of the woman and the state's interest in national progeny (i.e., ensuring that middle- and upper-class white women reproduced).<sup>179</sup> Reproduction as a public concern and control of reproduction by the state were thus embedded in the abortion discourse from its inception.<sup>180</sup> By the mid-twentieth century, however, some states allowed abortion when necessary to protect the life and/or health of the mother.<sup>181</sup> In order to obtain a "therapeutic abortion" in those states that allowed it, women had to prove to a doctor or panel of physicians that they fell under the "life or health" exception.<sup>182</sup> Women who could not hang their claim on a physical ailment had to present themselves as so mentally unstable that they would commit suicide if forced to carry the pregnancy to term (and hence were unfit to be mothers).<sup>183</sup> In other words, ironically, women had to prove themselves irrational in order to effect their decisional autonomy. Doing so played on and reinforced the link between insanity and reproduction and justified the involvement of the doctors and the state in the decision to abort.

The procedures used to assess requests for therapeutic abortions also reinscribed assumptions about the public's interest in women's social roles as mothers. In 1959, in common with many states, more than half of California hospitals required that a panel of physicians review requests for therapeutic abortions.<sup>184</sup> This constructed the decision to abort a pregnancy as a matter for public comment and concern.<sup>185</sup> As one doctor said, "[i]t no longer is a *personal* decision on anyone's part but becomes a problem to be solved by several doctors and can be freely discussed . . . . [Each case becomes] an *open* trial so to speak to be decided on its merits."<sup>186</sup> A majority of California hospitals surveyed agreed that the panel of doctors carried the responsi-

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<sup>177</sup> *Id.* at 281–82.

<sup>178</sup> *See id.* at 283–84.

<sup>179</sup> *Id.* at 279.

<sup>180</sup> *See id.* at 296–97 ("Laws against abortion and contraception were necessary to protect the *public's* interest in procreation.").

<sup>181</sup> Schwartz, *supra* note 174, at 101. In 1968, forty out of fifty states prohibited abortion except to save the life of the woman. *Id.* Alabama, Maryland, Oregon, New Mexico, Colorado, North Carolina, California, and the District of Columbia allowed abortions to protect the woman's health or safety as well as her life. *Id.*

<sup>182</sup> *See, e.g.,* Herbert L. Packer & Ralph J. Gampbell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 STAN. L. REV. 417, 427–28 (1959).

<sup>183</sup> SANDRA MORGEN, INTO OUR OWN HANDS: THE WOMEN'S HEALTH MOVEMENT IN THE UNITED STATES, 1969–1990, at 5 (2002); Reva B. Siegel & Linda Greenhouse, Before *Roe v. Wade*, Discussion at Harvard Law School sponsored by Harvard Law Students for Reproductive Justice (Nov. 4, 2010).

<sup>184</sup> Packer & Gampbell, *supra* note 182, at 428; *see* Schwartz, *supra* note 174, at 102.

<sup>185</sup> Siegel, *Reasoning from the Body*, *supra* note 2, at 296.

<sup>186</sup> Packer & Gampbell, *supra* note 182, at 430.

bility of “safeguarding society’s interest in avoiding this means of birth control”<sup>187</sup>—in other words, maintaining a social order in which women fulfilled their social roles as mothers and women’s sexuality was confined to procreative purposes.<sup>188</sup> This further solidified the location of women’s sexuality and reproduction in the public arena, just as seduction and employment law had done.<sup>189</sup> The woman was seen as the property of society as a whole by virtue of the public interest in her reproductive functions. Although the decision to request an abortion was her own, the woman’s desire for and consent to the procedure was only relevant insofar as it provided evidence of her insanity and thus unsuitability for her status role.

What exactly constituted a sufficient threat to mental health was a matter of ambiguity that created variation in the abortion practices across hospitals and gave rise to concern by physicians about potential criminal liability. Illustrating that many abortions provided under the mental and physical health exceptions were technically illegal, in 1959, two Stanford medical professors published a survey of different California hospitals assessing their responses to various case studies.<sup>190</sup> An exploration of the case studies involving potential mental health exceptions reveals the assumptions about women’s status roles as mothers and nurturers that underlay the physicians’ assessments of women’s mental health and justified intervention in their pregnancies.<sup>191</sup>

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<sup>187</sup> *Id.* at 429.

<sup>188</sup> KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 100 (1985).

<sup>189</sup> *See supra* Part I.B.

<sup>190</sup> Packer & Gambbell, *supra* note 182, at 430.

<sup>191</sup> Patient 1 lived at home “helping mother” with her seven siblings until she was 27, when she “married to ‘get away from home’ and felt quite happy ‘for the first time in her life.’” *Id.* at 433. However, she was soon confined to the same domestic role again, when she bore six children in a period of ten years; after the first three, “she began feeling tired, worried and overwhelmed with household and child care.” *Id.* With each pregnancy she became more and more depressed, and expressed concern that “her husband doesn’t love her anymore, that he gets angry with her and the children, feels that she’s not a good mother or housekeeper.” *Id.* Ten hospitals surveyed approved a therapeutic abortion and twelve did not. *Id.* at 434. The Stanford authors indicate that Patient 1’s mental dejection was not serious enough to pose a threat to her life, and so an abortion would be technically illegal. *Id.*

Patient 2 experienced post-partum depression after the birth of her third child, for which she received electro shock therapy and psychiatric treatment. *Id.* at 442. However, she still spoke often of suicide. After discovery of her fourth pregnancy, Patient 2 experienced a “severe emotional crisis,” “threatened suicide several times . . . saying that she could never be a ‘good mother’ and that she was a ‘useless member of society,’” and tried to overdose on sleeping pills. *Id.* Seventeen hospitals approved a therapeutic abortion in this case and four did not. *Id.* at 442. The report states that since confinement to a mental institution would “greatly decrease” the possibility of suicide, the legality of abortion in this situation is “at best, questionable.” *Id.* at 443.

Patient 3’s mother had been committed for insanity caused by “illicit sexual activities” when Patient 3 was a child. *Id.* at 435. Patient 3’s father was very strict and forbade any dating activity. *Id.* at 435–36. After having fantasized a romantic attachment with her employer “[w]ithout any justification,” Patient 3 was committed to a state hospital and subjected to electro shock therapy, after which she “quieted down” but “became dull and withdrawn.” *Id.* at 436. After her release, she “was dated by” a young man and became

First, the very inclusion of these women in the study indicates the doctors' view that women automatically qualify as having questionable mental health simply because they do not want to bear a child. The desire to abort a pregnancy is thus considered *prima facie* evidence of mental instability. This was in line with popular medical beliefs at the time, which saw a woman who desired to abort a pregnancy as a "sick person," requiring psychiatric treatment in order to help her overcome the conditions that prevented her from wanting to mother.<sup>192</sup> In addition, the case study patients deviate from their social roles in other ways: Patient 1 expresses discontent with her life as housekeeper and child-rearer; Patients 1 and 2 question their ability to mother; Patient 2 became depressed after giving birth; Patient 3 engaged in sex outside marriage and had sexual fantasies; Patient 4 is employed outside the home.<sup>193</sup> Their deviance makes them all mentally suspect—whether they reach the degree of mental illness necessary to justify an abortion is what is at issue.

