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Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent, and the First Amendment

Aziza Ahmed

Shifting laws and regulations increasingly displace the centrality of women's needs in the provision of abortion services. Lawmakers and judges contribute to this environment in two ways: by protecting the right of "Crisis Pregnancy Centers" (CPCs) to give false and misleading information about abortion and by supporting legislation mandating that abortion providers give misleading and unnecessary information for the purposes of informed consent. Litigation on informed consent is further complicated through the mobilization of facts — such as the gestational age or sonogram of the fetus — delivered with the intent to dissuade women from accessing abortion. In other words, factual information utilized for ideological purpose.

First Amendment litigation has done little to help prioritize women's access to appropriate information about abortion that is calibrated to their needs. Instead, we see anti-choice advocates utilizing a multi-pronged strategy through the legislature and the courts to support efforts designed to dissuade women from receiving abortions. Courts and lawmakers are playing a key role in deprioritizing women's needs and concerns. This paper will introduce CPCs and attempts to regulate CPCs in comparison with efforts to shape informed consent in the clinical context. Following this overview, the paper will review the public health literature on CPCs. This analysis demonstrates a need for centering women in the abortion law reform project as well as the need for more research on the impact of CPCs.

From Crisis Pregnancy Centers to Clinics

CPCs are designed to look and sound like abortion clinics, though in fact they exist to dissuade women from getting abortions.[1] The Guttmacher Institute estimates that there are between 2,500 and 4,000 CPCs[2] in the United States compared to approximately 1,800 abortion clinics.[3] A National Abortion Rights Action League (NARAL) study found that in Massachusetts alone for every abortion clinic there are three crisis pregnancy centers.[4]

Crisis Pregnancy Centers existed prior to *Roe v. Wade*.[5] Since the early 2000s, however, CPCs have expanded with increasing funding from state and federal governments. Federal sources of funding include Community Based Advocacy Education (CBAE) funding and Title V funds for Maternal and Child Health. Since 2001, CPCs received $30 million in federal funding.[6] At the state level "choose life" license plate sales[7] as well as state based legislative initiatives make fund-

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ing available to CPCs. 15 states dedicate money from "choose life" license plate sales to anti-choice organizations or CPCs. These states include, but are not limited to, Georgia,[8] New Jersey,[9] and Connecticut.[10]

Concerns raised by reproductive rights organizations about CPCs provided the impetus for a 2006 investigation launched by Representative Henry Waxman through the U.S. House of Representatives Special Investigations Division. The report, *False and Misleading Health Information Provided by Federally Funded Pregnancy Centers*,[11] found that 20 of the 23 centers provided misinformation to the investigators who posed as young adults needing abortion services.[12] This includes telling women that there is a link between abortion and breast cancer, that they will experience psychological distress following abortion, and that there is the possibility for future infertility following an abortion.[13] Reports by reproductive rights organizations also highlight that CPCs engage in delay tactics to move women outside of the legally permissible timespan to receive an abortion. A NARAL study done in Minnesota found that CPC staff push women out of the first trimester when abortion is easier and more affordable by delaying ultrasounds and pregnancy tests.[14] Given the existence of CPCs, the American Public Health Association (APHA) has raised concerns about the limited options that young and low-income women often have for unbiased health and accurate medical advice.[15]

> First Amendment litigation has done little to help prioritize women's access to appropriate information about abortion that is calibrated to their needs. Instead, we see anti-choice advocates utilizing a multi-pronged strategy through the legislature and the courts to support efforts designed to dissuade women from receiving abortions.

