

2020

A Woman's Choice? The Constitutionality of Down Syndrome Abortion Bans and the Breakdown of the Doctor-Patient Relationship

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— Note —

A WOMAN’S CHOICE? THE
CONSTITUTIONALITY OF DOWN
SYNDROME ABORTION BANS AND THE
BREAKDOWN OF THE DOCTOR-
PATIENT RELATIONSHIP

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INTRODUCTION

Each year in the United States, roughly six thousand infants are born with trisomy 21—a genetic disorder more commonly known as Down Syndrome.¹ In the United States, this genetic abnormality

1. *Data and Statistics on Down Syndrome*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/birthdefects/downsyndrome/data.html> [<https://perma.cc/PGX2-ELYT>] (last updated Dec. 5, 2019).

accounts for roughly one in 750 live births.² It is estimated that nearly 250,700 individuals with Down Syndrome currently live in the United States.³

The prevalence of Down Syndrome in the United States is strikingly different than that of Iceland. With a population of 333,000, Iceland typically has only one or two children born with Down Syndrome each year.⁴ The reason, experts claim, is that Icelandic women's abortion rate for children with an in utero Down Syndrome diagnosis is nearly 100%.⁵ Denmark has a similarly high abortion rate for in utero Down Syndrome diagnoses, at 98%.⁶ The United Kingdom has a 90% abortion rate for in utero Down Syndrome diagnoses.⁷ These high abortion rates have essentially eradicated Down Syndrome from these countries' populations. In comparison, the United States has a much lower abortion rate for an in utero Down Syndrome diagnosis, at 67%.⁸

Experts have expressed concern about the high abortion rates for Down Syndrome fetuses in Iceland and Denmark. Geneticist Kari Stefansson, whose company "has studied nearly the entire Icelandic population's genomes," said that the high abortion rate "reflects . . . relatively heavy-handed genetic counseling [Genetic counselors] are having [an] impact on decisions that are not medical"⁹ Hulda Hjartardottir, head of the Prenatal Diagnosis Unit at Landspítali University Hospital in Iceland, argues that her genetic counselors attempt to be as neutral as possible, but concedes that for some, "just offering the [prenatal genetic] test is pointing

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2. Stylianos E. Antonarakis, Robert Lyle, Emmanouil T. Dermitzakis, Alexandre Reymond & Samuel Deutsch, *Chromosome 21 and Down Syndrome: From Genomics to Pathophysiology*, 5 NATURE REVIEWS GENETICS 725, 725 (2004).
 3. Angela P. Presson, Ginger Partyka, Kristin M. Jensen, Owen J. Devine, Sonja A. Rasmussen, Linda L. McCabe & Edward R. B. McCabe, *Current Estimate of Down Syndrome Population Prevalence in the United States*, 163 J. PEDIATRICS 1163, 1167 (2013).
 4. Jillian Quinones & Arijeta Lajka, "What Kind of Society Do You Want to Live In?": *Inside the Country Where Down Syndrome Is Disappearing*, CBS NEWS (Aug. 14, 2017), <https://www.cbsnews.com/news/down-syndrome-iceland/> [<https://perma.cc/LU3X-LZW6>].
 5. *Id.*
 6. *Id.*
 7. George F. Will, *The Real Down Syndrome Problem: Accepting Genocide*, WASH. POST (Mar. 15, 2018) https://www.washingtonpost.com/opinions/whats-the-real-down-syndrome-problem-the-genocide/2018/03/14/3c4f8ab8-26ee-11e8-b79d-f3d931db7f68_story.html [<https://perma.cc/G6UF-BZ4S>].
 8. Quinones & Lajka, *supra* note 4.
 9. *Id.*

[women] towards a certain direction.”¹⁰ Furthermore, in Iceland the medical community considers Down Syndrome a deformity, which legally allows for women to obtain an abortion later in gestation than would normally be permitted.¹¹

Iceland and other European countries provide a unique look into the effects that making genetic screenings part of routine parental care can have on a woman's decision to abort a genetically abnormal fetus. As mentioned, the rate of abortion in the United States for Down Syndrome fetuses is much lower than some European countries. But studies have shown that women's attitudes toward prenatal genetic testing are becoming more positive.¹² There are two main reasons for this shift: first, these tests are available much earlier in a woman's pregnancy; and second, the tests are less invasive and safer for the fetus.¹³ These studies indicate that pregnant women have a high interest in these earlier and non-invasive prenatal genetic tests.¹⁴ It is therefore possible that, as non-invasive genetic testing becomes more widely available in the United States, abortion rates for Down Syndrome fetuses would increase in the United States as they have in countries like Iceland and Denmark.

The ethical conundrum that this increased rate of abortion presents in the United States is straightforward. On one hand, given our nation's history with eugenics and treating those with disabilities “differently and pejoratively,” there is a state interest in now protecting those with Down Syndrome in our population.¹⁵ Bioethicist David Wasserman argues that “[u]nlike people with obsolete skills, but like people of color, people with disabilities are not regarded as moral equals by the larger

10. *Id.*

11. *Id.*

12. *See, e.g.*, Rachel V. van Schendel, Johanna H. Kleinveld, Wybo J. Dondorp, Eva Pajkrt, Danielle R. M. Timmermans, Kim C. A. Holtkamp, Margreet Karsten, Anne L. Vlietstra, Augusta M. A. Lachmeijer & Lidewij Henneman, *Attitudes of Pregnant Women and Male Partners Towards Non-Invasive Prenatal Testing and Widening the Scope of Prenatal Screening*, 22 EUR. J. HUM. GENETICS 1345, 1347 (2014); Junko Yotsumoto, Akihiko Sekizawa, Keiko Koide, Yuditiya Purwosunu, Kiyotake Ichizuka, Ryu Matsuoka, Hiroshi Kawame & Takashi Okai, *Attitudes Toward Non-Invasive Prenatal Diagnosis Among Pregnant Women and Health Professionals in Japan*, 32 PRENATAL DIAGNOSIS 674, 678 (2012).

13. *See* Yotsumoto et al., *supra* note 12, at 678 (finding that women found these factors helped to relieve their anxiety during pregnancy).

14. *See* van Schendel et al., *supra* note 12, at 1347 (noting that many women participants felt it would be easier to decide to abort if the result was known earlier because a less intense bond was formed between mother and child).

15. Adrienne Asch, *Disability Equality and Prenatal Testing: Contradictory or Compatible?*, 30 FLA. ST. U. L. REV. 315, 328 (2003).

society, and the disadvantages they face reflect their devaluation.”¹⁶ But on the other hand, the right to privacy has been recognized as a fundamental right by the Supreme Court for decades.¹⁷ The Supreme Court has recognized that a woman’s choice to continue a pregnancy is so personal that she has the right, up until a certain point in gestation, to abort the fetus if she wishes.¹⁸ Though the Supreme Court has ruled that the government can assert a preference through waiting periods and required physician speech, the ultimate decision is still with the woman.¹⁹ Raising a child with a Down Syndrome diagnosis is much different than raising a genetically normal child, and many would argue the choice should remain with the woman.

Some states recently have determined that their interest in preserving the life of those diagnosed prenatally with Down Syndrome outweighs a woman’s right to choose. These laws place criminal liability on physicians who knowingly perform abortion procedures for women who are seeking the procedure “in part”²⁰ or “solely”²¹ because of a prenatal genetic diagnosis of Down Syndrome. It is crucial to consider how placing criminal liability on physicians may undermine how they interact with women seeking abortions. Such changes in the doctor-patient interaction likely result in an undue burden upon a woman’s right to seek a pre-viability abortion.²²

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16. David Wasserman, *Distributive Justice, in* DISABILITY, DIFFERENCE, DISCRIMINATION: PERSPECTIVES ON JUSTICE IN BIOETHICS AND PUBLIC POLICY 147, 175 (Anita Silvers, David Wasserman & Mary B. Mahowald eds., 1998).
 17. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 896 (1992) (describing abortion as a liberty interest); *Roe v. Wade*, 410 U.S. 113, 154 (1973) (“[T]he right of personal privacy includes the abortion decision . . .”).
 18. *Roe*, 410 U.S. at 154.
 19. *Casey*, 505 U.S. at 882 (recognizing a legitimate government interest in reducing the risk that a woman will choose to abort and allowing state-mandated disclosures to promote informed consent); *see also* *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 576 (5th Cir. 2012) (noting that requiring disclosure of truthful information does not pose an undue burden); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 734–35 (8th Cir. 2008) (en banc) (holding that the state can require a physician to provide non-misleading information to a woman seeking an abortion).
 20. OHIO REV. CODE ANN. § 2919.10 (Supp. 2020).
 21. IND. CODE § 16-34-4-6 (Supp. 2020).
 22. These laws also place a significant burden on physicians, but courts have been less willing to recognize an abortion providers’ interest in challenging state abortion restrictions. *See* *Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908, 916 (6th Cir. 2019) (en banc) (explaining that there is no constitutional right to perform an abortion). Thus, the unconsti-

This Note will argue that Down Syndrome abortion bans are unconstitutional under the *Planned Parenthood of Southeastern Pennsylvania v. Casey*²³ undue-burden test because of the harmful impact they have on the doctor-patient relationship. Part I of this Note provides a background on the current abortion landscape in the United States and explores how the Supreme Court has defined an unduly burdensome restriction. Part II illustrates the changing landscape in prenatal medical technologies and argues that women can now choose to have abortions earlier and with less risk. Part III explores the language of different states' restrictions and what these restrictions would look like in practice. Part IV argues that imposing criminal liability on a physician based on a woman's subjective motivations to seek an abortion has the potential to seriously degrade the doctor-patient relationship and impede the ability for a woman to give informed consent. Finally, Part V briefly discusses other implications Down Syndrome abortion bans have on a woman's right to choose. These discussions lead to the conclusion that restrictive abortion bans on Down Syndrome fetuses are unconstitutional under the current legal framework.

I. ABORTION UNDER ATTACK IN THE UNITED STATES

The legality of abortion in the United States has had a complicated history. The pivotal case *Roe v. Wade*,²⁴ decided in 1973, affirmed that abortion was protected under the fundamental right to privacy.²⁵ But the Supreme Court made clear that this right was not absolute.²⁶ Justice Blackmun noted that there came a point in a woman's pregnancy where the state's interest in life outweighed a woman's right to choose.²⁷ The Court therefore created the trimester framework, which allowed women to abort any time up until the third trimester.²⁸ During the third

tutionality of these laws rest on the undue burden which they place on the pregnant woman seeking care.

23. 505 U.S. 833 (1992).

24. 410 U.S. 113 (1973).

25. *Id.* at 153.

26. *Id.* at 154.

27. *Id.* at 163. For an interesting look at Justice Blackmun's personal medical research on pregnancy to determine when the state interest should outweigh the privacy interest of the woman, see Randy Beck, *Self-Conscious Dicta: The Origins of Roe v. Wade's Trimester Framework*, 51 AM. J. LEGAL HIST. 505, 513–26 (2011).

28. *Roe*, 410 U.S. at 164–65.

trimester, abortions were only permitted if there was significant risk to maternal health.²⁹

In 1992, the Supreme Court significantly altered the standard courts use to analyze abortion restrictions through its decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.³⁰ The case arose as a challenge to Pennsylvania's restrictions on abortion which included requirements that women wait twenty-four hours after a consultation, provide spousal notice, and receive parental consent if under the age of eighteen.³¹ In a plurality opinion written by Justices O'Connor, Kennedy, and Souter, the Court endorsed the basic holding of *Roe*, that a woman has a Fourteenth Amendment right to privacy that protects the right to choose to have an abortion.³² However, the Court did away with the trimester framework in favor of a viability standard, which allows for the cutoff to change as medicine advances.³³

Significantly, *Casey* reaffirmed and recognized a state's interest in protecting unborn life and extended to the states considerable power to exercise this right.³⁴ In doing so, the Court established the undue-burden test for determining the constitutionality of state restrictions on abortions.³⁵ Of this test, the Court wrote, "a statute which, while furthering . . . [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends."³⁶ Moreover, "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right."³⁷

Since *Casey*, the Supreme Court has further defined the meaning of what is an "undue burden" in specific situations, but there is still confusion because little guidance has emerged on what types of restrictions constitute such an undue burden.³⁸ Though clear and convincing evidence of maternal health benefits is required to justify an abortion restriction, there has been little direction to show how strong

29. *Id.*

30. 505 U.S. 833 (1992).