As in seduction law and in post-*Muller* labor regulations for women,<sup>194</sup> the woman's own decision about what to do with her body is irrelevant. This is an example of pure second-track treatment of women as dependent, abnormal-status individuals. The doctors, on behalf of the public, have access to the woman's body and decision-making power regarding what should best be done with that body in the interests of society. Unlike the Progressive ideal, the woman is not perceived as an embedded individual, capable of acting rationally but for her constricting circumstances; the woman's reasons for not wanting a child, and the cause of her pregnancy despite her obvious desire not to become pregnant, are not explored. Rather, the focus is on her emotional and mental response to her pregnancy for the purpose of determining whether each woman's psychological response is so intensely negative that it prevents her from mothering. The question at the heart of the inquiry is, "Can she mother?" (i.e., can she fulfill the function designated by her status?). Counterintuitively, then, "mental health" in the abortion con-

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pregnant. *Id.* Patient 3 is convinced that when her father discovers the pregnancy he will send her back to the state hospital, and her psychiatrist believes that "only a therapeutic abortion will prevent her from regressing into her previous psychotic state." *Id.* The report found that eight hospitals would approve a therapeutic abortion and thirteen would not, and that such an abortion was technically illegal because "the precipitation of a completely disabling psychosis is not a threat to 'life' under the statute." *Id.*

Patient 4, who has five children, went to work outside the home after her husband became ill. *Id.* at 443. She "has done well at this job and has also tried with reasonable success to maintain the home for her husband and children." *Id.* However, after discovering that she is pregnant, "she has become extremely tense and apprehensive. She cries a great deal and she is sure that the enforced cessation of her work will cause the collapse of the family unit which she has worked so very hard to hold intact." *Id.* One hospital approved a therapeutic abortion and twenty did not. *Id.* at 444. The report found that performing an abortion in this situation would be "plainly outside the existing legal justification." *Id.* at 443.

<sup>192</sup> Schwartz, *supra* note 174, at 111.

<sup>193</sup> See *supra* note 191.

<sup>194</sup> See *supra* Parts I.B, I.D.

text does not designate the woman's ability to think rationally, but her ability to fulfill a procreative and maternal role. Either the woman is capable of mothering, or so insane that she will not be able to bear a child.<sup>195</sup> The woman does not have to be happy while she mothers—she can be anxious, depressed, or even psychotic—but as long as her illness does not interfere with her ability to bear a child, she is of sufficient mental health to fulfill her mothering function and so negate the necessity of a therapeutic abortion.

The ambiguous legality of the therapeutic abortions offered by hospitals, revealed by inquiries like the California study, contributed to the promotion of abortion reform that incorporated a broader understanding of women's mental health.<sup>196</sup> However, even when they incorporated a more expanded view, reformed abortion laws continued to be based on the assumption that only mentally ill women would want to abort their pregnancies.<sup>197</sup> For instance, the reformed 1968 California law required that to obtain a therapeutic abortion for reasons other than physical health, the woman must exhibit "mental illness to the extent that [she] is dangerous to herself or to the person or property of others or is in need of supervision or restraint," adopting the definition used by the state Welfare and Institutions Code to specify causes for commitment to a mental institution.<sup>198</sup> This baseline assumption that women would carry their pregnancy to term unless they were so mentally unstable that they could not signifies the prevalent view that normal women wanted to bear children and only the mentally unstable did not. In meeting the definition of mentally ill required by the laws, women who "performed crazy" to obtain an abortion perpetuated the belief that only crazy women wanted abortions. Furthermore, these women then became evidence that social deviance (e.g., having a child out of wedlock) would lead to insanity. This reasoning, as explored below, was adopted by anti-abortion groups in support of informed consent, and became a central justification for second-track treatment of women in medical decision-making regarding abortion.<sup>199</sup>

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<sup>195</sup> Siegel, *Reasoning from the Body*, *supra* note 2, at 311, 364–65.

<sup>196</sup> See Christopher Z. Mooney & Mei-Hsien Lee, *Legislating Morality in the American States: The Case of Pre-Roe Abortion Regulation Reform*, 39 AM. J. POL. SCI. 599, 602 (1995).

<sup>197</sup> The American Law Institute's 1959 Model Penal Code proposal for abortion reform permitted abortion in cases of danger to the woman's mental health. *Id.* at 602–03. In 1968, Alabama, Maryland, Oregon, New Mexico, Colorado, North Carolina, California, and the District of Columbia allowed abortions to protect the woman's health. Schwartz, *supra* note 174, at 101.

<sup>198</sup> Keith Monroe, *How California's Abortion Law Isn't Working*, N.Y. TIMES, Dec. 29, 1968, at SM10 (alteration in original).

<sup>199</sup> See *infra* Part IV.

*B. The Physician's View*

Gradually, influenced by the growing Women's Rights and Civil Rights movements, physicians began to view the mental health effects of unwanted pregnancies in light of social as well as psychological factors. Although the assumption that women who wanted to abort their pregnancies were automatically somewhat mentally unsound went unchallenged, medical professionals began to suggest that abortions could be beneficial to women's mental health in certain instances.<sup>200</sup> By the late 1960s and early 1970s, some even suggested that the trauma resulting from factors like the "community ostracism" caused by unwed motherhood; bearing a child that was the result of impregnation by rape or incest; being compelled into an unhappy marriage with the father; giving a baby up for adoption; and disruption of educational or career goals should be considered in determining the mental health effects of abortion.<sup>201</sup>

The desire to explain and combat the social disturbances of the 1960s may have provided an impetus to this shift in thinking.<sup>202</sup> In a 1968 article, Cleveland psychiatrist Richard A. Schwartz argued for abortion reform as a means of combating social ills, explaining how adoption, foster-care, and illegitimacy advance psychological harm in children, who then grow up to be "social infections."<sup>203</sup> Concern about race is a strong undercurrent of Dr. Schwartz's article, which was published at the height of the Black Power movement, in the aftermath of race riots in Newark and Detroit, and a month before Dr. Martin Luther King, Jr. was shot. Dr. Schwartz noted that therapeutic abortions were rarely granted to indigent or black women;<sup>204</sup> that "less well-educated" black women had half as many abortions as their white counterparts;<sup>205</sup> that 22% of black babies were illegitimate and raised primarily by their mothers due to a shortage of black adoptive parents;<sup>206</sup> that "being raised in a fatherless home has been felt to be a source of much crime and social inadaptability";<sup>207</sup> and that unwanted children became "the willing cannon-fodder for wars of hate and prejudice."<sup>208</sup> Taken together, this line of reasoning implied that the social uprising by the black community was connected to abortion's illegality. Whether this was a conscious motive behind the increased embrace of abortion reform is of course too difficult to say, and certainly other elements of the 1960s environment also contributed to ideological change in medical and legal culture. However, as control of

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<sup>200</sup> Schwartz, *supra* note 174, at 105–06.

<sup>201</sup> *Id.*

<sup>202</sup> *See id.*

<sup>203</sup> *Id.* at 106.

<sup>204</sup> *Id.* at 102–03.

<sup>205</sup> *Id.* at 100.

<sup>206</sup> *Id.* at 105.

<sup>207</sup> *Id.*

<sup>208</sup> *Id.* at 104 (quoting Karl Menninger, *Psychiatric Aspects of Contraception, in THERAPEUTIC ABORTION* (H. Rosen ed., 1954)).

women's sexuality has often been linked with eugenics and struggles by the dominant (white) power group to maintain its hold in the gender/race/power hierarchy,<sup>209</sup> it is worth noting that race may have been a prompt to ideological change in this case as well.

Regardless of the reasons for the expansion in thinking about when abortion was justified, the inquiry was still framed in terms of psychological well-being rather than the rationality of the decision to abort.<sup>210</sup> The rub was determining when abortion was harmful or beneficial to a woman's mental health.<sup>211</sup> Physicians and medical institutions proposed to make this decision through pre-abortion counseling.<sup>212</sup> The American Public Health Association stressed, "[w]omen in need of abortion frequently have requirements for counseling, health education, tenderness, and understanding that are even greater than those of other patients."<sup>213</sup> Although many emphasized that counseling should be free of coercion and bias, even liberal advocates of reform accepted the view that "in some sense an unwanted pregnancy always represents a 'failure,' such as a failure of the state to provide sex education and contraception to teenagers, or "a failure of a woman to accept the prospects of imminent motherhood."<sup>214</sup> While still incorporating assumptions about women's natural role as mothers, this reasoning nonetheless expanded the autonomous space of women, allowing for greater control over sexuality and reproduction through the use of contraceptives and possibly abortion. Reformers emphasized that the counselor's most important function would be "to help the woman weigh the alternatives and arrive at her own decision" by offering "information regarding the physical and emotional aspects of the abortion procedure."<sup>215</sup>

This approach, which I am calling *guided autonomy*, departed from the previous view of physicians who assessed women's requests for therapeutic abortions, as detailed above. Rather than dismissing the woman's decision as irrelevant to the doctor's determination of whether she was capable of mothering or not, the guided autonomy approach respected the woman's capacity for individual decision-making. In this, it mapped onto the notion of

<sup>209</sup> See *supra* note 95 and accompanying text.

