

WHAT'S HARM GOT TO DO WITH IT? THE UNINTENDED CONSEQUENCES OF TEXAS'S ULTRASOUND LAW

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Primum non nocere: First, do no harm.¹ While the origins of this maxim are unknown, the sound medical judgment that it symbolizes in balancing the risks and benefits encountered in direct patient care has guided physicians for decades.² Presently, one of the most challenging frontiers in medicine involves the physician's role in providing urgent or emergency care to pregnant women who present with bleeding. Physicians understand that pregnancy is an equal opportunity offender of women's health and that physicians in every practice modality and location are not immune from dealing with pregnancy complications. However, under current Texas abortion statutes, little recourse is available to physicians who must navigate daily the stresses of managing these patients when there is evidence of a viable pregnancy by ultrasound. Physicians who intervene expeditiously with a procedure to evacuate the uterus without complying with the multitude of statutory requirements for informed consent essentially violate the law and risk losing their medical licenses. Thus, following the law in Texas means a physician might have to act against his or her medical judgment and do harm.

¹ MERRIAM-WEBSTER, *available at* <http://www.merriam-webster.com/dictionary/primum%20non%20nocere>.

² Cedric M. Smith, *Origin and Uses of Primum Non Nocere – Above All, Do No Harm!*, 45 J. CLINICAL PHARMACOLOGY 371, 372–75 (2005), *available at* <http://jcp.sagepub.com/content/45/4/371>.

I. INTRODUCTION

It is no mystery that those opposed to abortion have attempted to restrict abortion through various means with the ultimate goal of overturning *Roe v. Wade*.³ The overarching means of restricting access to abortion care—the weapon of choice—employs the doctrine of informed consent. Those opposed to abortion as well as those who support it have championed the idea that physicians and healthcare providers should freely discuss the medical risks, benefits, and alternatives of the abortion procedure with their patients, just as with any other medical treatment or surgical procedure. Since *Planned Parenthood v. Casey*, the realm of informed consent as it relates to abortion care has mushroomed into state-mandated speech, encompassing the availability of adoption, child support, prenatal and postnatal health insurance, as well as a description of embryo/fetus, as a conduit for “protecting the life of the unborn.”⁴

What has changed dramatically and recently is the information that is required to be exchanged under the guise of informed consent. Statutes dealing with informed consent for an abortion procedure in several states have leaped from purely information exchange to mandatory ultrasound examinations, along with numerous attendant restrictions.⁵ In Texas, the legislature passed House Bill 15, which became effective on September 1, 2011.⁶ House Bill 15 requires ultrasound examinations be performed either by the physician who is to perform the abortion or by a registered sonographer at least twenty-four hours before the abortion, in addition to verbal descriptions and heart auscultations of the embryo or fetus.⁷ Thus, the state legislature expanded the scope of informed consent by mandating a diagnostic examination as a work-up for a specific medical procedure. Even though House Bill 15 specifically addresses

³ *Roe v. Wade*, 410 U.S. 113 (1973).

⁴ *Planned Parenthood v. Casey*, 505 U.S. 833, 883 (1992).

⁵ See *State Policies in Brief: Requirements for Ultrasound*, THE GUTTMACHER INST. (Aug. 2013), available at http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf.

⁶ Act of May 19, 2011, H.R. 15, 82nd Leg., Reg. Sess. (Tex. 2011) (to be codified at Tex. Health & Safety Code Ann. §§ 171.002,.012,.0121-24, .013(a), .015, 241.007, 243.017, 245.006(a), 245.024 and at Tex. Occ. Code Ann. §§ 164.055(a), 164.0551) [hereinafter H.R. 15].

⁷ *Id.* at § 2(a)(4).

informed consent relating to abortion, it negatively impacts physician autonomy in obtaining informed consent and jeopardizes the practice of medicine relating to women in Texas.