31. *Id.* at 844.

32. *Id.* at 868–69.

33. *Id.* at 870.

34. *Id.* at 875–76.

35. *Id.* at 876.

36. *Id.* at 877.

37. *Id.* at 878.

38. Mary Ziegler, *Substantial Uncertainty: Whole Woman's Health v. Hellerstedt and the Future of Abortion Law*, 2016 SUP. CT. REV. 77, 79.

or how scientifically certain the state's evidence must be to successfully overcome the undue-burden test.³⁹

In 2000, the Supreme Court applied the undue burden test to a state statute prohibiting partial birth abortions in *Stenberg v. Carhart*.⁴⁰ This case involved a Nebraska statute that criminalized partial birth abortions.⁴¹ The statute in question defined a partial birth abortion as “an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery.”⁴² The Supreme Court held that the statute was unconstitutional for two reasons. First, the statute provided no health exception to protect the life of the mother. Second, the statute was unconstitutional because banning “partial birth abortion” would include prohibit the dilation and extraction procedure.⁴³ This type of procedure is the preferred method for abortions performed later in gestation, but still before the *Casey* viability point.⁴⁴ Alternative methods include inducement of labor or a caesarian section abortion, but medical professionals agree that the dilation and extraction procedure is safest for most women.⁴⁵ Therefore, the Court held that by criminalizing this type of abortion procedure, providers would “fear prosecution, conviction, and imprisonment”⁴⁶ for performing a pre-viability abortion and thus the statute placed an undue burden on women seeking a legal abortion.⁴⁷

Less than seven years later, the Supreme Court again applied the undue-burden test, this time to a federal partial birth abortion restriction law, in *Gonzales v. Carhart*.⁴⁸ The case arose as a challenge to the federal Partial Birth Abortion Act.⁴⁹ The Act was similar to the Nebraska statute in that it criminalized “partial birth abortions,” but different because it created an exemption for health risks, and more clearly defined the procedure to still allow for other late-term

39. *Id.*

40. 530 U.S. 914 (2000).

41. *Id.* at 921–22 (quoting NEB. REV. STAT. ANN. § 28-328(1) (West 2020)).

42. *Id.* at 922 (quoting the former version of current NEB. REV. STAT. ANN. § 28-326(8) (West 2020)).

43. *Id.* at 930.

44. *Id.* at 924.

45. *Id.*

46. *Id.* at 945.

47. *Id.* at 945–46.

48. 550 U.S. 124 (2007).

49. *Id.* at 132.

abortions.⁵⁰ The Court upheld the restriction, noting that the federal government has a “legitimate and substantial interest in preserving and promoting fetal life.”⁵¹ The Court reasoned that because the federal government had properly addressed the concerns from the Nebraska statute, the restrictions no longer placed an undue burden on women seeking lawful abortions.⁵² The seemingly contrary decisions in *Stenberg* and *Gonzales* resulted in differing methods of analyzing an undue burden at the circuit court level.⁵³

In 2016, the Supreme Court gave the *Casey* undue-burden test more credibility than ever before in *Whole Woman's Health v. Hellerstedt*,⁵⁴ when the Court held Texas laws requiring admitting privileges were unconstitutional.⁵⁵ The case was a challenge to a Texas statute that required doctors performing abortions to obtain admitting privileges to a hospital no more than thirty miles from the location the abortion was being performed, and the abortion clinic to meet the requirements for an ambulatory surgical center.⁵⁶ The Supreme Court, per Justice Breyer, noted that Texas could not cite a single instance where the admitting privileges helped a woman receive better care.⁵⁷ The Court wrote, “[t]he admitting-privileges requirement does not serve any relevant credentialing function.”⁵⁸ When the law went into effect, almost half of Texas’s abortion clinics were forced to close.⁵⁹ Of the ambulatory surgical center requirements, the Supreme Court wrote that because “abortions typically involve either the administration of medicines or procedures performed through the natural opening of the

50. *Id.* at 132–33.

51. *Id.* at 145.

52. *Id.* at 147.

53. Gillian Metzger, *Symposium: Hanging in the Balance*, SCOTUSBLOG (Jan. 6, 2016, 9:23 AM), <https://www.scotusblog.com/2016/01/symposium-hanging-in-the-balance/> [https://perma.cc/3T7G-JST9] (explaining that the Seventh and Ninth Circuits adopted a balancing test in the undue burden analysis in which the court must weigh the burdens of the restriction with the health benefits to the woman actually achieved; while the Fourth, Fifth, and Sixth Circuits opted for a rational-basis analysis); *see also* Becca Kendis, Note, *Faute de Mieux: Recognizing and Accepting Whole Woman's Health for Its Strengths and Weaknesses*, 69 CASE W. RESV. L. REV. 1007, 1019–21 (2019) (explaining the uncertainty at the circuit level in applying the undue burden analysis).

54. 136 S. Ct. 2292 (2016).

55. *Id.* at 2300.

56. *Id.*

57. *Id.* at 2311–12.

58. *Id.* at 2313.

59. *Id.*

birth canal, which is itself not sterile”⁶⁰ the standards imposed by the statute are “not necessary” to provide safe care to women seeking an abortion.⁶¹ In a five-to-three decision,⁶² the Court held that the statute significantly impeded abortion providers from performing legal abortions, which therefore placed an undue burden upon women seeking such abortions.⁶³ By requiring clear and convincing evidence of the benefits a restriction provided women, the Court significantly strengthened abortion protections.

These Supreme Court decisions have supplied the public with a greater understanding of the undue-burden test and what restrictions on abortion access will be seen as going too far. But abortion rights are always at the forefront American politics.⁶⁴ With a shift in the Court’s composition in recent years and a much more conservative bench now in the majority, many are anxious to see what the Court does with the

60. *Id.* at 2316.

61. *Id.* In making this statement, the Court also highlighted that the mortality rate in Texas resulting from abortions was about one death every two years. The Court noted that childbirth has a fourteen times higher likelihood of death, and Texas allowed for midwives to oversee births in non-surgical settings. Colonoscopies have a mortality rate ten times higher than that of abortions, and liposuction has a mortality rate of twenty-eight times that of abortions. Texas routinely allows for these procedures to take place outside a surgical center. Thus, Texas’ argument that the statute provides for safer patient care is not persuasive. *Id.* at 2315.

62. Many pro-life supporters anticipated that the Supreme Court would liken the undue-burden analysis to a rational-basis test. This test was seen as an easier burden of proof for states in upholding abortion restrictions. But the lopsided vote, coupled with the Supreme Court’s direct rejection of many arguments posed by the Americans United for Life’s amicus brief, indicate that the Supreme Court undoubtedly strengthened abortion rights and the protections that the undue burden analysis provides women. Ziegler, *supra* note 38, at 105–08.

63. *Whole Woman’s Health*, 136 S. Ct. at 2318. Justice Thomas dissented in *Whole Woman’s Health*, arguing that the plaintiffs did not have standing. *Id.* at 2321–22 (Thomas, J., dissenting). Chief Justice Roberts also dissented on the grounds that the abortion providers had failed to show with sufficient evidence that the Texas law forced the closures of abortion clinics. *Id.* at 2337 (Roberts, C.J., dissenting).

64. See, e.g., Jeremy Peters, *As Passions Flare in Abortion Debate, Many Americans Say ‘It’s Complicated,’* N.Y. TIMES (June 15, 2019), <https://www.nytimes.com/2019/06/15/us/politics/abortion-debate-pennsylvania.html> [<https://perma.cc/8RWW-EG3U>]; Amelia Thomson-DeVeaux, *Here’s Why the Anti-Abortion Movement is Escalating*, FIFETHIRTYEIGHT (May 21, 2019), <https://fivethirtyeight.com/features/we-categorized-hundreds-of-abortion-restrictions-heres-why-the-anti-abortion-movement-is-escalating/> [<https://perma.cc/A67A-G4WS>]; *What’s Going On in the Fight over US Abortion Rights?*, BBC NEWS (June 14, 2019), <https://www.bbc.com/news/world-us-canada-47940659> [<https://perma.cc/AQ32-VGHR>].

Casey framework.⁶⁵ States have passed dramatic abortion restrictions in recent years that, if upheld, would significantly erode the fundamental holdings of *Roe* and *Casey*.⁶⁶

In June of 2020, the Court decided *June Medical Services v. Russo*,⁶⁷ which challenged a Louisiana statute that required abortion providers to have admitting privileges to nearby hospitals, privileges which, according to the plaintiffs, only one physician was able to obtain.⁶⁸ Though the state regulation was strikingly similar to the one at issue in *Whole Woman's Health*, the Supreme Court struck down the statute in a close four-to-one-to-four decision.⁶⁹ Justice Breyer, joined by the three more liberal justices, wrote the plurality opinion and argued the statute was unconstitutional under the same reasoning the Court applied in *Whole Woman's Health*.⁷⁰ Chief Justice Roberts concurred in the result as the deciding vote and only conservative justice to vote in favor of striking down the statute, but he wrote separately. He argued that *Whole Woman's Health* was decided incorrectly, but that the statute in the present case must be overturned because *Whole Woman's Health* provided a clear precedent.⁷¹ The remaining conservative justices all wrote individual dissenting opinions.⁷² This was a major victory for

65. Linda Greenhouse, *What Does Amy Coney Barrett Mean for the Supreme Court?*, N.Y. TIMES (Oct. 22, 2020), <https://www.nytimes.com/2020/10/22/opinion/sunday/supreme-court-amy-coney-barrett.html> [<https://perma.cc/U9HB-UAYH>].

66. See Marcia Coyle, *4 Supreme Court Cases That Could Erode Roe v. Wade*, PBS (May 17, 2019, 5:35 PM), <https://www.pbs.org/newshour/politics/4-supreme-court-abortion-cases-that-could-erode-roe-v-wade> [<https://perma.cc/Z7RY-2VYX>] (analyzing legal challenges to various state laws that have the potential to undermine the current abortion framework).

67. 140 S. Ct. 2103 (2020).

68. *Id.* at 2113. In February of 2019, the Supreme Court received an emergency request from June Medical Services to block enforcement of the law after the Fifth Circuit ruled that the law was constitutional and enforceable. The request was granted, but four justices dissented: Justice Alito, Justice Gorsuch, Justice Kavanaugh, and Justice Thomas. Chief Justice Roberts was the only conservative justice to side with blocking the law from taking effect. *June Med. Servs., LLC v. Gee*, 139 S. Ct. 663 (2019).

69. *June Med. Servs. v. Russo*, 140 S. Ct. 2103, 2112 (2020) (plurality opinion).

70. *Id.* at 2109.

71. *Id.* at 2133–34.

72. *Id.* at 2111. Justice Thomas argued that the Fourteenth Amendment does not provide women the right to have an abortion. *Id.* at 2150 (Thomas, J. dissenting). Justice Alito instead focused on the issue of standing, arguing that the regulated party could not stand in to assert the rights of the third party. *Id.* at 2153 (Alito, J. dissenting). Justice Gorsuch argued the Court should have considered the reasons the legislature passed the law. *Id.* at 2171 (Gorsuch, J. dissenting). Justice Kavanaugh argued that there needed

abortion rights activists, and the *Casey* undue burden framework remains in place for the time being.

In the months since *June Medical*, it has become clear that Chief Justice Robert's concurrence has significantly confused lower courts. Some circuits have held that Chief Justice Robert's concurring opinion effectively overruled *Whole Woman's Health* under the *Marks* rule,⁷³ while other circuits have held that *June Medical* yielded no controlling opinion.⁷⁴ With Justice Amy Coney Barrett confirmed in October of 2020⁷⁵ and the Court granting certiorari to hear the constitutionality of a Mississippi law that bans most abortions after fifteen weeks,⁷⁶ many Americans are curious how the Court will rule on abortion regulations moving forward.⁷⁷

to be more factfinding as to the effect the law had on access to abortions. *Id.* at 2182 (Kavanaugh, J. dissenting).