<sup>210</sup> Schwartz, *supra* note 174, at 103–06.

<sup>211</sup> See generally Packer & Gampbell, *supra* note 182.

<sup>212</sup> John Asher, a Stanford Medical School psychiatrist, wrote that pre-abortion counseling was needed in cases where the woman displayed such symptoms as discernible guilt, previously unplanned pregnancies, strong religious beliefs opposing abortion, low self-esteem ("A history of breast or other cosmetic surgery may indicate a woman markedly uncertain of her feminine identity."), coercion by family members, "poor ego strength," "impulsive behavior," and "marked indecision and 'paralysis' or the opposite situation with no evidence of uncertainty or ambivalence whatsoever." John D. Asher, *Abortion Counseling*, 62 AM. J. PUB. HEALTH 686, 688 (1972). In other words, the situations in which pre-abortion counseling was not merited were few and far between.

<sup>213</sup> Am. Pub. Health Ass'n, *Recommended Standards for Abortion Services*, 61 AM. J. PUB. HEALTH 396, 398 (1971), cited with approval in *Roe v. Wade*, 410 U.S. 113, 144–46 (1973).

<sup>214</sup> Asher, *supra* note 212, at 686–87.

<sup>215</sup> *Id.* at 687.

embedded individualism as it was incorporated into informed consent doctrine, which was also taking shape at this time.<sup>216</sup> The woman was seen as embedded in a social context that threatened her with psychological harm in the event of a pregnancy, requiring the guidance of professionals to make the best decision in light of her circumstances. In line with this convergence with basic informed consent principles, some proponents of pre-abortion counseling began to advocate for incorporating the language of informed consent as a means of encouraging counseling. In 1970, the American Protestant Hospital Association called for the legalization of abortions made “at the request of, and with the informed consent of a woman.”<sup>217</sup> The American Medical Association adopted the view that abortion could be performed by doctors in certain circumstances, determined by “sound clinical judgment” and “informed patient consent.”<sup>218</sup> Although derived from a continued assumption that women required assistance in making decisions, this guided autonomy/informed consent approach viewed women as capable of acting rationally with the help of external guidance and information. Like the original notion of embedded individuality in Progressive thought and the doctrine of informed consent, this view presented an alternative to the first-track individual/second-track abnormal person dichotomy of legal treatment.

### C. *The Women’s Liberation View*

In addition to appealing to doctors as a means of guaranteeing that psychological assessment and guidance took place, pre-abortion counseling and informed consent appealed to pro-abortion women’s liberation activists as necessary for ensuring women’s right of self-determination.<sup>219</sup> One motivating factor behind the support of informed consent doctrine in the abortion context was to ensure that doctors did not withhold from pregnant patients information about abortion as an alternative treatment.<sup>220</sup> This was part of a larger movement, exemplified by the publication of *Our Bodies, Ourselves*, aimed at demystifying women’s reproductive systems and sexuality and giving women the information they needed to obtain control over their own bodies.<sup>221</sup>

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<sup>216</sup> See *supra* Part II.

<sup>217</sup> *Hospital Body OKs Abortion Conditionally*, CHI. TRIB., Mar. 3, 1970, at 10.

<sup>218</sup> PROCEEDINGS OF THE AMA HOUSE OF DELEGATES 220 (June 1970), noted in *Roe*, 410 U.S. at 143–44.

<sup>219</sup> See LUKER, *supra* note 188, at 94; MORGEN, *supra* note 183, at 11.

<sup>220</sup> See Sylvia Law, *Silent No More: Physicians’ Legal and Ethical Obligations to Patients Seeking Abortions*, 21 N.Y.U. REV. L. & SOC. CHANGE 279, 294–95 (1994).

<sup>221</sup> See *id.* at 296; MORGEN, *supra* note 183, at 7; see generally BOSTON WOMEN’S HEALTH BOOK COLLECTIVE, *OUR BODIES OURSELVES: A BOOK BY AND FOR WOMEN* (2d ed. 1976).

Pro-reform groups, such as the Margaret Sanger Clinic,<sup>222</sup> the newly-formed National Association for the Repeal of Abortion Laws (NARAL),<sup>223</sup> and other women's liberation organizations supported and offered pre-abortion counseling as a means of helping women achieve decisional autonomy.<sup>224</sup> During the late 1960s through the early 1970s, undercover abortion services like Jane, part of the Chicago Women's Liberation Union, offered counseling to women before, during, and after the procedure, which they also arranged.<sup>225</sup> As one Jane member wrote, "[t]he object of counseling was to make abortion available, but never to promote abortion; to provide the woman with an alternative, and then to give her support, whatever her choice."<sup>226</sup> Similar to the physicians, Jane members also used counseling as "a screening process for detecting conflicts and potential legal threats," like coercion from a parent or boyfriend or strong religious feelings that would lead to "physical and emotional problems afterward."<sup>227</sup> Unlike many physicians, the counselors saw abortion not as inherently traumatic, but as emotionally difficult due to the cultural and religious context.<sup>228</sup> As the informational pamphlet Jane used as a counseling aid explained, "[c]ultural, moral and religious feelings are largely against abortion, and society does all it can to make a woman feel guilty and degraded if she has one," which might lead to "emotional blues" after the abortion.<sup>229</sup> Although also a form of guided autonomy, this view exemplified the embedded individual approach more than the physician's view,<sup>230</sup> trusting women to be capable of rational decision-making once given the information to understand their options and identify the coercive social context in which they were operating. Sometimes this information supported the woman's decision to abort; sometimes it did not, as in the case of a nineteen-year-old Catholic girl in her second trimester who, after learning about the complicated procedure for a

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<sup>222</sup> The Margaret Sanger Clinic later became Planned Parenthood. See *History and Successes*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/about-us/who-we-are/history-and-successes.htm> (last visited Feb. 19, 2011).

<sup>223</sup> GREENHOUSE & SIEGEL, *supra* note 169, at 38. The organization has since changed its name to NARAL Pro-Choice America. See *About Us*, NARAL PRO-CHOICE AMERICA, <http://www.prochoiceamerica.org/about-us> (last visited Feb. 24, 2011).

<sup>224</sup> See LUKER, *supra* note 188, at 97; MORGAN, *supra* note 183, at 11.

<sup>225</sup> Cheryl terHorst, *Abortion in the Underground before Roe v. Wade, the Group 'Jane' Gave Women a Choice*, CHI. TRIB., Sept. 15, 1999, at 1.

<sup>226</sup> *Articles about Jane: The Most Remarkable Abortion Story Ever Told (June 1973)*, CHICAGO WOMEN'S LIBERATION HERSTORY WEBSITE, <http://www.uic.edu/orgs/cwluherstory/CWLUFeature/Remarkable1.html> (last visited Mar. 14, 2011) [hereinafter *The Most Remarkable Abortion Story Ever Told*].

<sup>227</sup> *Id.*

<sup>228</sup> *Abortion Counseling Service Brochure: Abortion—A Woman's Decision, a Woman's Right*, CHICAGO WOMEN'S LIBERATION HERSTORY WEBSITE, <http://www.uic.edu/orgs/cwluherstory/CWLUFeature/Janebroch.html> (last visited Mar. 14, 2011).

<sup>229</sup> *Id.* (internal quotation marks omitted).