Thus, Texas's medical community should pay heed to this legislative expansion of informed consent for several reasons. First, other procedures and treatments, whether traditional, controversial, or unconventional, in the future, could fall under the scrutiny of the legislature, which would feel empowered to exert its authority to regulate further the practice of medicine. Second and most importantly, the unintended consequences likely to arise from this legislation could be substantial and detrimental: decreased access to medical care for pregnant patients, increased costs in medical care in general, decreased quality of care for pregnant patients, and professional landmines for any physician treating a pregnant woman, particularly within the first trimester, who is having medical problems.

While the legislative purposes of House Bill 15 are to protect "the physical and psychological health and well-being of pregnant women" by "providing pregnant women access to information that would allow her [sic] to consider the impact an abortion would have on her [sic] unborn child" as well as "protecting the integrity and ethical standards of the medical profession,"⁸ this bill overreaches and infringes on many physicians' ability to practice proper medicine. By inserting multiple requirements into provisions of the Health and Safety Code specifically dealing with informed consent within the realm of abortion care, the legislature irrationally regulates medical care related to all pregnant women. Furthermore, the penalties for violations under House Bill 15 are severe, involving both criminal and civil (e.g., loss of medical licensure) sanctions.⁹ As a result, they create a heightened danger whereby physicians might purposefully avoid treating pregnant women who have medical complications.

House Bill 15 opened the door to legislative and partisan tinkering with well-established legal and medical principles, yet its ultimate fate is unknown. This comment will explore the emergence

⁸ H.R. 15, *supra* note 6 at § 12.

and importance of informed consent in medical care in general and how informed consent became the conduit for abortion restriction in Section II. In Section III, this comment will discuss the impact and negative ramifications that House Bill 15 will have on Texas's provision of healthcare to pregnant women because of the difficulties physicians will face in diagnosing and treating these particular patients.

II. INFORMED CONSENT

A. Informed Consent for Medical Care in General

Informed consent, as a concept, has undergone an extensive transformation. The common law remedy of the writ of trespass for assault and battery was evidence of the law's concern for the bodily integrity of the individual and applies today for non-consensual medical treatment.¹⁰ Presently, this doctrine promotes physician-patient dialogue for information exchange and decision making based on case law and statutes.¹¹ Underlying this concept is the ethical principle of autonomy: The unique, intrinsic capacity of an individual to self-legislate and to exercise one's will.¹² In addition, autonomy entails a sphere of personal freedom from external constraint.¹³ Within the medical context, Justice Cardozo declared that "every human being of adult years and sound mind has a right to determine what shall be done with his own body,"¹⁴ which emphasized the concept of voluntary consent.¹⁵

The seminal case for medically informed consent, *Canterbury v. Spence*, delineated the topics required for disclosure: "the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains

¹⁰ JESSICA W. BERG, ET AL., INFORMED CONSENT 41 (2nd ed. 2001).

¹¹ *Id.* at 11-13.

¹² *Id.* at 22.

¹³ *Id.* at 24.

¹⁴ *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914).

¹⁵ BERG, *supra* note 10, at 43-44.

untreated.”¹⁶ In addition, this case held that the physician’s duty to disclose the options and hazards of a proposed treatment is measured by the reasonable patient standard, whose scope is objective regarding “the patient’s informational needs . . . with suitable leeway for the physician’s situation.”¹⁷ With this standard, physicians are required to tell patients what a reasonable person would find material to making a medical decision.¹⁸

On the other hand, a professional standard for disclosure was applied in *Natanson v. Kline*.¹⁹ The *Natanson* court referred to the behavior of a “reasonable medical practitioner” and described the elements that were required to be disclosed with sufficiency to ensure an informed consent.²⁰ In addition, the court mandated that the disclosure be made in relatively simple language.²¹ While standards of disclosure (patient-centered or professional-oriented) addressed *how* much information patients must be given, exactly *what* information patients must be given has been shaped by both case law and statutes.²² As a result, the types of elements required for proper disclosure tend to vary among the states.²³

B. Informed Consent for Medical Care in Texas

The evolution of informed consent in Texas followed a similar pattern, originating in common law and continuing with legislative enactments. In this state, the courts treated the failure to disclose risks inherent in a particular medical or surgical procedure as a common law claim for assault and battery—a harmful or offensive

¹⁶ 464 F.2d 772, 787–88 (D.C. Cir. 1972).