The rise of CPCs coincides with the decrease in surgical abortion facilities. Since 1982 abortion clinics have been closing at a rapid rate.[16] Between 2011 and 2013 at least 73 clinics have closed.[17] Further, many abortion clinics that remain open are subject to a host of regulations on informed consent. Many of these informed consent requirements are the product of anti-choice activism and are motivated by the specific desire to dissuade a woman from receiving an abortion.[18] As of June 2014, 35 states have abortion-specific informed consent statutes. A sampling of laws illustrates the vast range and specific requirements of informed consent standards on abortion: 12 states require counseling "on the ability of a fetus to feel pain"; and 5 states require that the "woman be told that personhood begins at conception."[19] In South Dakota, for example, clinics are required to tell women that abortion causes "increased risk of suicide ideation and suicide" and that the abortion will terminate the life of a whole, separate, unique, living, human being.[20]

Alongside misinformation, informed consent laws also mandate that the physician deliver information that may be excessive. For example, some states require that physicians display sonograms and force women to hear the heart auscultation of the fetus.[21] Such informed consent regulations conflict with the ethical and legal standards of informed consent. In particular, these requirements diverge from the traditional view that informed consent requires the health care provider to explicate the medical risks, benefits, and alternatives to the procedure.[22] According to the American Medical Association:

> The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice.[23]

Further, the American Medical Association (AMA) guidelines also make clear that "Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients."[24] As recently argued in the *Journal of the American Medical Association*, too much information can undermine effective informed consent — in other words, it is not the quantity of information but its quality for the purposes of patient well-being that is critical for the purposes of informed consent.[25]

Regulating CPCs and Abortion Clinics

Depending on the state in which she lives, a woman seeking an abortion may go from a CPC that purposefully provides misinformation to an abortion provider who is forced to provide unnecessary or incorrect information. The courts, however, do not see CPCs and clinics as on a continuum with one another. Instead, attempts to regulate CPCs or clinics and the ensuing litigation reflect divergent concerns. In other words, we have two lines of free speech cases. In the first, reproductive rights advocates seek to regulate CPCs, forcing them to make a series of disclosures designed to give women information about the centers. CPCs are challenging these regulations. In the second, conservatives attempt to regulate informed consent procedures in clinics often forcing providers to give women inaccurate and irrelevant information. Reproductive justice organizations challenge these laws.

Tracking this litigation side-by-side as they occur in courts, we can observe a slow move towards a care environment that is increasingly complex for abortion seekers: courts frequently prevent legislatures from regulating CPCs as they simultaneously permit informed consent laws designed to dissuade abortion. These parallel tracks do not reflect the reality that women are seeking abortion services from both CPCs and clinics.

Regulating CPCs

CPCs often mislead clients into believing that they may receive an abortion at the facility.[26] In 2011 the APHA issued a policy statement calling for the regulation of Crisis Pregnancy Centers. Among other recommendations the APHA calls for "CPCs to disclose that (1) the center is not a medical facility or medical clinic, (2) the center does not perform or provide referrals for abortion, and (3) the center does not prescribe or provide referrals for Food and Drug Administration (FDA)-approved contraception." Further, it "urges federal, state, and local governments to support only programs that provide medically accurate and unbiased information to women facing unintended pregnancies."[27] Some jurisdictions have attempted to require that CPCs disclose the true nature of the services they provide with efforts varying from jurisdiction to jurisdiction. However, each attempt is met with resistance from religious groups, pro-life organizations, and CPCs.

This has raised a core constitutional issue. The courts have been sympathetic to the claim made by those resisting regulation that mandatory disclosure is in violation of First Amendment rights. A primary point of contention is whether or not the CPC engages in commercial speech. If the court deems that the CPCs are engaging in commercial speech, it will utilize a lower standard of review to assess the constitutionality of the regulations and likely allow for increased regulatory oversight about claims made by CPCs.[28] However, if the CPCs engage in non-commercial speech then the court uses a higher level of scrutiny which would likely disable attempts at regulating CPC speech.[29] The courts have not been consistent on whether or not a CPC engages in commercial or non-commercial speech but have more often landed on non-commercial speech.

Four recent examples demonstrate the largely unsuccessful attempts to regulate CPCs.