<sup>230</sup> See *supra* Part III.B.

late-term abortion and the Jane members' uncertainty about performing it, decided to have the baby instead.<sup>231</sup>

Disempowered groups of women, particularly those who had suffered from racially- and class-motivated involuntary sterilization campaigns, also supported informed consent as a means of guaranteeing that women were given adequate information and not operated on without their agreement. The Northern California branch of La Raza Unida, a Chicano political party, announced its support for "the right of self-determination for our women" in its 1971 platform.<sup>232</sup> The platform featured a section on "Birth Control," which laid out the following points: local birth control and abortion clinics "must be community-controlled, and a woman who is counseled must be thoroughly informed about all the dangers and possible side effects of any devices or operations"; "[n]o forced abortions or sterilizations of our women"; and "[t]he ultimate decision whether to have a child or not should be left up to the woman."<sup>233</sup> Echoing discourse in seduction law and early medical theories of abortion,<sup>234</sup> this language situates the woman in the public ("our" women), yet it also aligns with the women's rights groups in its emphasis on respect for informed, autonomous decision-making. Informed consent in reproductive procedures was seen as a way of reclaiming control and ensuring self-determination both of the women and the disempowered group as a whole.

#### D. *The Anti-Abortion View*

Anti-abortion groups also supported pre-abortion counseling and informed consent under the theory that a woman who was truly informed would choose not to terminate a pregnancy.<sup>235</sup> During the late 1960s, Catholic counseling centers sprang up in states that liberalized their abortion laws.<sup>236</sup> Some, like the Washington, D.C.-based Birthright, professed to be "careful not to impose our religious or moral beliefs on the callers," but merely to provide "practical, loving help" and "sympathy."<sup>237</sup> Other centers were vehemently anti-abortion. The Sons of Thunder, a militant Roman Catholic group, operated ten clinics across the country "whose volunteer doctors are committed to convincing pregnant women to have their ba-

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<sup>231</sup> *The Most Remarkable Abortion Story Ever Told*, *supra* note 226.

<sup>232</sup> LA RAZA UNIDA, PARTY PLATFORM ON CHICANAS (1971).

<sup>233</sup> *Id.*

<sup>234</sup> *See supra* Parts I.B, III.A.

<sup>235</sup> *See, e.g.*, Reginald Stuart, *Akron Divided by Heated Abortion Debate*, N.Y. TIMES, Feb. 1, 1978, at A10 (quoting Jane E. Hubbard, President of the Akron Right to Life Society: "When someone realizes that they are taking the life of a baby then they will realize that there are alternatives.").

<sup>236</sup> *See, e.g.*, Dierdre Carmody, *Catholics to Give Antiabortion Aid*, N.Y. TIMES, Apr. 12, 1971, at 34.

<sup>237</sup> *Id.*

bies.”<sup>238</sup> Many of these groups emphasized the “right” of the woman to be a mother, and saw the difficult circumstances unwed mothers found themselves in as preventing the exercise of that right.<sup>239</sup> They attempted to ameliorate such difficulties by providing “prenatal and post-natal medical care and access to homes for unwed mothers and adoption agencies.”<sup>240</sup> Although they viewed the women considering abortions as sympathetic victims instead of as mentally unstable persons, these clinics still assumed that women would choose to be mothers but for the difficult contextual circumstances they faced.<sup>241</sup>

Building on this conception of women as mothers, after abortion’s legalization, groups like the Citizen’s Committee for Informed Consent formed to encourage informed consent as a safeguard to abortion access.<sup>242</sup> They wrote and promoted state ordinances requiring, *inter alia*, that clinics give women seeking abortions “detailed information on the week-to-week development of the fetus so that they will know literally as well as medically what the procedure will entail.”<sup>243</sup> As one anti-abortion activist explained, the group’s purpose was “not . . . to cause guilt feelings about abortion,” but to give women “the biological facts” so that “women will be deciding what to do based on knowledge of options.”<sup>244</sup> In line with the embedded individual understanding of physicians and women’s liberation activists,<sup>245</sup> these anti-abortion advocates also considered informed consent necessary to counteract coercive forces in the woman’s environment that might be convincing her to undergo a procedure she did not desire. However, unlike the women’s liberation groups, anti-abortion proponents of informed consent saw abortion as inherently traumatic because it went against women’s mothering nature.<sup>246</sup>

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<sup>238</sup> Edward B. Fiske, *Catholic Right: Challenge by a Small but Very Determined Band*, N.Y. TIMES, Mar. 14, 1971, at E6.

<sup>239</sup> Carmody, *supra* note 236.

<sup>240</sup> *Id.*

<sup>241</sup> This view echoes that of courts that upheld protective labor legislation for women during the Progressive era. *See supra* Part I.D.

<sup>242</sup> *See, e.g.*, Nick Thimmesch, *Great Akron Abortion Debate*, SPARTANBURG HERALD (Ohio), Jan. 25, 1978, at A6.

<sup>243</sup> Stuart, *supra* note 235.

<sup>244</sup> *Id.*

<sup>245</sup> *See supra* Part III.B–C.

<sup>246</sup> For a more detailed discussion of anti-abortion rhetoric engaging conceptions of motherhood, see Siegel, *Dignity and the Politics of Protection*, *supra* note 2, at 1781–92.

PART IV. INFORMED CONSENT IN ABORTION TODAY: THE SUPREME COURT'S APPROACH

A. *Theoretical Recap: Dissonance Between Guided Autonomy and Informed Consent*

As detailed above, abortion gradually achieved a limited acceptance based on factors like concern for the mental health of the mother. This concern sometimes reflected a belief in women's autonomy and right to bodily integrity, as with the women's liberation groups; more often, as in the view of the physicians, it illustrated a public concern about the capacity for women to be good mothers and the social ills that would result if they were not. As in seduction law, labor law, and early laws criminalizing abortion, this latter view located the decision to abort in the sphere of public review. In so doing, it encouraged the involvement of the public, including anti-abortion groups, in the decision-making process. In line with the embedded individual philosophy of Progressive activists,<sup>247</sup> these anti-abortion groups aimed to help ameliorate circumstances that hampered individual rational autonomy. However, similar to *Lochner*-era courts like those in *Muller* and *Ritchie II*, they subscribed to a status-based conception of women that assumed that women who acted rationally and autonomously would choose to bear children rather than abort them.<sup>248</sup>

The view that guided autonomy was necessary to aid a woman in making a rational decision, and that making a rational decision meant choosing motherhood, contradicted the central tenet of informed consent, which prioritized individual self-determination even over perceived rationality or public opinion.<sup>249</sup> As "informed consent" was incorporated into abortion regulations, the phrase carried with it not its health law associations with autonomy and bodily integrity, but instead status-based assumptions about the link between reproduction and insanity, women's irrationality and inherent mothering nature, and the public's interest in reproductive decisions. Abortion law's adoption of this view reinforced women's situational "embeddedness" while forsaking a conception of the woman as an "individual," painting her as sub-rational in addition to only semi-autonomous—in effect, shifting women towards the second track of legal treatment even while employing language from the first.

As shown in Part III, under laws criminalizing abortion, women's decisions about their pregnancies had to be expressed in terms of health, either physical or mental, to be given effect. In couching their desire to abort their pregnancies in terms of mental health, women reinscribed medical assumptions linking insanity and reproduction. Emphasizing the mental health con-

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<sup>247</sup> See *supra* Part I.C.

<sup>248</sup> See *supra* Part I.D.

<sup>249</sup> Manian, *supra* note 2, at 225; see *supra* Part II.C.

sequences of pregnancy and abortion also justified state intervention to both protect the woman's health and guide the woman's decision; mentally unstable women, like traditional second-track abnormal persons, could not be trusted to act rationally. Like the view espoused in the Brandeis Brief that the employment context exerted pressure on women to act contrary to their best interests,<sup>250</sup> in the case of abortion, both pro- and anti-abortion groups considered situational factors to operate coercively on a woman's decision, and so supported pre-abortion informed consent and counseling.