73. The *Marks* rule is derived from *Marks v. United States*, 430 U.S. 188 (1977). The petitioners in the case argued that a recent Supreme Court decision was not controlling because it did not yield a majority opinion. *Id.* at 190. But Justice Powell, writing for the majority, concluded “the holding of the Court may be viewed as that position taken by those members who concurred in the judgments on the narrowest grounds” *Id.* at 192–93. However, the *Marks* rule has proven difficult for the lower courts to consistently apply. See Richard M. Re, *Beyond the Marks Rule*, 132 Harv. L. Rev. 1942 (2019) (arguing the *Marks* rule should be discarded and we should require a majority to reach binding precedent); Ryan C. Williams, *Questioning Marks: Plurality Decisions and Precedential Constraint*, 69 Stan. L. Rev. 795, 814–15 (2017) (arguing for a shared agreement approach, which is a clarification of the *Marks* rule so it is not as confusing as it currently is).
74. *Compare* Hopkins v. Jegley, 968 F.3d 912 (8th Cir. Aug. 7, 2020), *reh'g en banc denied* (Dec. 15, 2020); Preterm-Cleveland v. McCloud, 994 F.3d 512 (6th Cir. 2021) (en banc) (holding that Chief Justice Robert's concurrence in *June Medical* is controlling), *to* Whole Woman's Health v. Paxton, 978 F.3d 896 (5th Cir. 2020), *reh'g en banc granted, opinion vacated by* 978 F.3d 974 (5th Cir. 2020); Planned Parenthood of Indiana & Kentucky v. Box, 991 F.3d 740 (7th Cir. 2021) (holding that *June Medical* yielded no controlling opinion).
75. Barbara Sprunt, *Amy Coney Barrett Confirmed to the Supreme Court, Takes Constitutional Oath*, NPR (Oct. 26, 2020), <https://www.npr.org/2020/10/26/927640619/senate-confirms-amy-coney-barrett-to-the-supreme-court>.
76. *Dobbs v. Jackson Women's Health Organization*, 951 F.3d 246 (5th Cir. 2020), *cert. granted* (2021).
77. See Adam Liptak, *Supreme Court to Hear Abortion Case Challenging Roe v. Wade*, N.Y. Times (May 17, 2021), <https://www.nytimes.com/2021/05/17/us/politics/supreme-court-to-hear-abortion-case-challenging-roe-v-wade.html> (interviewing both pro-life and pro-choice activists for their take on the Supreme Court granting review).

II. AN UNDUE BURDEN FOR SOME? RAISING A CHILD WITH DOWN SYNDROME

Down Syndrome is a chromosomal anomaly where a fetus has three copies of chromosome twenty-one instead of two.⁷⁸ The average baby is born with forty-six chromosomes, but a baby with Down Syndrome instead has forty-seven chromosomes.⁷⁹ There are three types of genetic abnormalities that cause Down Syndrome: trisomy 21, translocation, and mosaic. Almost 95% of cases involve trisomy 21, where each cell has three copies of chromosome twenty-one; 3% of cases involve an extra chromosome 21 that is translocated to another location of the DNA code; and mosaic Down Syndrome is the rarest and found in only 2% of cases, where some cells have the normal number of chromosomes while others have a trisomy.⁸⁰ It is estimated Down Syndrome occurs naturally in one in every 750 live births.⁸¹

Down Syndrome is caused by an abnormal cell division, meaning it is not inherited from either parent.⁸² Because it is caused by an abnormal cell division, there is no test to determine if one is a “carrier” for the genetic abnormality. However, there is strong evidence that shows that maternal age is an external factor that can increase one’s chance of having a child with Down Syndrome.⁸³ One study, published by researchers at Emory University, found that a mother between thirty-five to thirty-nine years old is four to five times more likely to have a child born with Down Syndrome compared to a mother who is twenty to twenty-four years old.⁸⁴

78. *Facts About Down Syndrome*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/birthdefects/downsyndrome.html> [<https://perma.cc/B9CT-4EJ2>] (last updated Dec. 5, 2019).

79. *Id.*

80. *Id.*

81. Antonarakis et al., *supra* note 2, at 725. It is estimated that trisomy 21 is responsible for one in forty-three spontaneous abortions. Accordingly, because of the high self-abortion rates, it is very difficult for researchers to determine how often a trisomy naturally occurs. *Id.*

82. *Id.*

83. *Facts About Down Syndrome*, *supra* note 78.

84. Emily Graves Allen, Sallie B. Freeman, Charlotte Druschel, Charlotte A. Hobbs, Leslie A. O’Leary, Paul A. Romitti, Marjorie H. Royle, Claudine P. Torfs & Stephanie L. Sherman, *Maternal Age and Risk for Trisomy 21 Assessed by the Origin of Chromosome Nondisjunction: A Report from the Atlanta and National Down Syndrome Projects*, 125 *HUM. GENETICS* 41, 47 (2009).

The impact Down Syndrome has on an individual varies significantly on a case-by-case basis.⁸⁵ Most Down Syndrome individuals share similar physical features such as a flattened face, a shorter neck, and poor muscle tone.⁸⁶ They typically have a moderately lower IQ than individuals without Down Syndrome and tend to speak slower.⁸⁷ That said, many individuals with Down Syndrome go on to lead fulfilling lives. The life expectancy has increased dramatically over the last several decades and is now forty-seven years.⁸⁸ Many individuals are able to find fulfilling work, in part thanks to companies with Down Syndrome inclusion programs.⁸⁹

However, raising a child with Down Syndrome is a significant undertaking and lasts well beyond the traditional eighteen-year responsibility. Down Syndrome individuals often have other health issues associated with their trisomy 21, most notably heart defects and sleep apnea, which can cause significant problems later in life.⁹⁰ Depending on how much Down Syndrome affects an individual's IQ, those with Down Syndrome may have difficulty living independently. The Supreme Court has recognized that under the Americans with Disabilities Act, no person with a disability can be denied participation in services, programs, or activities of any public entity.⁹¹ But the

85. As is discussed *infra* notes 86–87 and accompanying text, it is difficult to make sweeping generalizations about the quality of life those with Down Syndrome may have.

86. *Facts About Down Syndrome*, *supra* note 78.

87. *Id.*

88. *Data and Statistics on Down Syndrome*, *supra* note 1.

89. Alexia Elejalde-Ruiz & Hailey Mensik, *Not Just a Feel-Good Step: Businesses are Increasingly Hiring People With Disabilities, and it's Helping the Bottom Line*, CHI. TRIB. (July 28, 2019, 2:00 PM), <https://www.chicagotribune.com/business/ct-biz-disability-employment-20180723-story.html> [<https://perma.cc/K55Q-M5JL>]; *see also* #DSWORKS Corporate Roundtable, NAT'L DOWN SYNDROME SOC'Y, <https://www.ndss.org/work/dsworks-campaign-roundtable/> [<https://perma.cc/WYW3-4NFS>] (last visited Mar. 17, 2020) (explaining the organization's initiative to partner with national businesses to provide work opportunities for Down Syndrome individuals).

90. *Facts About Down Syndrome*, *supra* note 78. Sleep apnea is associated with high blood pressure, heart attack, and stroke. *How Does Sleep Affect Your Heart Health?*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/features/sleep-heart-health/index.html> [<https://perma.cc/ZB7B-353U>] (last updated Dec. 3, 2018).

91. *Olmstead v. L.C.*, 527 U.S. 581, 589–90 (1999). But the Court made two observations of the exclusion of those with disabilities from public life. First, the “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Id.* at 600. Second, “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social

practicality of the matter is that they may not be able to pass the requisite tests to be able get their driver's license, to give an example. Although prenatal genetic testing has improved greatly over the past several decades, there is no way to determine prenatally how much Down Syndrome will affect an individual's IQ.⁹² Therefore, for many parents, a prenatal Down Syndrome diagnosis brings great concern and uncertainty as to what their lives may look like raising a child with Down Syndrome.

The United States also has a troubled history in accepting those with Down Syndrome. Up until the mid-twentieth century, children born with Down Syndrome were placed in state institutions within days of their birth.⁹³ Over thirty states during this time passed laws that allowed for the sterilization of the mentally disabled.⁹⁴ It is estimated that in total, state governments involuntarily sterilized more than

contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601. *See also* *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 450 (1985) (holding that the requirement of a building permit for a group home for the intellectually disabled was based on an irrational prejudice and therefore invalid under the Fourteenth Amendment).

92. *Facts About Down Syndrome*, *supra* note 78.

93. Jon Henley, "There's Places for Children Like Him": How Attitudes to Down Syndrome Changed for the Better, THE GUARDIAN (Oct. 4, 2007, 4:51 PM), <https://www.theguardian.com/society/2007/oct/04/socialexclusion.medicineandhealth> [<https://perma.cc/N235-ZMEL>].

94. ALA. CODE § 309-704-10 (1919); 1929 Ariz. Sess. Laws 118–19; 1909 Cal. Stat. 1093–94; 1909 Conn. Pub. Acts 1135–36; 33 Del. Laws 152–53 (1923); 1925 Idaho Sess. Laws 360; 1911 Iowa Acts 144–45; 1913 Kan. Sess. Laws 525–26; 1925 Me. Laws 198; 1925 Minn. Laws 140–41; 1928 Miss. Laws 370–73; 1923 Mont. Laws 534–37; 1917 N.H. Laws 704–05; 1919 N.C. Sess. Laws 504; 1913 N.D. Laws 63–66; 1931 Okla. Sess. Laws 80; 1917 S.D. Sess. Laws ch. 236 § 1–3, 378–79; 1925 Utah Laws 159; 1924 Va. Acts 569–70; 1929 W. Va. Acts 3–4; 1913 Wis. Sess. Laws 971–72; HARRY H. LAUGHLIN, EUGENICS RECORD OFFICE, BULLETIN NO. 10B: REPORT OF THE COMMITTEE TO STUDY AND TO REPORT ON THE BEST PRACTICAL MEANS OF CUTTING OFF THE DEFECTIVE GERM-PLASM IN THE AMERICAN POPULATION 14 (1914) (describing Indiana's law); *id.* at 27–28 (describing Michigan's law); *id.* at 38–40 (describing Nebraska's law and the Governor's subsequent veto); *id.* at 23–25 (describing New York's law); *id.* at 33–34 (describing Oregon's law and the Governor's subsequent veto); *id.* at 31–33 (describing Pennsylvania's law and the Governor's subsequent veto); *id.* at 34–37 (describing Vermont's law and the Governor's subsequent veto); Lutz Kaelber, *Georgia Eugenics*, UNIV. OF VT. <https://www.uvm.edu/~lkaelber/eugenics/GA/GA.html> [<https://perma.cc/S8XT-H3NJ>] (last visited May 20, 2021) (describing Georgia's law and the Governor's subsequent veto).