¹⁷ *Id.* at 787; see also Jamie Staples King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decisionmaking*, 32 AM. J. LAW & MED. 429, 493–501 (2006) (Appendix) (concluding that twenty-three states have patient-based standard, twenty-five have physician-based standard, and two have a hybrid standard).

¹⁸ BERG, *supra* note 10, at 50.

¹⁹ *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

²⁰ *Id.*; BERG, *supra* note 10, at 51 (including the nature of the illness and the proposed treatment, its probability of success (benefits), risks, and alternative treatments available).

²¹ BERG, *supra* note 10 at 51.

²² *Id.* at 53.

²³ *Id.*

touching without permission.²⁴ Thus, in an informed consent case brought under a battery theory of recovery, a patient needed only to prove that the physician failed to disclose a risk involved with the treatment in order to negate any consent given.²⁵ In 1967, the Texas Supreme Court held that the traditional elements of assault and battery were absent in most malpractice cases alleging a physician's failure to sufficiently disclose risks incident to a proposed treatment and that the plaintiff-patient had the burden to prove what a reasonable medical practitioner would have disclosed to the patient about the associated risks.²⁶

In August 1977, the 65th legislature enacted the Texas Medical Liability and Insurance Improvement Act (MLIIA), which defined informed consent as a cause of action for failure to disclose medical risks or hazards and limited application of the theory to non-disclosures.²⁷ The statute established the Texas Medical Disclosure Panel to evaluate all medical and surgical procedures to determine whether disclosure is required, and if so, how much disclosure is required.²⁸ Section 6.02 of the statute limited the theory of recovery to negligence in failing to disclose or to adequately disclose the risks and hazards involved in a medical treatment or a surgical procedure that would have influenced a reasonable person in making a decision to give or withhold consent. Consequently, in 1983, the Texas Supreme Court adopted the "reasonable person" standard in *Peterson v. Shields*.²⁹ The court referred to the legislature's enactment of section 6.02 as replacing the reasonable medical practitioner standard.³⁰

In locating informed consent requirements under Texas law, one has to make the distinction between general medical care and abor-

²⁴ *Greene v. Thiet*, 846 S.W.2d 26,35 (Tex. App.—San Antonio 1992, pet. denied).

²⁵ *Id.*

²⁶ *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

²⁷ Tex. Rev. Civ. Stat. Ann. art. 4590i §6.02 (West 1999).

²⁸ *Id.* at §§ 6.03–6.04.

²⁹ 652 S.W.2d 929 (Tex. 1983).

³⁰ *Id.* at 931; *see also* *Barclay v. Campbell* 704 S.W.2d 8, 9–10 (Tex. 1986) (holding that two requirements were needed to raise a fact issue: plaintiff must introduce evidence to show that the risk is inherent to the medical procedure and present evidence to show that the risk is material in influencing a reasonable person to consent to the procedure).

tion care. For both types of care, List A, which was developed by the Medical Disclosure Panel, divides the multitude of surgeries and procedures into anatomical groups and lists the associated risks required to be disclosed.³¹ Even though the same procedure, D&C (dilation and curettage), is used for an abortion and for a miscarriage with excessive bleeding, two categories exist within List A. For example, when a patient is miscarrying, the risks associated with an evacuation of the uterus are found under the heading “D&C of the uterus (diagnostic/therapeutic),”³² and the risks associated with an abortion procedure are found under the separate headings of “surgical abortion/D&C/D&E.”³³ However, abortion care has additional statutory requirements, dealing primarily with the disclosure of state-mandated information.³⁴ Thus, before a physician performs an abortion, he or she must obtain consent that conforms to this entire statutory scheme in order for it to be informed and valid.

In Texas, statutes regarding medical liability are found within chapter 74 of the Texas Civil Procedure and Remedies Code.³⁵ Subchapter C specifically deals with informed consent.³⁶ The treating or operating physician is the provider who is specifically required to disclose adequately the risks and hazards involved in the medical care or surgical procedure.³⁷ A physician is negligent if he or she fails to disclose the risks and hazards that could have influenced a reasonable person in making a decision to give or withhold consent.³⁸ If the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure according to List A, then the consent to the listed medical care will be considered

³¹ 25 Tex. Admin. Code §601.2 (2011); Tex. Civ. Prac. & Rem. 74.106(a)(1) (2011).