In *Roe v. Wade* and subsequent cases,<sup>251</sup> the Supreme Court has drawn from these different views of the role of informed consent in the decision to abort a pregnancy. Although maintaining the trappings of respect for individual autonomy, the Court has primarily conceptualized women as semi-autonomous and sub-rational, largely informed by the assumptions detailed above regarding the effects of abortion on women's mental and emotional health.<sup>252</sup> Like the spectrum of groups who supported informed consent,<sup>253</sup> the Court recognizes the trying situation in which women who desire to abort their pregnancies find themselves.<sup>254</sup> However, rather than promote an embedded individual approach aimed at balancing situational inequality, as employed in informed consent doctrine, the state's interest in life (fetal life) and traditional assumptions about women as both mentally unstable and naturally mothering has led the Court to promulgate a system of legal treatment of women more reflective of their historic treatment as status-dependent persons than first- or even middle-track liberal individuals.

### B. *The Roe v. Wade Framework: Liberty? or Mental Health?*

In *Roe v. Wade*, the Court paid lip service to women's autonomy by recognizing that the decision to abort a pregnancy was included in the constitutional right to liberty (privacy).<sup>255</sup> However, the Court declined to embrace a Lochnerian view of women as pure individuals.<sup>256</sup> Whereas the Court could have pitted the liberty right alone against the interest in fetal

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<sup>250</sup> See *supra* Part I.D.

<sup>251</sup> 410 U.S. 113 (1973). See also, e.g., *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).

<sup>252</sup> See *infra* Part IV.B–D.

<sup>253</sup> See *supra* Part III (discussing the views of physicians, women liberation activists, and anti-abortion groups regarding pre-abortion counseling).

<sup>254</sup> See *infra* Part IV.B.

<sup>255</sup> See *Roe*, 410 U.S. at 153–54.

<sup>256</sup> See *id.* at 153 (“[A]ppellant and some amici argue that the woman’s right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.”).

life, it instead introduced a third interest, women's health.<sup>257</sup> Women's health had been understood legally (since *Muller*) and medically, especially in the abortion context, to mean women's capability to reproduce and mother.<sup>258</sup> By introducing women's health into the justification for decriminalizing abortion, the Court built on the history of abortion's acceptability only in the context of severe physical and mental health issues, instead of framing the right to abort one's pregnancy purely as part of the liberty (privacy) right, or even, conceivably, as a medical decision entitled to respect regardless of perceived rationality.<sup>259</sup> This framework kept the assessment of the woman's reproductive choices public, a matter for the doctor and the state, and presumed as a normative baseline that women would bear children rather than abort them.<sup>260</sup>

*Roe* held that whether the woman's decision to abort would be effectuated depended on the policing of that decision by both the physician and the state.<sup>261</sup> To justify interfering in the woman's decision to abort, the Court emphasized the situational pressure surrounding abortion and its effects on the woman's mental health, stating:

Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.<sup>262</sup>

By focusing on the mental and emotional effects of the abortion, the Court underscores the potential irrationality of the woman's decision, reasoning that a woman in such distress requires guidance by her physician. This built off the nineteenth-century medical conception of women as generally irrational, verging on insane where reproductive functions were con-

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<sup>257</sup> *Id.* at 162. The inclusion of women's health was in part a response to the justifications behind abortion's initial criminalization, which included protecting women from dangerous abortions. *Id.* at 148–49. The Court justified the state's interest in regulating maternal health "because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." *Id.* at 163.

<sup>258</sup> See *supra* Part III.

<sup>259</sup> See Suk, *supra* note 2, at 1216; *supra* Part II.

<sup>260</sup> See Siegel, *Reasoning from the Body*, *supra* note 2, at 311.

<sup>261</sup> 410 U.S. at 153.

<sup>262</sup> *Id.*

cerned.<sup>263</sup> Like the California survey detailed above,<sup>264</sup> the Court also implies that the rationality of the decision to abort is limited to cases in which the woman is mentally or physically unable to fulfill a mothering role, as opposed to simply undesirous of motherhood. Even though the Court recognized that economic circumstances could factor into a woman's decision to abort a pregnancy, it saw the reason for the abortion as the detrimental mental effect caused by bearing a child under economic strain, rather than as a rational assessment of the pros and cons of having a child at that time.<sup>265</sup> Like the anti-abortion groups, the Court seems to assume that the default for women is motherhood, that rational women choose to mother, and that abortion is justified only when circumstances are sufficiently mentally or emotionally traumatic that a woman cannot mother.

To ensure that the reasons for the abortion fall within the circumscribed scope, the Court ascribes to the physician the role of policing and intervening in the woman's decision. The physician decides whether abortion is justified in each stage of pregnancy: in the first trimester, the woman's best interest controls, as determined by the woman's physician; in the second, the state's interest in the mother's health controls, again as determined by the physician; and in the third, the state's interest in potential life controls, with an exception for the physician's assessment of the abortion as necessary for the mother's life or health.<sup>266</sup> In other words, the physician under abortion's legalization plays the same role as under abortion's criminalization: that of social and medical arbiter of the proper reasons for aborting a pregnancy.

### C. Danforth and the Mobilization of Informed Consent

Fetal life advocates, however, feared that physicians could not be trusted to adequately perform the policing function.<sup>267</sup> Not only did they view physicians as potentially biased toward efficiency and economic gain, but they also believed that allowing a woman the "freedom to select her own doctor" meant that doctors might share the woman's lack of moral concern: "some women may mistake a doctor's judgment for moral approbation and

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<sup>263</sup> See *supra* Part III.A.

<sup>264</sup> *Id.*

<sup>265</sup> *Roe*, 410 U.S. at 153. Compare the Court's focus on mental health as a justification for abortion with the justifications put forth by women seeking abortions as detailed in a recent study: "The reasons most frequently cited were that having a child would interfere with a woman's education, work or ability to care for dependents (74%); that she could not afford a baby now (73%); and that she did not want to be a single mother or was having relationship problems (48%)." Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 110 (2005). Only 12% cited concerns for their own health (either mental or physical) as the reason for the abortion. *Id.* at 112.

<sup>266</sup> *Roe*, 410 U.S. at 164-65.

<sup>267</sup> See, e.g., Mary Anne Wood & W. Cole Durham, Jr., *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 BYU L. REV. 783, 784 (1978).

derive unwarranted moral solace from a clinical opinion.”<sup>268</sup> Yet *Roe* had “insulat[ed] the doctor-patient relationship” in the cloak of a constitutional right to privacy, preventing direct involvement in the abortion decision by other parties.<sup>269</sup>

Since the physician could not be counted on, informed consent statutes, which provided a semblance of pre-abortion counseling, were necessary to ensure that the woman was given sufficient information to “inform and sensitize” her to “feel the responsibility for her decision more keenly.”<sup>270</sup> Informed consent also encouraged the physician to assess whether the contextual circumstances were operating to coerce a woman into an abortion.<sup>271</sup> Fetal life advocates promoted informed consent regulations that included any information that could “have a crucial bearing on [the woman’s] postabortion mental health,” such as fetal development, in order to ensure that “all parties to an abortion decision clearly understand that the destruction of unborn human life will occur in the process.”<sup>272</sup> By relaying the force of public opprobrium and causing the woman to question her decision, detailed informed consent regulations were intended to compel the woman to police her own motivations. In the five years following *Roe*, nearly half of the states passed regulations requiring that the woman’s informed consent be obtained prior to the abortion.<sup>273</sup>

Fetal life advocates drew from the same line of concerns that had motivated physicians and anti-abortion reform activists in the years preceding

<sup>268</sup> *Id.* at 785.

<sup>269</sup> *Id.* at 792 (referencing *Danforth*’s finding that requiring the husband’s consent was unconstitutional).

<sup>270</sup> *Id.* at 793. See also Albert M. Pearson & Paul M. Kurtz, *The Abortion Controversy: a Study in Law and Politics*, 8 HARV. J.L. & PUB. POLY 427, 433–43 (1985) (discussing various strategies used by anti-abortion groups to decrease abortions by creating burdens to access through increased costs and scarce facilities; procedural hurdles like spousal or parental notification; increased risks of liability to doctors; and other coercive methods).