65,000 disabled individuals.⁹⁵ The Supreme Court held in *Buck v. Bell*⁹⁶ that these involuntary sterilizations were constitutional. In a now infamous opinion, Justice Holmes wrote, “Three generations of imbeciles are enough.”⁹⁷ *Buck v. Bell* has never explicitly been overruled, but other cases have signaled a shift in ideology.⁹⁸ Even so, it is an illustration of the tumultuous past those with disabilities faced in the United States. Though laws aimed at eliminating discrimination based on disabilities have significantly improved the quality of life for those living with Down Syndrome,⁹⁹ social stigmas still persist.¹⁰⁰

Recent scientific advancements in prenatal genetic testing have allowed for women to receive earlier and more accurate prenatal genetic screenings. Developed in the 1960’s, amniocentesis had long been the method for prenatal genetic testing.¹⁰¹ An amniocentesis cannot be

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95. Andrea Pitzer, *U.S. Eugenics Legacy: Ruling on Buck Sterilization Still Stands*, USA TODAY (June 24, 2009), http://usatoday30.usatoday.com/news/health/2009-06-23-eugenics-carrie-buck_N.htm?POE=click-refer [<https://perma.cc/J9KM-GDTK>]. It is also likely that sterilization laws disproportionately affected Down Syndrome women over Down Syndrome men. It was long believed that Down Syndrome men were infertile due to decreased spermatogenesis, however cases of Down Syndrome males fathering children have been reported. See Richard Sheridan, Juan Llerena Jr., Sally Matkins, Paul Debenham, Andrew Cawood & Martin Bobrow, *Fertility in a Male with Trisomy 21*, 26 J. MED. GENETICS 294, 294 (1989) (acknowledging that it is widely accepted the Down Syndrome men are infertile but conducting a case study showing one Down Syndrome male fathering a child).
96. 274 U.S. 200 (1927).
97. *Id.* at 207.
98. Pitzer, *supra* note 95; see also Conservatorship of Valerie N., 707 P.2d 760, 778 (Cal. 1985) (refusing to allow a guardian to have a mentally disabled female sterilized because there was a lack of evidence showing that other less-intrusive means of birth control were not available); *In re Guardianship of Hayes*, 608 P.2d 635, 641 (Wash. 1980) (holding that guardian failed to meet burden of proof that sterilization would be in the disabled woman’s best interest).
99. See, e.g., Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 (2018); Individuals with Disabilities Education Act of 1990, 20 U.S.C. §§ 1400–82 (2018). But see Deborah Pergament, *What Does Choice Really Mean?: Prenatal Testing, Disability, and Special Education Without Illusions*, 23 HEALTH MATRIX 56, 86–114 (2013) (critiquing current special education programs at public schools and indicating that families are turning more frequently to the private sector for help raise a child with disabilities).
100. See Ranu Jain, David C. Thomsma & Rasa Ragas, *Down Syndrome: Still a Social Stigma*, 19 AM. J. PERINATOLOGY 99, 101 (2002) (reviewing case studies of how Down Syndrome infants were welcomed by family members).
101. Maura Parker Quinlan, *Amniocentesis: Indications and Risks*, 10 AMA J. ETHICS 304, 304 (2008).

performed prior to fifteen weeks of pregnancy.¹⁰² The test is performed by obtaining a sample of amniotic fluid to test the fetal DNA.¹⁰³ Any time the amniotic sac is interrupted, there is risk to the fetus and the potential that the fetus will be lost.¹⁰⁴ Many women refuse such a test if they have low risk for a genetic abnormality or if they know that even if there was a genetic abnormality, they would not abort.¹⁰⁵ Studies also suggest that, because this test is performed later in pregnancy, abortion is often emotionally more difficult for a woman.¹⁰⁶ Most women begin to perceive fetal movement between sixteen and twenty-five weeks.¹⁰⁷ For many women, fetal movement represents a significant threshold in the pregnancy where the mother feels more connected to the fetus, and thus there are more reservations about ending a pregnancy.¹⁰⁸

Cell-free DNA testing is a newer technology that allows physicians to screen for genetic abnormalities as early as nine weeks into the pregnancy, with little risk to the mother.¹⁰⁹ Research has found that a fetus's DNA ends up in the blood stream of its mother.¹¹⁰ Thus, to test a fetus's DNA, a technician only needs to draw a blood sample from the mother. Lab technicians are then able to screen for major genetic abnormalities, including Down Syndrome. If the cell-free DNA test indicates a higher risk of a genetic abnormality, then a doctor can order

102. *Id.*

103. *Id.*

104. *Id.* at 305.

105. Pawel Sadlecki, Marek Grabiec, Pawel Walentowicz & Malgorzata Walentowicz-Sadlecka, *Why Do Patients Decline Amniocentesis? Analysis of Factors Influencing the Decision to Refuse Invasive Prenatal Testing*, 18 BMC PREGNANCY & CHILDBIRTH 174 (2018), <https://doi.org/10.1186/s12884-018-1812-3> [<https://perma.cc/36CR-83V7>].

106. See Carrie Purcell, Audrey Brown, Catriona Melville & Lisa M. McDaid, *Women's Embodied Experiences of Second Trimester Medical Abortion*, 27 FEMINISM & PSYCH. 163, 172–74 (2017) (suggesting that women seeking later-term abortions are ambivalent to their pregnancy at first and fetal movement made their pregnancy feel real).

107. *Id.* at 173–74.

108. *Id.* at 173–74 (noting some women's pregnancies did not feel real until they felt the baby kick around sixteen weeks); see also van Schendel et al., *supra* note 12 at 1347 (hypothesizing that the further a pregnancy progressed, the more intense bond between a mother and fetus).

109. Howard Cuckle, Peter Benn & Eugene Pergament, *Cell-free DNA Screening for Fetal Aneuploidy as a Clinical Service*, 48 CLINICAL BIOCHEMISTRY 932, 936 (2015).

110. *Id.* at 933.

more tests to confirm the abnormality.¹¹¹ This test completely changes the landscape of prenatal genetic testing. Pregnant mothers who participated in one study, when asked about the benefits of the newer genetic screenings, hypothesized that the earlier, non-invasive genetic testing would make decisions to terminate a pregnancy “easier because of [the] less-intense emotional bond between mother and her unborn child.”¹¹² It is yet to be seen if these genetic testing improvements greatly increase the number of abortions based on a prenatal diagnosis of Down Syndrome.

III. STATE ACTION THUS FAR

In recent years, advocates for Down Syndrome rights have championed legislation aimed at increasing information available to mothers who are carrying or recently delivered a child with Down Syndrome. Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act in 2008.¹¹³ The law sought to provide information to parents whose fetus was given a positive diagnosis of Down Syndrome about the life experiences of those with the condition, the services available to aid families who have members with the condition, and the availability of adoption services.¹¹⁴

Advocates started to push for legislation at the state level as well. As of February 2020, eighteen states have passed Down Syndrome information bills.¹¹⁵ These types of laws threaten one of the core

111. *Id.*

112. van Schendel et al., *supra* note 12, at 1347.

113. Prenatally and Postnatally Diagnosed Conditions Awareness Act, ch. 1810, 122 Stat. 4051 (2008) (codified at 42 U.S.C. § 280g-8). The law had bipartisan support in Congress, primarily because it is viewed as promoting both pro-life and pro-choice agendas through improving the dissemination of information to an expectant mother. Rebecca Dresser, *Prenatal Testing and Disability: A Truce in the Culture Wars?* 39 HASTINGS CTR. REP. 7, 7–8 (2009).

114. 42 U.S.C. § 280g-8 (2018).

115. DEL. CODE ANN. tit. 16 § 801B (West 2020); FLA. STAT. ANN. § 383.141 (West 2020); 410 ILL. COMP. STAT. ANN. 511/10 (West 2020); KY. REV. STAT. ANN. § 211.192 (West 2020); LA. STAT. ANN. § 40:1109:2 (2020); ME. REV. STAT. ANN. tit. 22, § 1642 (2019); MD. CODE ANN., HEALTH–GEN. § 20-1502 (West 2020); MASS. GEN. LAWS ANN. ch. 111, § 70H (West 2020); MINN. STAT. ANN. § 145.471 (West 2020); MO. ANN. STAT. § 191.923 (West 2020); NEB. REV. STAT. ANN. § 74-4104 (West 2020); N.J. STAT. ANN. § 26:2-195 (West 2020); OHIO REV. CODE ANN. § 3701.69 (West 2020); 35 PA. STAT. AND CONS. STAT. § 6243 (West 2020); TENN. CODE ANN. § 68-1-1304 (West 2020); TEX. HEALTH & SAFETY CODE ANN. § 161.652 (West 2019); VA. CODE ANN. § 54.1-2403.01 (West 2020); WASH. REV. CODE ANN. § 18.50.170 (West 2020). For the most up-to-date information regarding Down Syndrome information laws, see *Pro-Information Laws & Toolkit*, NAT'L

principles of genetic counseling—neutrality.¹¹⁶ Of these laws, one bioethicist wrote it was the signaling “of what may become many other efforts to insist that those involved in genetic testing, screening, and counseling move away from nominal ethical neutrality to a more disability-friendly normative message.”¹¹⁷

Going beyond genetic-counseling requirements, some states have banned genetically driven abortions. In 2011, Arizona enacted legislation that made it a class-three felony for physicians to perform an abortion “based on the sex or race of the child.”¹¹⁸ Arkansas, Kansas, Mississippi, Missouri, North Carolina, North Dakota, Oklahoma, Pennsylvania, and South Dakota have also enacted similar sex or race abortion bans.¹¹⁹

Currently, twelve states have passed Down Syndrome abortion bans: Arizona, Arkansas, Indiana, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Ohio, South Dakota, Tennessee, and Utah.¹²⁰ Most of these bans seem to mirror the language of statutes from other

DOWN SYNDROME SOC'Y, <https://www.ndss.org/advocate/ndss-legislative-agenda/healthcare-research/pro-information-laws-toolkit/> [https://perma.cc/GA3V-R6RN] (last visited Nov. 29, 2020).

116. Arthur L. Caplan, *Chloe's Law: A Powerful Legislative Movement Challenging a Core Ethical Norm of Genetic Testing*, PLOS BIOLOGY, Aug. 2015, at 3 (2015).

117. *Id.*

118. ARIZ. REV. STAT. ANN. § 13-3603.02 (2020). At least one court has noted there does not appear to be a significant concern for sex-selection in the United States. *Planned Parenthood of the St. Louis Region v. Parson*, 408 F. Supp. 3d 1049 (W.D. Mo. 2019), *appeal filed*, No. 19-3134 (8th Cir. Oct. 3, 2019). But in some countries where male children are preferred, like India, parents often try to sex-select their children, and laws have been passed to prevent such a practice. *See* Sital Kilantriy & Arindam Nandi, *Evaluating the Impact of the Indian Supreme Court Judgment on Sex-Selective Abortion* 18 (Cornell L. Sch. Res. Paper No. 19-24, 2011) (discussing the reasoning and lack of enforcement of India's sex-selection ban).

119. ARK. CODE ANN. § 20-16-1904 (2020); KAN. STAT. ANN. § 65-6726 (West 2020); Miss. Life Equality Act of 2020, H.B. 1295; MO. ANN. STAT. § 188.038 (West 2020); N.C. GEN. STAT. ANN. § 90-21.121 (West 2020); N.D. CENT. CODE ANN. § 14-02.1-04.1 (West 2019); OKLA. STAT. ANN. § 63-1-731.2(B) (West 2020); Pa. Stat. § 3204 (West 2020); S.D. CODIFIED LAWS § 34-23A-10.1 (West 2020).

120. Ariz. S.B. 1457, 55th Leg., 1d Reg. (Ariz. 2021); ARK. CODE ANN. § 20-16-2103 (West 2020); IND. CODE ANN. § 16-34-4-6 (West 2020); KY. REV. STAT. ANN. § 311.731 (West 2020); LA. STAT. ANN. § 40:1061.1.2 (2020); Miss. Life Equality Act of 2020, H.B. 1295; MO. ANN. STAT. § 188.052 (West 2020); N.D. CENT. CODE ANN. § 14-02.1-04.1 (West 2019); OHIO REV. CODE ANN. § 2919.10 (West 2020); S.D. H.B. 1110, 96th Leg., Sess. 694 (S.D. 2021); TENN. CODE ANN. § 39-15-217 (West 2020); UTAH CODE ANN. § 76-7-302.4 (West 2020). As this Note was approaching publication, other states had proposed but not yet passed Down Syndrome abortion bans.

states, of which there are two approaches. Some states ban abortions “solely” because of Down Syndrome and other genetic abnormalities; others ban abortions “in part” because of Down Syndrome and other genetic abnormalities. Indiana and Ohio’s laws illustrate the different statutory approaches and provide insight as to how courts have analyzed their implications thus far. For the purposes of this Note, it is useful to analyze both and the consequences the language has on liability for physicians.