³² 25 Tex. Admin. Code §601.2(g)(12)(2011)((A) hemorrhage with possible hysterectomy, (B) perforation of the uterus, (C) sterility, (D) injury to bowel and/or bladder, (E) abdominal incision and operation to correct injury).

³³ *Id.* at (g)(13), identical to (12) except for the addition of (F) failure to remove all products of conception.

³⁴ *See infra* Section II (Woman’s Right to Know Act and H.R. 15).

³⁵ TEX. CIV. PROC. & REM. §§ 74.001–74.507 (2011).

³⁶ *Id.* §§ 74.101–74.107.

³⁷ *See id.* § 74.101.

³⁸ *Id.*

valid.³⁹ Consent obtained in this manner creates a rebuttable presumption that is valid in any suit against a physician involving a healthcare liability claim alleging failure to obtain informed consent.⁴⁰

Thus, List A serves as the statutory basis for establishing the standard of care for informed consent. For example, in order to avoid tort liability related to informed consent for a D&C in the context of a miscarriage, it is sufficient for a physician to disclose the specific risks in List A. However, the disclosure of risks in List A is merely one component of the expansive informed consent required statutorily for an abortion.

C. Abortion Restrictions Utilizing Informed Consent

In *Roe v. Wade*, the landmark case establishing a woman's constitutional right to choose abortion, the Supreme Court wrote that this right is not absolute and that it must be balanced against other factors, such as the state's interest in protecting "prenatal life."⁴¹ By dividing pregnancy into three trimesters, the Court attempted to balance the competing interests of the state and a pregnant woman.⁴² Thus, the government could not prohibit abortions in the first trimester but could regulate abortion procedures only as it regulated other medical procedures. Also, the government could, if it chose to do so, "regulate the abortion procedure in ways that are reasonably related to maternal health" during the second trimester.⁴³ The Court concluded that "[w]ith respect to the State's important and legitimate interest in potential life, the 'compelling' point is viability."⁴⁴ Overall, *Roe* focused on "vindicat[ing] the right of the physician to administer medical treatment according to his professional judgment."⁴⁵

³⁹ *Id.* § 74.105.

⁴⁰ *Id.* § 74.106(a)(1).

⁴¹ *Roe*, 410 U.S. at 155.

⁴² *Id.* at 164–65.

⁴³ *Id.* at 164.

⁴⁴ *Id.* at 163.

⁴⁵ *Id.* at 165.

Shortly thereafter, the Supreme Court consistently invalidated informed consent requirements concerning abortion care that required that women be given information about fetal development. In *Planned Parenthood of Central Missouri v. Danforth* and *City of Akron v. Akron Center for Reproductive Health, Inc.*, the Supreme Court upheld written informed consent requirements that were identical to other surgical and medical procedures.⁴⁶ Overall, the question was whether the government could require more information be given to a patient who desires an abortion in addition to information designed to discourage abortions. In *Akron*, the Court said that information required to be given to women seeking abortions (which included fetal development, the concept that human life began at conception,⁴⁷ the date of potential viability, and numerous physical and psychological ramifications resulting from an abortion)⁴⁸ was not designed to obtain informed consent but instead to influence them to withhold it.⁴⁹ The Court recognized that the city had unreasonably created obstacles in the dialogue between a physician and a patient with its ordinance requiring a “lengthy and inflexible” list of information.⁵⁰

Again, in *Thornburgh v. American College of Obstetricians and Gynecologists*, information required to be included in the informed consent for abortion care was challenged.⁵¹ The Court declared a Pennsylvania law unconstitutional because it required women seeking abortions be given seven different kinds of information at least twenty-four hours before consenting to the abortion.⁵² Besides discussing the availability of printed materials describing the characteristics of an embryo or a fetus at two-week increments, the information encompassed a father’s liability for child support, possible availability of state funds for prenatal and childbirth expenses, as

⁴⁶ *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 53 (1976); *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 416 (1983).