In 2009 the City of Baltimore passed Ordinance 09-252.[30] This ordinance required that a limited service pregnancy center that does not provide abortions and will not facilitate women's access to contraceptive services post a sign that states that the center does not provide or make referrals to abortion or birth control services. The ordinance was challenged by the Greater Baltimore Center for Pregnancy Concerns and St. Brigid's Roman Catholic Congregation on grounds that it violated the First Amendment rights of free speech, free assembly, and free exercise of religion. In response, the city argued that the CPC engaged in commercial speech and therefore the mandatory language should be subjected to a lower standard of review. The district court granted summary judgment to the Pregnancy Center dismissing arguments pertaining to the commercial nature of CPCs.[31] On appeal, the Fourth Circuit upheld the injunction on the grounds that the lower court correctly found the ordinance to be non-commercial compelled speech.[32] In 2013, in an en banc hearing the Fourth Circuit vacated the decision and remanded to the lower court. The Circuit Court said that the lower court must at least consider the arguments of the city that the CPC is a commercial enterprise.[33] If the ordinance is struck down, women who approach CPCs in Baltimore seeking abortions, not realizing the intent of CPCs, may not receive the services they need.

Similarly, the City of Austin, Texas enacted ordinance 10-9 in 2010 which mandates that any organization that diagnoses pregnancy, but does not provide abortion or birth control services and is not licensed by the state must clearly display signage which states that they do not provide abortion services and do not refer to abortion services.[34] Threatened with a First Amendment lawsuit by several religious institutions that run pregnancy resource centers, including the Gabriel Project (Catholic), Catholic Charities, the Austin Pregnancy Resource Center, and the South Austin Pregnancy Resource Center, the Austin City

Council amended the ordinance and removed the references to abortion and birth control.[35] The new 2012 ordinance states that institutions diagnosing pregnancy or administering a sonogram must display signage that states whether the center provides medical services, whether these medical services are provided by a licensed health care provider, and if the center is licensed to provide medical services. The specific language on abortion and birth control was removed.[36] In a victory for pro-life groups, in June 2014 the U.S. District Court for the Western District of Texas parsed through the language of Ordinance 10-10 finding it void for vagueness. Thus, as in Baltimore, women in Austin who are not aware that CPCs may not have licensed health providers will not be informed by CPC signage and instead are reliant on a CPC volunteer to disclose this information.

From a reproductive rights perspective, in upholding aspects of the ordinances aimed at regulating CPCs the regulatory efforts in Montgomery County, Maryland and New York paint a slightly more optimistic picture. The Montgomery County Board of Health adopted a resolution that mandated that limited service pregnancy resources centers post a sign that states that the center "does not have a licensed professional on staff" and that the "Montgomery County Health Officer encourages women who are or may be pregnant to consult with a licensed health care provider."[37] Upon challenge from the Limited Service Pregnancy Center, a CPC, the federal District Court for the District of Maryland enjoined the requirement that the CPC state the government's position on women seeking a licensed health care provider. The court found that the CPC was not engaged in commercial speech; thus, the regulation was subject to strict scrutiny.[38] The court rationalized that the first half of the mandatory disclosure requiring CPCs to post a sign stating that there are no licensed professional staff was narrowly tailored. The second requirement, however, did not withstand strict scrutiny. On appeal, the Fourth Circuit affirmed that the District Court acted within its discretion in issuing an injunction only against the latter half of the resolution's mandate.[39] In turn, CPCs are no longer required to have signage that encourages women to go to a licensed health care provider. Women will know, however, that the clinic does not have a licensed health care provider on staff.

Similarly, in March 2011 the New York City Council passed Local Law 17 which went further than Montgomery County. Local Law 17 stated that pregnancy service centers must disclose if they (1) "have a licensed medical provider on staff who provides or directly supervises the provision of all of the services at such pregnancy service center" (the "Status Disclosure"); (2) "that the New York City Department of Health and Mental Hygiene encourages women who are or who may be pregnant to consult with a licensed provider" (the "Government Message"); and (3) whether or not they "provide or provide referrals for abortion," "emergency contraception," or "prenatal care" (the "Services Disclosure")."[40] Several pregnancy services centers including Expectant Mother Care Pregnancy Center, Life Center of New York, Inc., and AAA Pregnancy Problems Center challenged the law.[41] Acting in favor of the CPCs, the United States District Court for the Southern District of New York enjoined Local Law 17 in its entirety finding that the CPC was not engaging in commercial speech.[42] On appeal, the Second Circuit chose not to determine whether or not the CPC was engaging in commercial speech. Instead, the court severed the three aspects of Local Law 17 finding that the "status disclosure" withstands strict scrutiny and was not in violation of the First Amendment while the "government message" and "services disclosure" do not. The Second Circuit then remanded the case to the lower court. The court does recognize, however, the attempt to prevent women from being deceived by a CPC:

> Local Law 17 seeks to prevent woman from mistakenly concluding that pregnancy services centers, which look like medical facilities, are medical facilities, whether or not the centers engage in deception. The law thus applies to facilities that "have the appearance of a licensed medical facility."[43] [sic]

Pro-life groups are pushing back against the decision, arguing that the status disclosure requirement is unconstitutionally vague and does not withstand strict scrutiny.[44] In the meantime, women in New York City will be informed if the CPC has a licensed health provider via a sign. However, signage will not encourage women to seek care with a licensed provider or state the services offered by the CPC. Once again, this information will be provided only at the will of the CPC staff or volunteer.

The mixed attempts to regulate CPCs through mandatory disclosure requirements stands in stark contrast to the successful efforts to regulate the speech of abortion providers also utilizing mandatory speech requirements.

Informed Consent in Clinics

Since the 1992 Supreme Court case *Casey v. Planned Parenthood (Casey),* heightened informed consent standards in the case of abortion have been assessed by whether or not they constitute an "undue burden"

on a woman's ability to access abortion.[45] The court set a low bar for the undue burden standard:

> As a result, the District Court found that for those women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to husbands, employers, or others, the 24–hour waiting period will be "particularly burdensome." These findings are troubling in some respects, but they do not demonstrate that the waiting period constitutes an undue burden.[46]

Further, the court found that truthful and non-misleading information may be consistent with the state's "interest in potential life."[47]

Post-*Casey* there as been a growth of legislated informed consent requirements. Again, rather than placing a woman's right to access abortion as central, the courts have played a key role in legitimating misinformation about abortion. Although not about an informed consent statute, in *Carhart v. Gonzales* (*Carhart*), the 2007 Supreme Court decision on the late trimester abortions serves as the most vivid example of this,[48] as Justice Kennedy's opinion illustrates:

> Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.[49]

Kennedy cited to an amicus brief filled with anecdotes that highlight the negative experiences of women when they had their abortions.[50] Together *Casey* and *Carhart* enable courts to find that heightened informed consent standards pass constitutional muster.[51]

Lower courts reproduce the idea that abortion has negative mental health consequences while finding mandatory speech requirements do not burden a woman's access to abortion.[52] While it is outside the scope of this paper to detail the informed consent cases, it is worth highlighting three examples to demonstrate the way courts treat attempts to regulate provider speech.

In 2012, the Eighth circuit overturned an injunction in favor of Planned Parenthood of Minnesota, North Dakota, and South Dakota barring enforcement of a mandatory disclosure that abortion causes "increased risk of suicide ideation and suicide." The circuit court found that the mandated statement did not unduly burden access to abortion, nor did it violate the physician's free speech rights.[53] On the First Amendment arguments in particular, the court held that the information was truthful and not misleading. In 2011, the Fifth Circuit upheld the Texas Women's Right to Know Act which states that:

> the physician "who is to perform an abortion" to [perform and] display a sonogram of the fetus, make audible the heart auscultation of the fetus for the woman to hear, and explain to her the results of each procedure and to wait 24 hours, in most cases, between these disclosures and performing the abortion.[54]

In ruling that heightened informed consent standards are necessary, the Fifth Circuit Court replicated Justice Kennedy's logic that a woman needs this information so that she will not later come to regret her abortion.[55]

A decision by the District Court for the Middle District of North Carolina provides one of the few examples of the court striking down heightened informed consent standards for abortion. Like Texas, North Carolina passed a Women's Right to Know Act that mandated that the provider perform a "real-time view" of the unborn child, provide an explanation of what the "display" depicts, and must offer the opportunity to hear the fetal heartbeat.[56] The District Court specifically criticized the use of the undue burden standard to examine an issue raising First Amendment concerns and enjoined the act, finding that it compelled government speech in violation of the First Amendment.[57] In upholding the injunction, the North Carolina decision resisted the move made by the Fifth and Eighth Circuit to reproduce (and validate) the claim that the heightened informed consent standards aid in preventing regret. In turn, the court struck down the act as unconstitutional.