A. Indiana’s Down Syndrome Abortion Ban

The Indiana Down Syndrome abortion ban statute states that a physician may not perform an abortion “if the person knows that the pregnant woman is seeking an abortion solely because the fetus has been diagnosed with Down [S]yndrome or has a potential diagnosis of Down [S]yndrome.”¹²¹ Physicians face various forms of punishment for performing such an abortion. First, physicians who perform unlawful abortions commit a level five felony,¹²² which carries a sentence of one to six years in prison.¹²³ Second, physicians may face disciplinary sanctions such as loss of license, suspension of license, formal reprimand, placement on probation status requiring regular reviews, and a fine.¹²⁴ Third, physicians may be held civilly liable for both wrongful death and discriminatory practices.¹²⁵ Women who seek an abortion may not be prosecuted for violating the chapter or for conspiracy to violate the chapter.¹²⁶

The United States District Court for the Southern District of Indiana held that the law was unconstitutional.¹²⁷ Indiana argued that the better prenatal genetic testing options allowed for an earlier and more accurate diagnosis of genetic abnormalities and that this was leading to an increased rate of abortion of Down Syndrome fetuses.¹²⁸ The district court rejected this argument, acknowledging the state interest in fetal life, but also noting that those interests are not strong

121. IND. CODE ANN. § 16-34-4-6 (West 2020).

122. *Id.* § 16-34-2-7 (West 2020).

123. *Id.* § 35-50-2-6 (West 2020).

124. *Id.* § 25-1-9-9 (West 2020).

125. *Id.* § 16-34-4-9 (West 2020). The statute does not make readily apparent who would have standing to sue the physician in a civil case or who would have the ability to file a complaint with the Civil Rights Commission.

126. *Id.*

127. *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. State Dep’t of Health*, 265 F. Supp. 3d 859, 861 (S.D. Ind. 2017), *aff’d*, 888 F.3d 300, 310 (7th Cir. 2018), *cert. denied in relevant part*, 139 S. Ct. 1780 (2019).

128. *Id.* at 862.

enough to limit a woman's right to choose to have a pre-viability abortion.¹²⁹ The state also argued that *Roe* and *Casey* only protect a woman's right to choose to have an abortion if the woman did not want a child generally, but this right did not extend to the right to choose to abort based on a genetic abnormality.¹³⁰ The court also rejected this argument, finding no support for the argument in those cases.¹³¹ The district court noted that the woman's right to choose was rooted in a right to privacy, which means the woman had a right to make important and personal decisions outside the eye of the state.¹³²

The United States Court of Appeals for the Seventh Circuit affirmed.¹³³ The Seventh Circuit wrote, “[n]othing in the Fourteenth Amendment or Supreme Court precedent allows the State to invade this privacy realm to examine the underlying basis for a woman's decision to terminate her pregnancy prior to viability.”¹³⁴ The Down Syndrome abortion provisions are “far greater than a substantial obstacle; they are absolute prohibitions on abortions prior to viability which the Supreme Court has clearly held cannot be imposed by the State.”¹³⁵

The Supreme Court denied certiorari on this question.¹³⁶ Justice Thomas, concurring in the denial, wrote that the Supreme Court would soon need to take up this issue because “this law and other laws like it promote a State's compelling interest in preventing abortion from becoming a tool of modern-day eugenics.”¹³⁷ But Justice Thomas ultimately agreed not to take up the issue just yet, writing that further percolation could assist the Court in making a ruling later.¹³⁸ Thus, Indiana's Down Syndrome abortion ban has been permanently enjoined because it failed the *Casey* undue burden test.

129. *Id.* at 866–67.

130. *Id.* at 868.

131. *Id.* at 869.

132. *Id.* at 865–66.

133. *Planned Parenthood of Ind. & Ky., Inc. v. Comm’r, Ind. State Dep’t of Health*, 888 F.3d 300, 310 (7th Cir. 2018), *cert. granted in part and denied in part*, 139 S. Ct. 1780 (2019).

134. *Id.* at 307.

135. *Id.* at 306 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992)).

136. *Box v. Planned Parenthood of Ind. & Ky, Inc.*, 139 S. Ct. 1780, 1782 (2019).

137. *Id.* at 1782–83 (Thomas, J., concurring).

138. *Id.* at 1784 (Thomas, J., concurring).

B. Ohio's Down Syndrome Abortion Ban

The Ohio statute bans abortions based “in part” because of a prenatal diagnosis of Down Syndrome.¹³⁹ Any hint from the patient about a Down Syndrome diagnosis presents a concern that the patient is aborting the fetus “in part” because of the diagnosis. A physician proceeding with an abortion when he knows of a Down Syndrome diagnosis would potentially open himself or herself up to penalties. First, performance of an abortion in violation of the statute is a felony of the fourth degree.¹⁴⁰ Second, the state medical board will revoke a physician’s license to practice.¹⁴¹ Third, a physician may be held civilly liable to any person or his or her representative for compensatory damages and attorney’s fees for any injury or death that results from the prohibited abortion.¹⁴²

The United States District Court for the Southern District of Ohio held that the state’s argument for antidiscrimination was just a new way of the state inserting its interest in the preservation of life, which under *Casey* is not sufficient to deny a woman an abortion pre-viability.¹⁴³ A divided panel of the United States Court of Appeals for the Sixth Circuit upheld the district court’s ruling on much the same basis.¹⁴⁴ The majority wrote, “To give credence to the argument that an interest such as preventing discrimination or stigma may lay outside the interest in potential life and be considered separately to determine a women’s [sic] rights to abortion would be to ignore the unique condition of abortion recognized in *Casey*.”¹⁴⁵

However, after a rehearing en banc, the Sixth Circuit narrowly reversed in a nine-to-seven decision and held that the Down Syndrome abortion ban was constitutional.¹⁴⁶ Judge Alice M. Batchelder, who was the lone dissent in the original three-judge panel, wrote the majority opinion. In the opinion, she explained, first, that there was no “*per se* right [to abortion] based on the stage of the pregnancy.”¹⁴⁷ Second, she argued that Ohio’s interest in protecting Down Syndrome individuals from stigma and protecting women from physician coercion has nothing

139. OHIO REV. CODE ANN. § 2919.10(B) (West 2006).

140. *Id.* § 2919.10(C).

141. *Id.* § 2919.10(D).

142. *Id.* § 2919.10(E).

143. *Preterm-Cleveland v. Himes*, 294 F. Supp. 3d 746, 748–49 (S.D. Ohio 2018).

144. *Preterm-Cleveland v. Himes*, 940 F.3d 318 (6th Cir.), *vacated and reh’g en banc granted*, 944 F.3d 630 (6th Cir. 2019).

145. *Id.* at 324.

146. *Preterm-Cleveland v. McCloud*, 994 F.3d 512 (6th Cir. 2021) (en banc).

147. *Id.* at 521.

to do with the viability of the fetus.¹⁴⁸ Accordingly, the majority argued that the law allows for women to make their own choice about whether to abort a fetus with Down Syndrome without undue influence from physicians.¹⁴⁹ Chief Judge Cole dissented, arguing the majority turned the restriction into a “don’t ask, don’t tell” law because it prevents physicians from engaging in certain conversations with their patients in order to avoid liability.¹⁵⁰ The Down Syndrome abortion ban went into effect April 13, 2020.¹⁵¹

C. Where Do Other States Fall?

Ten other states have passed Down Syndrome or genetic abnormality bans. As illustrated above, these abortion bans essentially fall into two categories: bans based “solely” on a Down Syndrome diagnosis and bans based “in part” on a Down Syndrome diagnosis. Though it is unnecessary to go into the details of every state’s law, it is important to have a general landscape of the language other states have utilized when enacting these abortion bans.

Currently, Arizona, Louisiana, Kentucky, Arkansas, Mississippi, Missouri, North Dakota, South Dakota, Tennessee, and Utah have enacted some form of a Down Syndrome abortion ban.¹⁵² Arkansas,¹⁵³

148. *Id.* at 521.

149. *Id.* at 522–23.

150. *Id.* at 551 (Cole, C.J., dissenting).

151. *Id.* at 535.

152. *See generally Genetic Anomalies: Laws*, Rewire News, <https://rewire.news/legislative-tracker/law-topic/genetic-anomalies-abortion-ban/> [<https://perma.cc/DSL2-ZKVQ>] (last visited Jan. 16, 2020) (tracking abortion restriction laws by state). As this Note was approaching publication, Down Syndrome abortion restrictions were also pending in North Carolina and Texas. *See* David Crary and Iris Samuels, *Down Syndrome Abortion Bans Gain Traction After Court Ruling*, AP NEWS (May 19, 2021), <https://apnews.com/article/us-supreme-court-donald-trump-down-syndrome-abortion-courts-ab09552bd57aa5306f0341189f70b1cb> (noting that the Sixth Circuit en banc decision has cleared the way for states to pass these types of laws).

153. ARK. CODE ANN. § 20-16-2103 (West 2020). One significant difference in the Arkansas law is that if the pregnant patient knows of any test result, the physician must request her medical records to determine whether she has previously had an abortion after becoming aware of any test results, prenatal diagnosis, or any other evidence that the fetus may have had Down Syndrome. *Id.* The physician is prohibited from performing an abortion until at least fourteen days have passed since trying to obtain the medical records of the pregnant woman. *Id.* On August 6, 2019, the United States District Court for the Eastern District of Arkansas issued a preliminary injunction to keep the law from going into effect while the case proceeds. *Little Rock Fam. Plan. Servs. v. Rutledge*, 397 F. Supp. 3d 1213 (E.D. Ark. 2019). This was affirmed by the Eighth Circuit. *Little Rock Family Planning Services v. Rutledge*, 984 F.3d 682 (8th Cir. 2021), *petition for cert. filed*.

Missouri,¹⁵⁴ South Dakota,¹⁵⁵ Tennessee,¹⁵⁶ and Utah¹⁵⁷ prohibit abortions solely because the fetus has or may have Down Syndrome. Arizona,¹⁵⁸ Louisiana,¹⁵⁹ Mississippi,¹⁶⁰ and North Dakota¹⁶¹ have passed laws that prohibit abortions solely because the fetus has or may have a genetic abnormality.¹⁶² Kentucky's law bans abortions when the physician knows the abortion is sought in part because the fetus has or may have Down Syndrome or any other disability.¹⁶³

154. MO. ANN. STAT. § 188.038(2) (West 2020). The United States District Court for the Western District of Missouri, upon finding that “a small number of women would predictably need protection during litigation,” issued a preliminary injunction prohibiting enforcement of the statute. *Planned Parenthood of the St. Louis Region v. Parson*, 408 F. Supp. 3d 1049, 1052 (W.D. Mo. 2019). The Eighth Circuit upheld the injunction. *Planned Parenthood of the St. Louis Region v. Parson*, Nos. 19-2882, 19-3134, 2021 U.S. App. LEXIS 17099 (8th Cir. 2021).
155. S.D. H.B. 1110, 96th Leg., Sess. 694 (S.D. 2021).
156. H.B. 2263/S.B. 2196., 111th Gen. Assemb. (Tenn. 2020). The United States District Court for the Middle District of Tennessee found that while the Sixth Circuit reviewed the *Preterm-Cleveland* case, a significant number of women would be harmed by the statute, and therefore a preliminary injunction was granted. *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-cv-00501, 2020 WL 4274198, at *16, *21 (M.D. Tenn. July 24, 2020). However, in November of 2020, a three-judge panel for the Sixth Circuit issued a stay of the district court's preliminary injunction and the law went into effect. *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-cv-00501, 2020 U.S. App. LEXIS 36780 (6th Cir. 2020).
157. H.B. 166, 63d Leg., Gen. Sess. (Utah 2019). The statute has what is known as a “trigger clause,” which means that the statute will go into effect only if a similar law is upheld in court elsewhere. *Id.*
158. Ariz. S.B. 1457, 55th Leg., 1d Reg. (Ariz. 2021).
159. LA. STAT. ANN. § 40:1061.1.2 (2020). The statute places criminal liability on a physician for performing an abortion twenty weeks post-fertilization up until viability on a patient knowing “the pregnant woman is seeking the abortion solely because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality.” *Id.* The United States District Court for the Middle District of Louisiana found that enjoining the statute would not provide relief because another state statute, LA. STAT. ANN. § 40:1061.1(E)(1) (2020), criminalized all abortions after twenty weeks. *June Med. Servs. LLC v. Gee*, 280 F. Supp. 3d 849, 863–64 (M.D. La. 2017).
160. Miss. Life Equality Act of 2020, H.B. 1295.
161. N.D. CENT. CODE ANN. § 14-02.1-04.1 (West 2019). No lawsuits have been filed challenging the law. Thus, it is currently in effect.
162. This language is much broader, and its implications are discussed *infra* notes 255–258 and accompanying text.
163. KY. REV. STAT. ANN. § 311.731 (West 2020). The law also required physicians to certify in writing whether the attending physician had knowledge that the pregnant person was seeking the abortion, in whole or in part,

In October 2019, a federal Down Syndrome abortion ban bill was introduced in Congress.¹⁶⁴ These proposals are at the forefront of many conservative lawmakers' agendas, meaning the issue will continue to percolate in the court system. The hope, by both pro-life and pro-choice advocates, is that the Supreme Court will address the issue. Both sides are confident the highest court will come out on their side.¹⁶⁵

IV. THE BREAKDOWN OF THE DOCTOR-PATIENT RELATIONSHIP

The choice to have an abortion is a very difficult one, and accordingly all parties involved have an interest in ensuring that a woman makes an informed choice. The choice to have the procedure will undoubtedly have lifelong consequences. A woman's attitudes towards her abortion will be influenced by her interactions with her abortion provider. This Part argues that Down Syndrome abortion bans that place criminal liability on an abortion provider impose a restriction on a woman's ability to give informed consent. The physician, to avoid learning information that may open him or herself up to liability, will be closed off, and as a result, the woman will not feel comfortable asking questions about the procedure. As such, these laws undermine the central tenets of medical ethics and place an undue burden on a woman seeking a pre-viability abortion.