⁴⁷ *Akron*, 462 U.S. at 444.

⁴⁸ *Id.* at 442.

⁴⁹ *Id.* at 444.

⁵⁰ *Id.* at 444–45.

⁵¹ *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 748 (1986).

⁵² *Id.* at 760.

well as the possible negative physical and emotional effects of having an abortion.⁵³ The Court ruled that the state law was unconstitutional because it disregarded the patient's needs and officially structured the dialogue between physician and patient by inappropriately inserting the state's message.⁵⁴

In 1989, in *Webster v. Reproductive Health Services*, the Supreme Court upheld a Missouri abortion law that declared the state's view that life begins at conception and allowed abortions after twenty weeks only if a test was performed to ensure that the fetus was not viable (i.e., capable of surviving outside of the uterus).⁵⁵ Chief Justice Rehnquist, in a plurality opinion along with Justices White and Kennedy, attacked the trimester system announced in *Roe* to balance the competing interests of the state in protecting the embryo or fetus and the rights of the pregnant woman.⁵⁶ He said that "the State's interest, if compelling after viability, is equally compelling before viability."⁵⁷ Consequently, this case laid the foundation for further government regulation of abortions, particularly in mandating that certain information be included in the informed consent for the abortion procedure.

Three years later, the Supreme Court reaffirmed *Roe's* essential holding that states cannot prohibit abortion prior to viability in *Planned Parenthood v. Casey*.⁵⁸ However, the joint opinion, written by Justices Kennedy, O'Connor, and Souter, rejected the trimester framework, stating that the framework "misconceives the nature of the pregnant woman's interest; and in practice it undervalues the State's interest in potential life, as recognized in *Roe*."⁵⁹ Most importantly, the joint opinion announced the new test for determining the constitutionality of any state law regulating abortion: whether a state regulation places an "undue burden" on a pregnant

⁵³ *Id.* at 760-61.

⁵⁴ *Id.* at 762-63.

⁵⁵ *Webster v. Reproductive Health Services*, 492 U.S. 490, 491 (1989).

⁵⁶ *Id.* at 519.

⁵⁷ *Id.*

⁵⁸ *Casey*, 505 U.S. 833 (1992).

⁵⁹ *Id.* at 873.

woman's right to choose and to access abortion.⁶⁰

According to the joint opinion, the "undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty."⁶¹ Overall, "an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."⁶² However, in order to promote its interest in protecting the potential life of an embryo or a fetus, "throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion."⁶³ As a result, the joint opinion upheld various provisions of informed consent for an abortion under a Pennsylvania law, including a twenty-four-hour waiting period and a requirement that the woman be told that detailed information was available concerning fetal development, medical assistance for childbirth, child support from the father, and a list of adoption agencies.⁶⁴ Ironically, these provisions were virtually identical to the informed consent provisions in *Thornburgh* that were previously struck down by the Court.

Because the joint opinion in *Casey* did not assign any level of scrutiny to the undue burden standard, the new standard's application seemed destined for conflict. However, in *Stenberg v. Carhart*, the Court expressly adopted and applied the undue burden test to declare unconstitutional Nebraska's law banning "partial birth abortions."⁶⁵ In this case, the state's statutory ban did not contain an exception for preserving the health of the pregnant woman, which the Court said was necessary with any regulation of abortions under *Casey*.⁶⁶ The Court went on to say that a "State may promote but not

⁶⁰ *Id.* at 874

⁶¹ *Id.* at 876.

⁶² *Id.* at 877.

⁶³ *Id.* at 878.

⁶⁴ *Id.* at 881-83, 887.

⁶⁵ *Stenberg v. Carhart*, 530 U.S. 914, 921-22 (2000).

⁶⁶ *Id.* at 930.

endanger a woman's health when it regulates the methods of abortion."⁶⁷ The issue of allowing exceptions in medical emergencies to protect both the health and the life of the pregnant woman appeared settled under *Casey*, but as other cases, state laws, and federal laws arose, it suddenly became infirm.