Despite a few positive outcomes for reproductive justice providers, in the clinical context these heightened "informed consent" standards are often held to be constitutional.[58] Where these cases are assessed utilizing a First Amendment analysis, as in the Fifth Circuit case assessed here, the courts remain sympathetic to the regulation of provider speech when the information is deemed "truthful" or "non-misleading."[59]

Impact on Women's Lives: The Existing Research and the Need for More

There is little research on the impact of the slow march towards protecting the state's interest in life

over a woman's need to access abortion in a supportive environment.

Reproductive rights organizations have produced numerous reports documenting the harms of CPCs.[60] Many of these reports highlight the methods utilized by CPCs to dissuade women from seeking abortions. However, the public health peer-reviewed literature is lacking when it comes to studies on the impact of CPCs. A simple search on PubMed for "crisis pregnancy center" reveals only five articles, only three of which were published in the last 20 years and only two in the peer-review literature. Only one of these articles, published in July of 2014, addresses the issue of false and misleading information in CPCs. This study, published in *Contraception,* follows referrals from state resource directories to CPCs. After a review of 254 CPC websites, researchers found that 203 of the 254 websites provided at least one false or misleading piece of information. Researchers also found that the most common piece of misleading information was the assertion of a link between abortion and mental health followed by the link between abortion and preterm birth, breast cancer, and future infertility. Researchers recommended that states should not refer women to agencies that provide misinformation to women.[61] A search beyond PubMed reveals a 2012 study published in *Perspectives on Sexual and Reproductive Health.* The author, Joanne D. Rosen, highlights in a viewpoint article, that the delay in obtaining access to abortion introduced by CPCs results in negative outcomes, especially for young and socioeconomically disadvantaged women who take longer to suspect pregnancy and thus arrive at CPCs further along in their pregnancy.[62]

The informed consent requirements for clinics have undergone greater assessment in the public health literature but information is still lacking. In 2009 the Guttmacher Institute completed a literature review of studies that examines waiting periods and mandatory counseling on abortion access — 12 studies in total. With some variation, the literature revealed what one might suspect: women who obtained abortions and were subject to mandatory counseling and waiting period laws described physical discomfort and mental distress. Women also reported increased burdens from visiting clinics multiple times.[63] In particular, the literature review highlights Mississippi studies that found mandatory counseling and waiting periods are associated with a decline in the abortion rate, a rise in abortions obtained out of state as well as an increase in second-trimester abortions.[64] For poor women, however, this effect on reproductive outcomes may not be the entirety of the story. The data further shows that the mandatory counseling and waiting period laws increase the personal and financial costs of obtaining an abortion and prevent women from accessing abortion services.[65] A complete analysis might go beyond a simple consideration of reproductive outcomes and should take on the financial, emotional, and physical toll on women. Unfortunately, this data does not exist.

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Conclusion

While in the process of searching for services and receiving an abortion, women must parse through unnecessary information, be able to ignore factual information mobilized for ideological purpose, and be able to dismiss misinformation. This is a difficult task: women are being asked to disregard information developed by state governments, given to them at medical clinics, or provided by volunteers at centers designed to look like clinics. This assumes a patient who is adept and aware of the political realities of the local contexts in which she seeks care. This environment does not place the woman at the center of the health care process. Instead political battles structure and replace concern for women's health. The broader literature on health and inequality teaches us that an inability to seek out credible information will likely be worse for a woman with few financial resources, or

who may simply now know how to navigate this highly political health care landscape.

The current political, judicial, and legislative picture is dismal. Courts and lawmakers largely protect the efforts of pro-life organizations and advocates to perpetuate a care environment in which the woman, the patient, is not at the center of service delivery. Remaining within the broader ethical framework of informed consent will require a concerted effort on the part of legislators and courts to place the woman's autonomy at the center of decision-making about health.

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