A. What Is the Purpose of Informed Consent?

A patient who agrees to medical intervention must do so with an understanding of the risks associated with the treatment and alternatives so she may make a voluntary and informed choice about her care.¹⁶⁶ This is known as informed consent.¹⁶⁷ Without informed consent from a patient who has decision-making capacity, medical intervention

due to the sex, race, or potential diagnosis of a disability. *Id.* The United States District Court for the Western District of Kentucky permanently enjoined the enforcement of the law. *EMW Women's Surgical Ctr. v. Meier*, 373 F. Supp. 3d 807 (W.D. Ky. 2019), *aff'd*, *EMW Women's Surgical Center v. Friedlander*, 960 F.3d 785 (6th Cir. 2020).

164. S. 2745, 116th Cong. (2019).

165. For a discussion on why now is a crucial time for lawmakers to challenge *Roe v. Wade*, see Jessica Ravitz, *Courts Say Anti-Abortion 'Heartbeat Bills' Are Unconstitutional. So Why Do They Keep Coming?*, CNN (May 16, 2019, 9:28 AM), <https://www.cnn.com/2019/01/26/health/heartbeat-bills-abortion-bans-history/index.html> [<https://perma.cc/8QV2-BCBA>].

166. *Informed Consent*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> [<https://perma.cc/YNC4-77H2>] (last visited Mar. 10, 2020).

167. *Id.*

is not permitted.¹⁶⁸ Common law recognized actions for trespass, assault, and battery against those who performed non-consensual medical procedures.¹⁶⁹ Over time, United States constitutional law developed the right of privacy,¹⁷⁰ which reflects “society’s concern for the individual’s right to be let alone, both by agents of the state and by private parties.”¹⁷¹

The American Medical Association provides guidelines for a physician seeking informed consent from a patient.¹⁷² First, the physician should “assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives” in order to make an “independent, voluntary decision.”¹⁷³ Second, the physician should “present relevant information accurately and sensitively,” keeping in mind “the patient’s preferences for receiving such information.”¹⁷⁴ Third, the physician should document the conversation with the patient in the medical chart.¹⁷⁵ The AMA further emphasizes that patients have the right to receive information and ask their physicians questions as part of the informed consent process.¹⁷⁶ Successful

168. There are, of course, instances where the patient does not have decision-making capacity. In these cases, a physician may make decisions on behalf of the patient. *Id.* These situations most commonly occur in emergency situations where a patient is unconscious and there is no surrogate decision maker available and in pediatric cases. *Id.* Physicians typically make these decisions based on the medical condition of the patient, but sometimes non-medical factors to influence their decision, such as the cost relative to the expected outcome or hospital resources. *See, e.g.,* Monica Escher, Thomas V. Perneger & Jean-Claude Chevrolet, *National Questionnaire Survey on What Influences Doctors’ Decisions About Admission to Intensive Care*, 329 BRIT. MED. J. 1, 2 (2004).

169. JESSICA W. BERG, PAUL S. APPELBAUM, CHARLES W. LIDZ & LISA S. PARKER, *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 41–42 (2d ed. 2001).

170. *See, e.g.,* *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 *passim* (1990) (discussing state treatments of the constitutional privacy right with respect to state laws governing the treatment of incompetent patients); *Roe v. Wade*, 410 U.S. 113, 152–54, 164–65 (1973) (holding that women have a right to abortions before fetal viability rooted in a right of privacy); *Griswold v. Connecticut*, 381 U.S. 479, 483–86 (1965) (holding that, because of the penumbral right to privacy, states cannot prohibit married women from using contraception).

171. BERG ET AL., *supra* note 169, at 42.

172. *Informed Consent*, *supra* note 166.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

communication between the physician and patient helps foster trust and improves shared decision making.¹⁷⁷

Leading bioethicists Ruth Faden and Tom Beauchamp have noted that informed consent in clinical practice has two distinct frameworks: moral and legal. Informed consent from a moral perspective focuses on preserving the patient's autonomy.¹⁷⁸ The legal perspective focuses on allowing the patient to recover financially if she is injured and the physician did not disclose the risks of the treatment.¹⁷⁹ Physicians have obligations under both moral and legal frameworks.¹⁸⁰ A physician should discuss with his patient the procedure, its likelihood of success, the risks, and what other treatment options are available.¹⁸¹ The doctrine of informed consent evolved as a response to paternalistic physicians imposing their own personal views onto patients instead of respecting individual autonomy.¹⁸² Now, the doctrine of informed consent provides an avenue for patients to learn about different treatment options so they can make their own value-based decisions.¹⁸³

When courts evaluate what is sufficient physician disclosure for informed consent, most jurisdictions rely on either the "reasonable physician" or "reasonable patient" standard.¹⁸⁴ Under the reasonable physician standard, a physician could be held liable for failing to disclose what a reasonable physician would have disclosed in similar circumstances.¹⁸⁵ This standard mirrors that of medical malpractice and negligence cases, so courts are familiar with it.¹⁸⁶ But this standard fails to recognize that often there is not a consensus across the medical

177. *Id.* Shared decision making is defined as an approach where clinicians share the best available evidence with patients and where patients are supported to consider options, to achieve an informed preference. Glyn Elwyn, Dominick Frosch, Richard Thomson, Natalie Joseph-Williams, Amy Lloyd, Paul Kinnersley, Emma Cording, Dave Tomson, Carole Dodd, Stephen Rollnick, Adrian Edwards & Michael Barry, *Shared Decision Making: A Model for Clinical Practice*, 27 J. GEN. INTERNAL MED. 1361, 1361 (2012). Informed consent and shared decision making are inextricably linked. *Id.* at 1362.

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

179. *Id.*

180. Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 CORNELL J.L. & PUB. POL'Y 1, 19 (2011).

181. *Id.*

182. BERG ET AL., *supra* note 169, at 42.

183. *Id.* at 46.

184. Sawicki, *supra* note 180, at 31.

185. BERG ET AL., *supra* note 169, at 46.

186. *Id.*

profession about the risks that should be disclosed to a patient regarding certain procedures.¹⁸⁷ Under a reasonable patient standard, a physician could be held liable for failing to disclose information a reasonable patient would deem material.¹⁸⁸ This standard leaves physicians with a lot of uncertainty. But it is also beneficial because it compels a physician to have a discussion with his patient to ascertain what information she deems material.¹⁸⁹ Sufficient disclosures under the informed-consent doctrine are highly dependent on social norms and values.¹⁹⁰

B. Informed Consent in the Abortion Context

Studies consistently show that the way physicians present patients with information affects their decision making.¹⁹¹ These are known as framing effects.¹⁹² Studies also show that when physicians spend more time with the patient discussing and elaborating on the risks, benefits, and alternatives, the effect of physician framing goes down and the patient makes a more autonomous and informed decision.¹⁹³ Most medical ethicists promote doctor and patient discussion so true informed consent can be obtained.

For example, one study looked at the impact physician interactions had on the decisions of patients regarding cancer treatment.¹⁹⁴ Researchers presented participants with a scenario where they were diagnosed with lung cancer and the physician gave two treatment options: surgery or radiation.¹⁹⁵ The results of the treatments were framed in one of two ways. In one group, the success of the treatment was described using the survival rate; in another group, the success of

187. *Id.* at 46–47.

188. *Id.* at 48.

189. *Id.* at 49.

190. Sawicki, *supra* note 180, at 19.

191. *See, e.g.*, Sammy Almashat, Brian Ayotte, Barry Edelstein & Jennifer Margrett, *Framing Effect Debiasing in Medical Decision Making*, 71 PATIENT EDUC. & COUNSELING 102, 102 (2008); Elwyn et al., *supra* note 177, at 1361–62.

192. Almashat et al., *supra* note 191, at 102.

193. *See id.* at 106 (finding that elaboration on treatment methods, risks, and projected outcomes minimizes framing effects); Elwyn et al., *supra* note 177, at 1362 (noting that there have been nearly 86 case studies indicating that the more a patient and physician share in the decision-making process, the more confident the patient feels in his or her decision).

194. Almashat et al., *supra* note 191, at 103.

195. *Id.* at 104.

the treatment was described using the mortality rate.¹⁹⁶ Patients who were presented information using survival rates were much more likely to choose the riskier procedure compared with those who were presented information using mortality rates for the same procedure.¹⁹⁷ The same test was performed with another two groups, but this time, the physician elaborated more on the nature of the treatment, the risks, and the likelihood of success.¹⁹⁸ The study found that the elaboration reduced the impact of the framing effect.¹⁹⁹

Similar results have emerged in the abortion setting. One study indicated that ninety-four percent of women who received counseling from their reproductive health care provider were satisfied with the information they received prior to their abortion.²⁰⁰ The study recommended that during these counseling sessions, physicians ask women open-ended questions, encourage patient questions, and validate women's emotions. When women feel respected by abortion providers, they are more likely to communicate what additional information they need to make a final decision.²⁰¹ These discussions can help a woman learn about her options and feel more confident in her ultimate choice.²⁰²

Each state has developed its own informed-consent statutes that physicians must follow for a medical procedure to take place.²⁰³ But in the abortion context, some states have chosen to impose even stricter informed-consent requirements. Take, for example, Alabama's Women's Right to Know Act, which employs almost all of the possible informed-consent provisions in the abortion setting.²⁰⁴ This law requires that a physician give a pregnant woman seeking an abortion information about adoption agencies, fetal development, paternal responsibilities, and alternatives to abortion.²⁰⁵ A physician must then perform an ultrasound, and the woman has to sign a form to indicate she "either saw the ultrasound image or was given the opportunity and

196. *Id.*

197. *Id.* at 105.

198. *Id.*

199. *Id.* at 106.

200. Vicki Breitbart, *Counseling for Medical Abortion*, 183 AM. J. OBSTETRIC GYNECOLOGY 26, 26 (2000).

201. *Id.* at 26–28.

202. *Id.* at 32.

203. *See, e.g.*, CAL. CIV. CODE § 1714.8 (West 2020); FLA. STAT. ANN. § 766.103 (West 2020); OHIO REV. CODE ANN. § 2317.54 (West 2017).