<sup>271</sup> See Brief of John C. Danforth, *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976) (No. 74-1151), 1976 WL 178720, at \*30:

A woman is frequently exposed to conflicting pressures from parents, husband, putative father or peers, who, because of their personal interests, might impel the woman improvidently to terminate her pregnancy. Having recognized the conflicts and pressures inherent in the abortion decision, this Court contemplated that the woman would reach her decision in consultation with her responsible physician.

<sup>272</sup> Wood & Durham, *supra* note 267, at 825.

<sup>273</sup> Among these states are Arkansas, Idaho, Illinois, Indiana, Iowa, Kentucky, Massachusetts, Minnesota, Missouri, Montana, Nevada, New York, North Dakota Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Virginia, and Washington. Wood & Durham, *supra* note 267, at 817–18 nn.155 & 157–58. Although these states often adopted regulations requiring the “informed consent” of a range of parties, from the woman to her husband or parents to the fetus itself, Pearson & Kurtz, *supra* note 270, at 431–32, this inquiry will focus on the requirements of the informed consent of the woman. It is nonetheless important to note that the fact that the woman’s decision was seen as accountable to others in her family circle echoes the view that the woman’s reproductive capacity was a matter of public concern.

*Roe*. They promoted in-depth counseling as necessary to facilitate “the full, if sometimes painful, exercise of the woman’s autonomy along lines consistent with her true interests and in ways that can alleviate abiding psychological conflicts and anguish.”<sup>274</sup> In line with the familiar pattern, they considered women’s “true interests” to be motherhood, and the opposite of acting according to these “true interests” to be psychological trauma.<sup>275</sup> While their arguments employed a definition of autonomy that accorded with the Progressive embedded individual model,<sup>276</sup> they presumed that “rational” equated with non-deviant—a rational woman is one who chooses to continue her pregnancy.<sup>277</sup> They also continued to utilize a mental health lens that reinforced women’s emotionality and irrationality surrounding abortions, justifying state and physician intervention.<sup>278</sup>

Arguing for the constitutionality of Missouri’s 1974 abortion law, which required the written informed consent of the woman,<sup>279</sup> lawyers for the state adopted this reasoning to argue that physicians did not perform the counseling role envisioned in *Roe* and that informed consent was necessary to ensure women’s true autonomy.<sup>280</sup> Upholding the law, the Supreme Court seemed to accept the dichotomy drawn between rational autonomy (choosing motherhood) and irrational coercion (choosing deviance), noting forebodingly that “[t]he decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full

<sup>274</sup> Wood & Durham, *supra* note 267, at 841.

<sup>275</sup> *Id.*

<sup>276</sup> *Id.* at 786 (“A woman’s autonomy, after all, is protected not by ensuring her the ability to make any choice she wishes, but by protecting her right to make an informed, calm, and rational choice.”).

<sup>277</sup> *Id.*

<sup>278</sup> *Id.* at 784 (“[M]any women contemplating abortion have apprehensions, unresolved conflicts, or feelings of ambivalence regarding abortion. . . . [W]omen with previous histories of emotional instability have a particularly great tendency to develop psychological complications following abortion.”).

<sup>279</sup> *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 65 (1976) (requiring, *inter alia*, that before submitting to an abortion a woman must consent in writing to the procedure and certify that “her consent is informed and freely given and is not the result of coercion”).

<sup>280</sup> See Brief of John C. Danforth, *supra* note 271, at 14:

As the evidence at trial demonstrated, in reality there is frequently no opportunity for the woman to consult with a physician for the purpose of determining whether pregnancy termination is in her best interest. Many abortions are performed in out-patient clinics and teaching hospitals and not by the woman’s regular physician. Often the woman does not even meet the physician until she arrives at the clinic for her abortion. Whatever counseling takes place may be performed by nonmedical personnel with no special skill, training or experience.

See also Wood & Durham, *supra* note 267, at 784 (arguing that the doctor-patient relationship envisioned in *Roe*, in which “the woman and her doctor counsel[ ] together to carefully consider the variety of factors relevant to her abortion decision,” is “not the reality in today’s abortion practice,” where doctors in “freestanding abortion clinics” have “a direct financial interest in seeing that abortions are performed as rapidly and efficiently as possible”).

knowledge of its nature and consequences.”<sup>281</sup> The Court does not clarify whether abortion is stressful because of the social and religious pressures identified by Jane and other women’s liberation groups, or if it is inherently stressful because it contradicts women’s nature. By leaving this vague, the Court opens the door to further incorporation of the view that abortion is inherently mentally traumatic.<sup>282</sup>

The Court also manifests distrust of the physician, noting that the consent requirement “insures that the pregnant woman retains control over the discretions of her consulting physician.”<sup>283</sup> Although this argument might seem to merely reflect the informed consent doctrine’s focus on balancing the patient’s autonomy against the physician’s unilateral decision-making, it also ensures that the state maintains control over the physician as the state’s moral agent. As the Court says, “we see no constitutional defect in requiring [written consent] only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions.”<sup>284</sup> Yet unlike heart surgery, abortion is not a particularly dangerous or complicated operation.<sup>285</sup> It seems the Court, like the fetal life advocates, is considering the morality, rather than the mortality risk, of the procedure.

#### D. *They Know Not What They Do: Information Negates Consent*

At first, post-*Danforth* cases found that overly restrictive informed consent regulations of abortion constituted an unconstitutional undue burden, reflecting the emphasis on respect for autonomy and self-determination free from coercion of the original informed consent doctrine.<sup>286</sup> However, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court broke with this understanding.<sup>287</sup> States could prioritize their interest in fetal life

<sup>281</sup> *Danforth*, 428 U.S. at 67. The Court’s line of reasoning assumes that whatever stress may accompany aborting a pregnancy is somehow inherent (i.e., goes against women’s natural role as nurturers), and is not a result of the complicated social and contextual factors, which make procurement of the operation difficult.

<sup>282</sup> See Suk, *supra* note 2, at 1217.

<sup>283</sup> *Danforth*, 428 U.S. at 66.

<sup>284</sup> *Id.* at 67.

<sup>285</sup> *Roe v. Wade*, 410 U.S. 113, 149 (1973).

<sup>286</sup> See, e.g., *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 762 (1986) (“a rigid requirement that a specific body of information be given in all cases, irrespective of the particular needs of the patient,” constitutes an undue burden); *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 417, 444 (1983) (“insisting upon recitation of a lengthy and inflexible list of information” that is “designed not to inform the woman’s consent but rather to persuade her to withhold it altogether” is an unreasonable burden on the woman and the doctor).

<sup>287</sup> 505 U.S. 833 (1992). The statute at issue in *Casey* required the following, except in an emergency:

at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the ‘probable gestational age of the unborn child.’ The physician or a qualified

over the woman's autonomy, the Court held, as long as the "structural mechanism" employed by the state to "express profound respect for the life of the unborn" did not create a "substantial obstacle to the woman's exercise of the right to choose."<sup>288</sup> The Court justified this change by underscoring the state's interest in women's health, and the need to protect women from the detrimental psychological effects of abortion.<sup>289</sup> Building off a tradition that saw mental health as commensurate with ability to mother, this meant that the state's interest in women's health aligned with its interest in the fetus, disrupting *Roe's* purported equipoise between liberty and fetal life.

*Casey* emphasized that regardless of their treatment of particular informed consent statutes, post-*Roe* cases had recognized "a substantial government interest justifying a requirement that a woman be apprised of the health risks of abortion and childbirth," and that "[i]t cannot be questioned that psychological well-being is a facet of health."<sup>290</sup> To protect the woman's psychological health, the mandatory provision of detailed information prior to obtaining consent is crucial: "In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."<sup>291</sup> The Court insisted that it cannot "be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision."<sup>292</sup> As other scholars have pointed out, this reasoning assumes that women are naturally nurturing such that the destruction of potential life is devastating to them, and implies that women who elect to abort a pregnancy somehow may not understand that the abortion terminates the fetus.<sup>293</sup>

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nonphysician must inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion. An abortion may not be performed unless the woman certifies in writing that she has been informed of the availability of these printed materials and has been provided them if she chooses to view them.