In *Gonzales v. Carhart*, the Court ruled that the Congressional statute banning partial birth abortions (i.e., intact dilation and evacuations or D&E) "is not void for vagueness, does not impose an undue burden from any overbreadth, and is not invalid on its face."⁶⁸ Here, the statute imposes criminal penalties only when the requisite intent to perform an intact D&E is proven.⁶⁹ The Court stated that a physician, while performing an abortion beyond the first trimester and who mistakenly delivers a fetus beyond a certain anatomical landmark, will not face criminal liability because the statute does not act as "a trap for those who act in good faith."⁷⁰

In addition, the Court ruled that the absence of a health exception was constitutional.⁷¹ Whether the ban on this procedure creates significant health risks for the woman was hotly contested with medical facts presented to Congress and to the trial courts.⁷² The Court's rationale relied on its precedents in allowing state and federal legislatures broad discretion in passing laws in areas where medical and scientific uncertainty exists.⁷³ Further, the Court declared that facial attacks on the health exception "should not have been entertained in the first place" and that an as-applied challenge in a discrete case can better quantify and balance the nature of any

⁶⁷ *Id.* at 931.

⁶⁸ *Gonzales v. Carhart*, 550 U.S. 124, 147 (2006).

⁶⁹ *Id.* at 149.

⁷⁰ *Id.* at 149–50 (quoting *Colautti v. Franklin*, 439 U.S. 379, 395 (1979)).

⁷¹ *Id.* at 164.

⁷² *Id.* at 161. However, Justice Ginsburg argued that the Court gave no reason to reject the district courts' records, which indicated that significant medical authority considered intact D&E to be the safest procedure under certain circumstances. *Id.* at 179–80.

⁷³ *Id.* at 163 (citing *Kansas v. Hendricks*, 521 U.S. 346, 360, n.3 (1997); *Jones v. United States*, 463 U.S. 354, 364–65, n. 13 (1983); *Lambert v. Yellowley*, 272 U.S. 581, 597 (1926); *Jacobson v. Massachusetts*, 197 U.S. 11, 30–31 (1905)).

medical risk.⁷⁴ Again, the Court emphasized the state's "significant role . . . in regulating the medical profession" and that "[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman."⁷⁵ Thus, the Court set the tenor for abortion regulation generally and targeted abortion providers specifically, stating that "[t]he law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community."⁷⁶

Since *Casey*, the unresolved issue remains: How much and how far can the state regulate abortion care using informed consent statutes? With the vague undue burden standard, states are free to experiment in developing ways to restrict access to abortion care in the name of protecting women's health and regulating the medical profession. Consequently, numerous states have systematically enacted statutes specifically creating burdensome requirements for informed consent for abortion procedures.⁷⁷ However, as abortion restrictions increase, spillover effects will invariably occur. Both pregnant women and physicians who do not perform abortions will feel the pressure to diagnose pregnancies accurately and earlier.

D. Informed Consent for Abortions in Texas

Starting in 1989, Texas's Department of Health instituted numerous regulatory rules through chapter 245 of the Texas Health and Safety Code, which affected facilities and physician offices that offered abortion care.⁷⁸ Numerous provisions were amended and added in 1997.⁷⁹ While the majority of the rules pertained to require-

⁷⁴ *Id.* at 167.

⁷⁵ *Id.* at 157.

⁷⁶ *Id.* at 163.

⁷⁷ Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL'Y REV. 6, 7-8 (Fall 2007), <http://www.guttmacher.org/pubs/gpr/10/4/gpr100406.html>.

⁷⁸ Texas Abortion Facility Reporting and Licensing Act, 71st Leg., Reg. Sess., ch. 678, § 1 (Tex. 1989) (codified as Tex. Health & Safety Code, Ch. 245).

⁷⁹ Acts 1997, 75th Leg., Reg. Sess., ch. 1120, § 1 (Tex. 1997).

ments for specific licensure to provide abortion services,⁸⁰ these rules had no direct impact on patient access or the physician-patient relationship.