204. ALA. CODE § 26-23A-4 (2020).

205. *Id.*

rejected it.²⁰⁶ Once this is completed, the woman must sign a consent form and wait forty-eight hours before returning to have the physician perform the procedure.²⁰⁷ Thirty-three other states impose some form of additional requirement to informed consent in the abortion setting.²⁰⁸

Abortion is not the only medical procedure over which states have asserted more stringent informed-consent standards. These types of statutes often arise when there is a perceived disconnect between the information that physicians are conveying to their patients versus the type of information that should be made available to patients. For example, breast cancer statutes arose out of a perceived overuse of mastectomies in treatments of early-stage breast cancer.²⁰⁹ These statutes required physicians to provide patients with information regarding their diagnosis and include advantages and disadvantages of various treatment options.²¹⁰ While these types of laws certainly increase information available to a patient, it is not clear how much the state-mandated information actually enhances the decision making of the patient.²¹¹

For many, the intrusion of the state into the doctor-patient relationship poses concern. Robert Post wrote of the doctor-patient relationship, “when physicians speak to us as our personal doctors, they must assume a fiduciary obligation faithfully and expertly to commun–

206. *Id.*

207. *Id.*

208. ALASKA STAT. ANN. § 18.16.060(b) (West 2020); ARIZ. REV. STAT. ANN. § 36-2153(A) (2020); ARK. CODE ANN. § 20-16-1703(a)–(b)(1) (Supp. 2019); FLA. STAT. ANN. § 390.0111(3) (West 2020); GA. CODE ANN. § 31-9A-3 (West 2020); IDAHO CODE § 18-609 (2020); IND. CODE ANN. § 16-34-2-1.1 (West 2020); IOWA CODE § 146A.1 (2020); KAN. STAT. ANN. § 65-6709 (West 2020); KY. REV. STAT. ANN. § 311.727 (West 2020); LA. STAT. ANN. § 40:1061.16 (2020); MASS. GEN. LAWS ANN. ch. 112, § 12S (West 2020); MICH. COMP. LAWS ANN. § 333.17015(3) (West 2020); MINN. STAT. § 145.4242(a) (2020); MISS. CODE ANN. § 41-41-34(1)(a)–(d) (West 2020); MO. ANN. STAT. § 188.027 (West 2020); MONT. CODE ANN. § 50-20-106 (West 2019); NEB. REV. STAT. ANN. § 28-327 (West 2020); N.C. GEN. STAT. ANN. § 90-21.82(a) (West 2020); N.D. CENT. CODE ANN. § 14-02.1-04 (West 2019); OHIO REV. CODE ANN. § 2317.56(B) (West 2017); OKLA. STAT. ANN. tit. 63, § 1-738.8 (West 2020); 28 PA. CODE § 29.37(b)(1) (2020); 23 R.I. GEN. LAWS ANN. § 23-4.7-5(b)(1) (West 2020); S.C. CODE ANN. § 44-41-330 (2020); S.D. CODIFIED LAWS § 34-23A-10.1 (2020); TENN. CODE ANN. § 39-15-202 (West 2020); TEX. HEALTH & SAFETY CODE ANN. § 171.013 (West 2019); UTAH CODE ANN. § 76-7-305 (West 2020); VA. CODE ANN. § 18.2-76 (West 2020); W. VA. CODE ANN. § 16-2I-2 (West 2020); WIS. STAT. ANN. § 253.10(3) (West 2019); WYO. STAT. ANN. § 35-6-119 (West 2020).

209. Rachael Andersen-Watts, *The Failure of Breast Cancer Informed Consent Statutes*, 14 MICH. J. GENDER & L. 201, 206–07 (2008).

210. *Id.* at 211–12.

211. *Id.* at 217–18.

icate the considered knowledge of the ‘medical community.’”²¹² In *Colautti v. Franklin*,²¹³ the Supreme Court emphasized that the role of the abortion provider was “both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out.”²¹⁴

Since *Casey*, states have become increasingly emboldened to enact laws that require physician speech in the abortion context. When the state has the ability to manipulate information that is being presented to women by physicians to help satisfy state ends, then there is cause for concern as to how this may affect the doctor-patient relationship.²¹⁵ Some women may think the views of the state are endorsed by her physician if there is not clear demarcation of what is required speech and what is individualized discussion.²¹⁶ Furthermore, required state disclosures and the informed-consent discussion between the physician and woman often happen at the same time, which can lead to patient confusion.²¹⁷

C. Applying These Principles to Down Syndrome Abortion Bans

In an abortion context involving a Down Syndrome diagnosis, there are arguably two types of informed consent that a woman must provide. First, the woman must understand the benefits and risks of the abortion procedure, which will be different depending on the gestational age of the fetus. Second, the woman must express an understanding of her fetus’s Down Syndrome diagnosis.

Practically, it is difficult for abortion providers to satisfy this second prong of informed consent. Genetic tests are usually administered by a primary care physician or genetic counselor, who are

212. Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 977 (2007).

213. 439 U.S. 379 (1979).

214. *Id.* at 387.

215. Sawicki, *supra* note 180, at 32; *see also* Post, *supra* note 212, at 977–78. Some argue that mandatory-disclosure laws violate a physician’s First Amendment right to free speech. Robert Post argues that physicians should be protected from state statutes that limit their speech in abortion settings if: (1) the statute focuses on the right of the woman to receive information; (2) the statute compels the professional speech of physicians; and (3) the state is prohibiting physicians from disclosing accurate and non-misleading information. *Id.* at 979. Post writes, “[r]egulation of informed consent thus controls the dissemination of knowledge, rather than the dispensation of medical care.” *Id.* at 972.

216. Sawicki, *supra* note 180, at 32.

217. *Id.* at 32 n.132.

typically unaffiliated with the abortion provider.²¹⁸ So, even in cases where a positive Down Syndrome diagnosis is a major factor in a woman choosing to have an abortion, the abortion provider would not necessarily be privy to that information. Accordingly, either the patient or the physician would have to breach the topic during the informed-consent conversation.

It is easy to imagine a situation where a woman may bring up a positive Down Syndrome diagnosis on her own. Take for example a woman who is seeking a medical abortion. She may ask her physician if the abortion medication will work any differently because her fetus has Down Syndrome. Or in the case of a woman who needs a surgical abortion, she may ask if the procedure needs to be any different because of the anatomical differences of a Down Syndrome fetus. Though abortion procedures do not need to be altered because of a genetic abnormality,²¹⁹ it is understandable why women may question if they do.

But what if a woman does not bring up her fetus's Down Syndrome diagnosis? In states that have Down Syndrome abortion restrictions, it is unclear how much of an affirmative duty an abortion physician has to ask a pregnant woman about any genetic test results.²²⁰ As the physician pries into the woman's reasons for having an abortion, the conversation extends beyond the purview of informed consent. The "why" behind a woman's decision to have an abortion does not relate to the woman's understanding of the risks and benefits to the procedure, or to her understanding of a Down Syndrome diagnosis. If a woman discloses that she is seeking an abortion for an impermissible reason, it only furthers the concerns that the physician and the patient are no longer the only ones discussing the medical procedure—that in essence the state is a third party in the discussion through the restrictions it has placed on the physician.

In an abortion context, the physician and patient's values often do not conflict. A recent study found that 54% of abortion care providers felt "proud to work in abortion care 'all of the time,' and an additional 29% felt proud 'often.'"²²¹ 84% of providers felt they were making a

218. *How Is Genetic Testing Done?*, MEDLINEPLUS, <https://ghr.nlm.nih.gov/primer/testing/procedure> [<https://perma.cc/E6CB-U5PG>] (last updated Sept. 18, 2020).

219. *See What Facts About Abortion Do I Need to Know?*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/abortion/considering-abortion/what-facts-about-abortion-do-i-need-know> [<https://perma.cc/25MF-PHEQ>] (last visited Nov. 18, 2020) (explaining two different abortion methods that hinge on how far into a pregnancy a woman is).

220. Mary Ziegler, *The Disability Politics of Abortion*, 2017 UTAH L. REV. 587, 619–20 (2017).

221. Lisa A. Martin, Michelle Debbink, Jane Hassinger, Emily Youatt, Meghan Eagen-Torkko & Lisa H. Harris, *Measuring Stigma Among Abortion Pro-*

positive contribution to society “‘all the time’ or ‘often.’”²²² Abortion providers willingly undertake the task of providing controversial abortions, and thus are likely to respect a woman’s right to choose. Physicians empathize with the moral conflicts women face, and want to have open discussions with their patients about the best course of action.

Abortion providers, it would seem, would want to do everything in their power to still provide abortions while avoiding criminal liability. In practice, this may not be difficult. Physicians can easily frame questions to let women know what are impermissible reasons for seeking an abortion.²²³ Further, unless a woman outwardly admits her motivations for seeking an abortion, a physician could only be prosecuted using circumstantial evidence, which is likely to be minimal in the abortion setting.²²⁴ Abortion providers typically only interact with their patients once or twice.²²⁵ There is little to no familiarity with a patient which would allow an abortion physician to challenge a woman’s motives for seeking the abortion.²²⁶

Despite challenges to enforcement, threatening abortion providers with criminal liability will still likely change the way they interact with their patients. If a provider faces criminal liability for providing an abortion sought for an impermissible reason, that physician may be on edge when he interacts with a patient who he suspects may be seeking an abortion because of a Down Syndrome diagnosis. When a physician comes across to a patient as uncomfortable or not trustworthy, a patient is much less willing to ask questions about risks, alternatives, or other concerns.²²⁷ There cannot be an open discussion which allows for a woman to become more confident in her final choice.²²⁸ Rather, the woman would largely be coming to a decision to proceed with an abortion on her own, which can make the woman feel as if she has been

viders: Assessing the Abortion Provider Stigma Survey Instrument, 54 *WOMEN & HEALTH* 641, 647 (2014).

222. *Id.*

223. Ziegler, *supra* note 220, at 619–20.

224. *Id.* at 620.

225. *Id.* (“For the most part, women seeking abortions are not repeat players, and physicians may lack the context or experience that would allow them to second-guess women’s explanations of their own request.”).

226. *Id.*

227. See Jaime Staples King, *Not This Child: Constitutional Questions in Regulating Noninvasive Prenatal Genetic Diagnosis and Selective Abortion*, 60 *UCLA L. REV.* 2, 37 (2012).

228. Elwyn et al., *supra* note 177, at 1362.

abandoned by her physician.²²⁹ Failure to give true informed consent is a significant failing in patient care.

After considering the effects Down Syndrome abortion bans will likely have on women, it is clear that these laws create an undue burden. The Supreme Court in *Casey* defined an undue burden as having “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”²³⁰ The Supreme Court further explained that even when a statute purports to further a legitimate state interest, it still poses an undue burden if it creates a substantial obstacle for a woman to exercise her fundamental right to choose.²³¹ Down Syndrome abortion bans put the state’s interest above that of the woman and limit permissible discussions about the abortion procedure with her physician. Accordingly, a woman is deprived of the right to make an informed choice about whether or not to terminate her pregnancy.

The Supreme Court acknowledged the importance of informed consent in *Gonzales v. Carhart*.²³² Justice Kennedy wrote, “some women come to regret their choice to abort.”²³³ Justice Kennedy further wrote that a woman who did not give full informed consent “must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know.”²³⁴ Though Justice Kennedy’s statement comes off as paternalistic, its application to Down Syndrome abortion bans is still clear: a woman must give true informed consent so she understands the consequences of her decision to abort. Accordingly, open discussions between a patient and physician are crucial to ensure a woman understands the implications of her choice.²³⁵

In *Stenberg v. Carhart*, the Supreme Court found a statute which caused those who performed pre-viability abortions to “fear prosecution, conviction, and imprisonment” unconstitutional.²³⁶ “The result is an undue burden upon a woman’s right to make an abortion decision.”²³⁷ Here, the Supreme Court illustrated that placing criminal liability on physicians can be unduly burdensome on a woman seeking

229. *Id.* at 1363.

230. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992).

231. *Id.*

232. 550 U.S. 124 (2007).

233. *Id.* at 159.

234. *Id.* at 159–60.

235. See Elwyn et al., *supra* note 177, at 1362 (noting that discussions between physician and patient help improve the confidence the patient has in the ultimate choice she makes).

236. 530 U.S. 914, 945 (2000).