*Id.* at 881. The trend towards the Court's acceptance of increased state restrictions on abortion was highlighted several years earlier in *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 538 (1989) (Blackmun, J., dissenting) (noting that the plurality's decision upholding Missouri's abortion law "invites every state legislature to enact more and more restrictive abortion regulations").

<sup>288</sup> *Casey*, 505 U.S. at 877. The Court states, "we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion." *Id.* at 883.

<sup>289</sup> *Id.* at 882.

<sup>290</sup> *Id.*

<sup>291</sup> *Id.*

<sup>292</sup> *Id.*

<sup>293</sup> See, e.g., Siegel, *Reasoning from the Body*, *supra* note 2, at 326-28.

In response to *Casey*, more than half of the states have enacted detailed informed consent regulations.<sup>294</sup> These statutes require, *inter alia*, that women be told about purported links between abortion and breast cancer;<sup>295</sup> informed of mental health effects like “postabortion traumatic stress syndrome”;<sup>296</sup> shown ultrasound images of the fetus;<sup>297</sup> and told that the fetus can feel pain.<sup>298</sup> The underlying assumption of most of these provisions is clear: rational women choose motherhood and deviating from this status role affects mental health.

*Gonzales v. Carhart* upheld a Congressional prohibition on intact dilation and evacuation (“D & E”) abortions.<sup>299</sup> Although the statute in *Carhart* did not involve informed consent on its face, the Court viewed the ban on intact D & E abortions in light of the dichotomization of rational autonomy (motherhood) and psychological harm (deviance) adopted in *Casey*.<sup>300</sup> In upholding the ban, the Court relied primarily on the procedure’s effect on women’s mental health to justify overriding the right to liberty, rather than the state’s interest in fetal life.<sup>301</sup>

From the beginning, the *Carhart* opinion put significant emphasis on the “gruesome and inhumane” nature of intact D & E abortions.<sup>302</sup> Quoting alternately a male physician and a female nurse, Justice Kennedy relates the procedure in detail, like the screenplay of a horror movie: the doctor “grab[s]” the fetus (whom the nurse calls a “baby”)<sup>303</sup> and “tear[s it] apart,” during which “a leg might be ripped off,”<sup>304</sup> then “[sticks] the scissors in the back of [its] head,” and “[sucks] the baby’s brains out.”<sup>305</sup> Unlike the role of the doctor in earlier abortion jurisprudence as an arbiter of the woman’s decision versus the public’s interest or a mandated mouthpiece

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<sup>294</sup> As of April 1, 2011, thirty-four states require that a woman receive pre-abortion counseling, two-thirds of which detail the information to be given. GUTTMACHER INST., STATE POLICIES IN BRIEF: COUNSELING AND WAITING PERIODS FOR ABORTION 1 (2011), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_MWPA.pdf](http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf).

<sup>295</sup> As of April 1, 2011, seven state statutes included information about breast cancer, five of which gave inaccurate information. *Id.* The National Cancer Institute has stated that there is no correlation between induced abortion and breast cancer risk. Gold & Nash, *supra* note 2, at 11; see also Richardson & Nash, *supra* note 2, at 7–8.

<sup>296</sup> Gold & Nash, *supra* note 2, at 11. Of the twenty state statutes that include information about possible psychological effects of abortion, seven describe only negative effects. GUTTMACHER INST., *supra* note 294, at 1.

<sup>297</sup> Gold & Nash, *supra* note 2, at 10. As of April 1, 2011, eighteen states regulate the physician’s provision of an ultrasound. GUTTMACHER INST., STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND 1 (2011), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_RFU.pdf](http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf).

<sup>298</sup> Gold & Nash, *supra* note 2, at 12. Ten states include information about the ability of the fetus to feel pain. GUTTMACHER INST., *supra* note 294, at 1.

<sup>299</sup> 550 U.S. 124, 147 (2007). In intact D & E abortions, the fetus is removed intact from the uterus. *Id.* at 137.

<sup>300</sup> *Id.* at 159–60.

<sup>301</sup> *Id.*

<sup>302</sup> *Id.* at 141.

<sup>303</sup> *Id.* at 138.

<sup>304</sup> *Id.* at 135.

<sup>305</sup> *Id.* at 139.

of the state,<sup>306</sup> here the physician is portrayed as the perpetrator of the crime.<sup>307</sup> His dispassion (he “evacuates the skull contents”)<sup>308</sup> is juxtaposed with the female nurse’s horror (he “sucked the baby’s brains out”).<sup>309</sup> The doctor is the enemy, while the nurse is emblematic of the woman herself, becoming informed of what the procedure entails for the first time.<sup>310</sup>

In essence, *Carhart* can be read as illustrating the need for informed consent, as well as the Court’s perception that consent to certain procedures in response to full information is impossible. The loaded language of Kennedy’s description, combined with the average reader’s unfamiliarity with medical procedures in general, particularly abortion, encourage shock and revulsion. The audience grasps the full weight of the meaning of “information”<sup>311</sup> as Kennedy understands it.<sup>312</sup> If we revolt in disgust, Kennedy implies, imagine the woman who has elected to have this procedure performed on her own baby:

It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.<sup>313</sup>

The horror is compounded, Kennedy intimates, because such a procedure is antithetical to the natural mothering instinct of the woman.<sup>314</sup> Although Kennedy is careful to note that only “some women regret their choice to abort [an] infant life,” and that the psychological harm is paramount for them,<sup>315</sup> the implication is that most women (“mothers”) do regret their abortions and that no woman can consent to such a procedure and remain

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<sup>306</sup> See *supra* Part IV.A–B.

<sup>307</sup> This language echoes the portrayal of abortion providers as criminals during the period of abortion’s criminalization. See Ashley Gorski, *The Author of Her Trouble: Abortion in Nineteenth- and Early Twentieth-Century Judicial Discourses*, 32 HARV. J.L. & GENDER 431, 451 (2009).

<sup>308</sup> *Carhart*, 550 U.S. at 138.

<sup>309</sup> *Id.* at 139.

<sup>310</sup> Many thanks to Joelle Milov, Editor, *Harvard Journal of Law & Gender*, for this insight.

<sup>311</sup> *Carhart*, 550 U.S. at 159.

<sup>312</sup> See Suk, *supra* note 2, at 1235.

<sup>313</sup> *Carhart*, 550 U.S. at 159–60.

<sup>314</sup> “Respect for human life finds an ultimate expression in the bond of love the mother has for her child.” *Id.* at 159. See also Linda Greenhouse, *Adjudging a Moral Harm To Women From Abortions*, N.Y. TIMES, Apr. 20, 2007, at A18 (stating that Justice Kennedy’s majority opinion “suggest[s] that a pregnant woman who chooses abortion falls away from true womanhood.”).

<sup>315</sup> *Carhart*, 550 U.S. at 159.

psychologically unscathed. In the name of women's health, it is better to uphold the ban and prevent the possibility of consent altogether.<sup>316</sup>

Thus, shunning both the embedded individual approach of informed consent doctrine as well as the sub-autonomous, transferrable treatment of *Muller* and initial informed consent abortion restrictions, *Carhart* re-relegates women to treatment as purely abnormal, status-defined persons in the case of intact D & E abortions. It could do so because of a long-abiding tradition of legal treatment of women as less than autonomous and less than rational, justifying state intervention ostensibly for their own health but really to prevent them from abandoning their role as producers of national progeny.

#### CONCLUSION. ENGAGING A DISCOURSE BASED ON MOTHERHOOD AND MENTAL HEALTH?

Although women's track-transferability has prompted important reconceptualizations of the individual in both labor law and informed consent, it has also reinscribed a separate system of legal treatment for women based on a conception of women as semi-autonomous, sub-rational, and defined by their status as abnormal persons. As the abortion cases above illustrate, justifications based on mental health and women's natural mothering role have been triggers for transferring women between tracks, and informed consent has proved a valuable vehicle to effectuate this transference.