Flowing from the holding in *Casey*, Texas joined the growing contingency of states requiring specific information be included in informed consent for an abortion when its Woman's Right to Know Act became effective on September 1, 2003.⁸¹ Under this statute, abortion providers are required to obtain the voluntary and informed consent of a patient by providing state-mandated information orally by telephone or in person and at least twenty-four hours before the scheduled abortion.⁸² Numerous topics must be discussed, and the patient has the right to review printed materials provided by the Department of State Health Services.⁸³ These printed materials must include information concerning the probable anatomical and physiological characteristics of the "unborn child" at two-week increments, including any relevant information on the possibility of the "unborn child's" survival.⁸⁴ For the first time, a physician faced criminal penalties if he or she intentionally performed an abortion without complying with the specific informed consent requirements.⁸⁵ Overnight, the landscape for those who provided abortions and for those who sought abortion care changed dramatically in Texas. Overall though, the conservative political will was predictable and steadfast, as evidenced by the sweep of state legislation

⁸⁰ Tex. Health & Safety Code, Ch. 245 (2011).

⁸¹ Woman's Right to Know Act, 78th Leg., Reg. Sess., ch. 999, § 1 (codified as Tex. Health & Safety Code §§ 171.001-171.018) (Tex. 2003).

⁸² *Id.* at § 171.011-171.012.

⁸³ *Id.* at § 171.012. The requirements include: name of physician performing the abortion; the particular medical risks associated with the particular abortion procedure, including when medically accurate, the risks of infection and hemorrhage, the potential danger to a subsequent pregnancy and of infertility, and the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer; the probable gestational age of the unborn child, the medical risks associated with carrying the child to term. This also includes information about medical assistance for prenatal and childbirth care, liability of the father for child support, and agencies providing counseling and adoptions.

⁸⁴ *Id.* at §171.016.

⁸⁵ *Id.* at §171.018 (any violation of the statute is a misdemeanor offense, punishable by a fine not to exceed \$10,000).

involving informed consent for abortions after *Casey*.⁸⁶

III. TEXAS HOUSE BILL 15 AND ITS POTENTIAL RAMIFICATIONS

In the twenty years since *Casey*, with its introduction of the undue burden standard and rejection of strict scrutiny for abortion regulation, state statutes regulating abortion care have been routinely upheld, even though they have become increasingly burdensome to both patient and provider.⁸⁷ Presently, with House Bill 15, Texas joins Oklahoma and North Carolina in passing the most intrusive legislation (mandating ultrasounds in conjunction with displaying and describing images) within the context of informed consent for abortion care.⁸⁸ Texas's law stands alone because the laws in Oklahoma and North Carolina are temporarily enjoined from enforcement.⁸⁹

A. Statutory Provisions of House Bill 15

Texas House Bill 15 contributes to changing dramatically the abortion landscape once again. This statute inserts numerous amendments and additions into the Woman's Right to Know Act.⁹⁰ As a component of informed consent, the statute adds a provision

⁸⁶ See Gold & Nash, *supra* note 77.

⁸⁷ See, e.g., *State Policies in Brief: An Overview of Abortion Laws*, GUTTMACHER INST. (Jan. 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf; *Planned Parenthood Minnesota v. Rounds*, 653 F.3d 662, 663 (8th Cir. 2011) (en banc decision upholding informed consent provision regulating abortion providers against compelled speech attack which required disclosure that "the abortion will terminate the life of a whole, separate, unique, living human being" with whom the woman "has an existing relationship" which is entitled to legal protection).

⁸⁸ See *State Policies in Brief: Requirements for Ultrasound*, *supra* note 5. Excluding Texas, Oklahoma, and North Carolina, six states mandate that an ultrasound be performed on each woman seeking an abortion and that the provider offer the patient the opportunity to view the image, nine states require the provider to provide the opportunity to view the image if the ultrasound is performed as part of the preparation for the abortion, and five states require that the patient be given the opportunity to view the ultrasound image.

⁸⁹ See *Nova Health Sys. v. Edmondson*, 233 P.3d 380, 382 (Okla. 2010) (declaring Okla. H.B. 2780 (Session Laws 2010) to be unconstitutional); *Stuart v. Huff* 834 F.Supp.2d 424 (M.D. N.C. 2011)(invalidating Woman's Right to Know Act, 2011 N.C. Sess. Law 405 (2011)).