237. *Id.* at 945–46.

to exercise her right to choose. Under these Down Syndrome abortion bans, the sanctity of the doctor-patient relationship is broken and instead is viewed as a criminal-victim relationship. Under the guise of a confidential conversation in which a woman believes she is openly discussing whether an abortion procedure is best for her, the physician is in reality ensuring she does not discuss any impermissible motivations for seeking an abortion. The result abortion providers face is distrust from patients. These external pressures will undoubtedly permeate into the way a physician interacts with his patients and affect a woman's access to abortion care. No other medical practice is subject to this type of intrusion into the exam room.²³⁸

The inability for a pregnant woman to talk openly to her physician and make an informed choice of whether to have an abortion places a substantial obstacle in her path to seek an abortion. There is no support for the argument that a Down Syndrome diagnosis increases the state interest in preserving life any more than that of a fetus without Down Syndrome such that it would allow the state to impose greater restrictions to abortion access before the viability point.²³⁹ Accordingly, the Down Syndrome abortion bans do nothing more than create a significant barrier to a woman's access to abortion care. In her concurrence in *Whole Woman's Health v. Hellerstedt*, Justice Ginsburg warned of the potential negative results if safe abortion access is restricted, writing, "[w]hen a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners."²⁴⁰

238. It can be argued that research ethics committees and organ transplantations also present a high level of paternalism. See, e.g., S.J.L. Edwards, S. Kirchin & R. Huxtable, *Research Ethics Committees and Paternalism*, 30 J. MED. ETHICS 88 (2004) (arguing that research ethics committees "should not be paternalistic by rejecting research that poses risk to people competent to decide for themselves"); Arthur L. Caplan & Mark Siegler, *Risks, Paternalism, and the Gift of Life*, 145 ARCHIVES INTERNAL MED. 1188, 1189 (1985). These fields typically deal with very vulnerable patient populations whose consent may be easily manipulated, like patients who need entry into a potentially lifesaving research study. See Kirchin & Huxtable, *supra*. Or, in the case of organ donation, there is a scarce resource involved. See Caplan & Siegler, *supra*. Abortion differs in that it is not a life-or-death medical procedure for the woman. Failure to have an abortion simply leads to the woman carrying the fetus to term. Though abortion clinics are scarce, abortions are not subject to resource allocation. There is not one woman who perhaps has a better chance of success than another.

239. See *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health*, 265 F. Supp. 3d 859, 867 (S.D. Ind. 2017) (explaining that the legitimate state interest in protecting Down Syndrome fetuses does not create an exception to *Casey*), *aff'd*, 888 F.3d 300 (7th Cir. 2018).

240. 136 S. Ct. 2292, 2321 (2016) (Ginsburg, J., concurring).

Proponents of Down Syndrome abortion bans may argue that the statutory language should be the deciding factor when analyzing if a restriction is unduly burdensome. For example, in states that have adopted the “in part” statutory language utilized in Ohio, the obstacle the law places to informed consent is clearer. The slightest indication of a Down Syndrome diagnosis now subjects a physician to criminal liability. The “in part” language creates such a low threshold for criminal liability, so it is easier to envision how the doctor-patient relationship could be undermined.

On the other hand, some may argue that the “solely” language utilized in Indiana’s statute protects women’s ability to receive an abortion because it is less burdensome on physicians.²⁴¹ As long as a woman can give any other permissible reason besides the Down Syndrome diagnosis, the procedure can proceed without the provider fearing criminal prosecution. Thus, it could be argued, the state interest in preventing eradication of Down Syndrome can be preserved while still allowing pre-viability abortions to proceed. The United States District Court for the Western District of Missouri found this argument unpersuasive at a recent hearing for a preliminary injunction. “If an abortion were sought [after a Down Syndrome diagnosis], most of us, including an abortion provider, would suppose that the diagnosis was the principal cause of the request, and that a jury or licensing agency would have little trouble with the ‘sole cause’ requirement for a violation.”²⁴² Accordingly, for the purposes of the informed consent argument, the “in part” and “solely” language have very little bearing on the undue-burden analysis. Any obstacle a woman faces in the informed-consent process is an undue burden placed on her right to obtain a pre-viability abortion.

Choosing to have an abortion is one of the most intimate and private decisions that a woman may ever face. The Supreme Court has long protected the right of the woman to make this choice without undue governmental influence.²⁴³ Though these Down Syndrome abortion laws are unique in that they do not prohibit a patient from accessing an abortion provider, they potentially create a situation where a provider can be made so uncomfortable by the prospect of criminal liability that the back-and-forth conversation that is the staple of informed consent cannot happen. Informed consent is a necessary component to any medical procedure. Abortion restrictions that negatively impact the informed-consent process place an undue burden

241. *Planned Parenthood of the St. Louis Region v. Parson*, 408 F. Supp. 3d 1049, 1052 (W.D. Mo. 2019).

242. *Id.*

243. *See, e.g., Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); *Roe v. Wade*, 410 U.S. 113, 165–66 (1973).

on the woman exercising her right to choose whether to terminate a pregnancy.

V. OTHER CONSIDERATIONS

Some fear that allowing the abortion of Down Syndrome fetuses will eventually lead to fewer children being born with Down Syndrome in the United States, which will then lead to a less accepting society towards those with Down Syndrome. Some would argue that prenatal testing “cannot comfortably coexist with society’s professed goals of promoting inclusion and equality for people with disabilities.”²⁴⁴ Though these additional arguments regrettably fall beyond the purview of this Note, they are inextricably intertwined in the discussion of Down Syndrome abortion bans and thus should be briefly mentioned.

A. *Acceptance in Society*

Proponents of genetic abnormality abortion bans argue that the current model of prenatal testing encourages a negative view of disabilities in society.²⁴⁵ Take for example the Human Genome Project, which was commissioned by Congress in 1988 for the purpose of mapping the human genome to help discover cures for diseases and disabilities.²⁴⁶ More than thirty years later, that desired effect has not been achieved with genetic disabilities. “Instead of developing therapies or treatments for most of the genetic conditions for which the specific gene is known, researchers developed prenatal tests and embryo selection techniques that inform prospective parents about future children, but do nothing for anyone now living with a genetic condition.”²⁴⁷

The general purpose of developing prenatal genetic testing is to provide a woman with information she can use to help her “decide whether to carry a particular fetus to term.”²⁴⁸ It is also generally accepted that most women, upon learning of a genetic disability, will not want to continue with the pregnancy.²⁴⁹ Consider that there are no tests to show a prospective mother what color hair or eyes her child may have, despite the scientific ability to do so.²⁵⁰ That is because there

244. See Asch, *supra* note 15, at 315; see also Ziegler, *supra* note 220, at 621 (noting that anti-abortion advocates’ framing of abortions due to disability as discriminatory has proven successful in strengthening support).

245. Asch, *supra* note 15, at 318.

246. *Id.* at 335–36.

247. *Id.* at 336.

248. *Id.* at 336–37.

249. *Id.* at 336.

250. *Id.*

is nothing society views as negative in what color hair or eyes someone is born with.²⁵¹ By comparing the types of genetic screenings offered to expectant mothers versus what science can actually test for, the biases our society has against those with disabilities become apparent.

Many leading bioethicists, such as Bonnie Steinbock, Peter Singer, Mary Ann Baily, and Allen Buchanan, acknowledge that problems encountered by people with disabilities still largely stem from the fact that our society has not made changes that allow for them to be fully integrated among their non-disabled peers.²⁵² However, these bioethicists reject arguments that prenatal testing should be avoided. Steinbock wrote, “disabilities are not generally advantageous, not something to be hoped for; indeed, they are to be avoided, if possible. They are not merely neutral forms of variation.”²⁵³

The major problem with the argument that Down Syndrome abortion bans are discriminatory is that it focuses entirely on shortcomings in society. Abortion rights, on the other hand, are focused on the private right of the woman to choose whether to have a child. The Supreme Court’s reasoning in *Roe* that having unwanted children “may force upon the woman a distressful life and future”²⁵⁴ is applicable to having children with disabilities as well. Fixing a societal problem by restricting private choice is not the answer. Rather than legislatures trying to do so through abortion restrictions, it seems their efforts would be better served in funding accessibility and education programs to help address the larger issues of integration.

B. Where Do We Draw the Line? Other Genetic Abnormalities and Abortion

Another major implication that arises from Down Syndrome abortion bans is that they are not inclusive of other genetic abnormalities. The quality of life for individuals with Down Syndrome can be very high: they have a higher life expectancy than before, can make personal connections, have jobs, and lead fulfilling lives. But what about other chromosomal abnormalities like cystic fibrosis, where the life expectancy is less than forty years?²⁵⁵ Or Tay-Sachs disease, where

251. *Id.*

252. *Id.* at 320.

253. Bonnie Steinbock, *Disability, Prenatal Testing, and Selective Abortion*, in *PRENATAL TESTING AND DISABILITY RIGHTS* 108, 113 (Erik Parens & Adrienne Asch eds., 2000).

254. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

255. Wendy Henderson, *Life Expectancy When You’re Living with Cystic Fibrosis*, *CYSTIC FIBROSIS NEWS TODAY* (May 24, 2017), <https://cysticfibrosisnewstoday.com/2017/05/24/living-cf-life-expectancy/> [https://perma.cc/TTX7-ABMP].

most children die before their fifth birthday?²⁵⁶ The average life span in the United States is more than seventy years.²⁵⁷ Any parent would prefer that their child live a normal lifespan than die earlier.²⁵⁸

Down Syndrome abortion bans place a societal value judgment on certain types of disabilities. If society agrees that women should not be permitted to abort fetuses diagnosed with Down Syndrome, then society is putting a higher value on those fetuses' lives than those with other genetic disabilities which can be screened for by the same cell-free DNA test. It sends a message that Down Syndrome is a "superior" genetic abnormality.

As was discussed earlier, some state statutes prohibit abortion on the basis of any genetic abnormality.²⁵⁹ But then, if these restrictions are permitted, society is not providing women the choice to determine the quality of life they want for their child. Diseases like Tay-Sachs, where the child has almost no chance of living past his or her fifth birthday, are absolutely devastating for a mother to watch her child experience. To expect a mother to carry and give birth to a child with this disease is a cruel imposition on a broad state interest.²⁶⁰ These decisions should be made on an individualized basis, without the government imposing their values on what a woman should do.

Although only mentioned briefly in this Note, these additional arguments are still relevant in the discussion surrounding the constitutionality of abortion bans based on genetic abnormalities. These laws undermine the well-established right to private choice and argue that the ideals of a society should prevail. These ethical and legal issues are intertwined, and as challenges to these laws continue to percolate in the courts, there is no doubt they will need to be addressed.

CONCLUSION

A woman's choice to seek an abortion is a personal and private one. The capabilities of genetic testing have improved to inform women of genetic abnormalities well before a baby's first kick, allowing for earlier decisions on whether an abortion may be appropriate. But, as countries

256. Jaime Herndon, *Tay-Sachs Disease*, HEALTHLINE, <https://www.healthline.com/health/tay-sachs-disease#symptoms> [https://perma.cc/DT6Y-SY8A] (Last updated July 26, 2017).

257. Asch, *supra* note 15, at 321.

258. *Id.*

259. *See supra* notes 152–163 and accompanying text.

260. *See King, supra* note 227, at 38 (arguing that a state interfering with how a woman reaches a decision to abort would reach some of the most private decisions a woman could make, and must be protected from undue government influence).

like Iceland have illustrated, these earlier tests have resulted in the near eradication of Down Syndrome from their populations.²⁶¹

Thus, the United States is challenged with trying to protect private interests while promoting a society that values those with disabilities. This Note did not attempt to address how lawmakers should handle this tension. But the recently passed laws that place criminal liability on physicians for performing an abortion on a woman who seeks the procedure partially or solely because of a Down Syndrome diagnosis places such a stress on the doctor-patient relationship that a woman's ability to give informed consent will inevitably be obstructed. The societal interest has stretched too far into the woman's right to privacy. The conversations between physician and woman will be less open and will impede her ability to give informed consent. Accordingly, these laws must be found unconstitutional because they place an undue burden on a woman seeking a pre-viability abortion.

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261. Quinones & Lajka, *supra* note 4.

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