This is not to say that informed consent as a doctrine has no place in the abortion context; rather, if we subscribe to a view of all individuals as embedded, then obtaining informed consent to treatment as a means of counterbalancing situational inequality is a valuable patient tool in all health law scenarios. The trouble comes when assumptions interweave themselves with a conception of social relations so that only certain individuals are viewed as contextually dependent, and their individual autonomy qualified by a perceived natural or inherent characteristic or role—a process that makes them no longer embedded individuals but abnormal persons. As illustrated above, conceptualizing abortion in terms of its justification by or consequences for women's mental health, and hence women's ability to mother, masks deep-

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<sup>316</sup> For a detailed study of the evolution of the "woman-protective anti-abortion argument," see generally Siegel, *Dignity and the Politics of Protection*, *supra* note 2. It is important to note that *Carhart* only overrides the woman's decision-making power in the case of intact D & E abortions. It leaves the "substantial obstacle" test of *Casey* intact. *Carhart*, 550 U.S. at 128. This could be seen as reflecting the Court's cognitive dissonance about how, ultimately, to view women and women's autonomy. In circumscribing the woman's decision-making power by limiting intact D & E but leaving other procedural options open, the Court mirrors the approach taken in labor cases like *Muller*. It views women as rational enough to make a general decision (to work or not to work; to abort or not to abort), but not necessarily rational enough to determine the precise contours of that decision (how many hours to work, what procedure to use), in which areas the Court may decide for them. Many thanks to Professor Reva Siegel for this point.

rooted assumptions about women's social role. Women may be semi-autonomous (because, as Progressive activists recognized, the truly autonomous individual is a myth); they may also sometimes be irrational (because as informed consent scholars pointed out, everyone can be irrational). They may sometimes be depressed or even traumatized, which (as the Jane activists observed) may be due in part to the circumstances surrounding an unwanted pregnancy. This is all part of their embeddedness. The aim of informed consent doctrine is to help individuals overcome their embeddedness by ensuring respect for their decisional autonomy and bodily integrity. However, in the abortion context, both the type of information relayed to the woman and the respect given her decision are colored by concerns for the woman's mental health and mothering ability, a practice that rescripts informed consent doctrine from a tool of first-track empowerment to a means of furthering second-track treatment.

In response to the Court's decision in *Carhart*, it has been suggested that pro-choice activists engage the Court in its own terms, by utilizing the language of mental health and motherhood.<sup>317</sup> The purpose of this approach would be not only to utilize the Court's clear obsession with women-as-mothers, but also to appeal to a possibly alienated contingent of pro-choice mothers who feel that abortion is mischaracterized as the right *not* to mother, rather than the right to decide *how* to mother.<sup>318</sup> This latter framing is supported by data indicating that over 60% of women who abort a pregnancy already have children.<sup>319</sup> The strategy stresses that "[u]nhealthy behaviors and postpartum depression are more prevalent among mothers with unintended births,"<sup>320</sup> and that "unintended childbearing leads to outcomes that are problematic for both mothers and their children, including mental health problems for mothers, lower quality relationships between mothers and children in terms of affection and social support, and increased violence and less leisure time interaction during childhood."<sup>321</sup> The right to an abortion should be supported, this strategy claims, because women who elect to terminate their pregnancies are doing so in order to be better mothers to their existing children, or to their future children when they decide to have them; "[t]hey are choosing abortion in the interest of motherhood."<sup>322</sup>

Thinking about the long-term effects of a strategy and its ability to be co-opted by the other side is, as Jeannie Suk illustrates, imperative to future

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<sup>317</sup> Priscilla J. Smith, *Responsibility for Life: How Abortion Serves Women's Interests in Motherhood*, 17 J.L. & POL'Y 98 (2009).

<sup>318</sup> *Id.* at 99–101.

<sup>319</sup> *Id.* at 105.

<sup>320</sup> *Id.* at 124.

<sup>321</sup> *Id.* at 127 (quoting Jennifer S. Barber, William G. Axinn & Arland Thornton, *Unwanted Childbearing, Health, and Mother-Child Relationships*, 40 J. HEALTH & SOC. BEHAVIOR 231, 253 (1999)).

<sup>322</sup> *Id.*

women's rights jurisprudence.<sup>323</sup> Motherhood and women's capacity for reproduction as a dialectical tool has been persuasive in altering women's legal treatment for the past century, as this article has shown. Although this proposed strategy may be useful for prolonging support for abortion in the short term, it raises several concerns. First, it adopts the baseline assumption of psychiatrists during the early years of abortion reform that because women are mothers, we should help them be good mothers, which includes providing abortions in the event that they cannot mother well at that time.<sup>324</sup> Like the Court, this strategy implies that women would be mothers but for circumstances that prevent them from mothering well—circumstances either caused by or, in the event of an unwanted pregnancy, leading to mental health problems. It thus also re-emphasizes the connection between mental health and abortion, a framework that has contributed to the normative standard that healthy women choose motherhood and women who don't choose motherhood have mental health problems. Finally, this strategy locates women's reproductive decisions in the sphere of public review by encouraging public support for those decisions made in the interest of motherhood.

A true embedded individual approach, in line with the ideal of informed consent doctrine, would treat women as rational, autonomous individuals, who, educated about all their options in an unbiased manner, can abort their pregnancies if they choose. The woman's mental health and ability to mother may be factors the woman herself considers, but would not be exceptions to the rule of motherhood that she must prove in order to obtain an abortion. However, as we have seen, the Court does not treat women as embedded individuals. Emphasizing women's varying motivations as policy reasons for abortion during litigation may help support the principle of liberty justifying the right to abortion; however, it raises the risk that these reasons will be assimilated into the legal opinion only as permissible deviations from a normative standard of motherhood for women. The short-term benefits of this strategy may thus be belied by its long-term damage of reinscribing women into their status roles and bolstering the assumption that women are mothers except when particular circumstances justify them not bearing a child at that time.

Whether this strategy can avoid this outcome depends on whether *motherhood* can be reclaimed so that its definition and realization is no longer something the state or the public-at-large has a voice in deciding. Perhaps, as Victoria Baranetsky suggests, we need to reclaim the Medea-like power of motherhood—the power both to conceive and to destroy.<sup>325</sup> Although the destruction of children by women is hotly contested in our soci-

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<sup>323</sup> See generally Suk, *supra* note 2 (discussing the co-optation of the trauma discourse in rape law by anti-abortion activists).

<sup>324</sup> See *supra* Parts III, IV.

<sup>325</sup> Victoria Baranetsky, *Aborting Dignity and Equality and Embracing Power in the Lexicon of Roe 1* (June 1, 2011) (unpublished manuscript) (on file with author).

ety,<sup>326</sup> destruction of children by men is implicitly permitted under the tolerated residuum of abuse<sup>327</sup> that exempts from legal sanction state agents who ignore child abuse perpetrated by fathers.<sup>328</sup> Although rebellious claims to women's power of destruction may not fly on the stand—as long as Justice Kennedy is around, sympathetic mother plaintiffs may be the pro-choice movement's best bet—perhaps a concurrent, extra-legal social movement emphasizing women's power in all areas, including whether or not and how to mother, would help prevent the further reinscription of women as abnormal persons.

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<sup>326</sup> See, e.g., *INFANTICIDE: PSYCHOSOCIAL AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL*, at xv (Margaret G. Spinelli ed., 2003) (discussing social, cultural, and legal attitudes towards motherhood and infanticide).

<sup>327</sup> Duncan Kennedy's term, suggesting that types of action that are not covered by law or where the law is not enforced, such as sexual abuse, creates a zone of permissiveness around that action. Duncan Kennedy, *Sexual Abuse, Sexy Dressing, and the Eroticization of Domination*, 26 *NEW ENG. L. REV.* 1309, 1320 (1992).

<sup>328</sup> See *Town of Castle Rock v. Gonzales*, 545 U.S. 748, 768 (2005) (holding that a woman had no Due Process claim against police officers who refused to enforce a restraining order against her husband, who ended up killing their three daughters); *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 203 (1989) (holding that the failure of the social services department to provide a young boy with adequate protection against his father's abuse did not violate his Due Process rights).