⁹⁰ TEX. HEALTH & SAFETY CODE §§ 171.001-171.018, *supra* note 76.

that an ultrasound examination must be performed by the physician “who is to perform the abortion or an agent of the physician who is also a sonographer certified by a national registry of medical sonographers.”⁹¹ Next, the physician must display the sonogram images in a manner such that the pregnant woman may view them⁹² and must provide a verbal explanation of the sonogram image.⁹³ In addition, the physician is required to make audible the heart auscultation along with a verbal explanation of the auscultation.⁹⁴ Before the ultrasound, the patient is required to complete and certify with her signature an “abortion and sonogram election” form, stating that, among other things, she understands that Texas law “requires” her to “receive a sonogram prior to receiving an abortion.”⁹⁵ Furthermore, the patient also certifies that she is making the election of her “own free will and without coercion.”⁹⁶

Very few provisions allow the patient any options in this informed consent discourse. It is true that a patient may choose not to view the sonogram images or choose not to hear the heart auscultation.⁹⁷ However, a pregnant woman may only refuse the verbal explanation of the sonogram image if the pregnancy is a result of a sexual assault, incest, or other violation of the penal code; the patient is a minor and has obtained a judicial bypass in order to receive an abortion; or the fetus has been diagnosed with an irreversible medical condition or abnormality.⁹⁸

Other key features of the statute apply specifically to medical judgments made by physicians. An amendment to the Texas Occupations Code states that the state medical board “shall take an appropriate disciplinary action” against a physician who performs an

⁹¹ Informed Consent to an Abortion Act, 2011 Tex. Sess. Law Serv. ch. 73 (H.R. 15) at § 2(a)(4)(A)(Tex. 2011) [amending TEX. HEALTH & SAFETY CODE § 171.012].

⁹² *Id.* at § 2(a)(4)(B).

⁹³ *Id.* at § 2(a)(4)(C).

⁹⁴ *Id.* at § 2(a)(4)(D).

⁹⁵ *Id.* at § 2(a)(5)(3).

⁹⁶ *Id.* at § 2(a)(5)(7).

⁹⁷ Informed Consent to Abortion Act, *supra* note 5, at §§ 2(a)(5)(6); 3 [amending TEX. HEALTH & SAFETY CODE § 171.0122].

⁹⁸ *Id.*

abortion without complying with the abortion informed consent provisions.⁹⁹ Specifically, the board “shall refuse to admit to examination or refuse to issue a license or renewal license” to those who violate the statute.¹⁰⁰ In addition, an amendment to the Health and Safety Code includes the definition of medical emergency: a “life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.”¹⁰¹ Plainly, this statute, with its complex requirements for informed consent alongside its criminal and professional penalties, creates a high-stakes poker game for both physicians who choose to provide abortions and those who treat emergently pregnant women experiencing bleeding complications.

B. Constitutional Challenge

Physicians and other medical providers of abortions filed suit on behalf of patients seeking abortions on June 13, 2011, in the U.S. District Court for the Western District of Texas, Austin Division.¹⁰² Shortly thereafter, the plaintiffs filed a motion for preliminary injunction to enjoin the defendants, the Commissioner of the Texas Department of State Health Services, and the Executive Director of the Texas Medical Board, from enforcing the amendments in H.B. 15.¹⁰³ Plaintiffs claimed: (1) the Act is unconstitutionally vague; (2) the Act compels physicians to engage in government-mandated speech in violation of the First and Fourteenth Amendments; (3) the Act violates the First and Fourteenth Amendments by requiring patients to submit to government-mandated speech, regardless of whether it is wanted or medically necessary; and (4) the Act treats abortion providers and their patients differently than other providers

⁹⁹ *Id.* at § 10 (amending 3 TEX. OCC. CODE § 164.055).

¹⁰⁰ *Id.*

¹⁰¹ TEX. HEALTH & SAFETY CODE, § 171.002(3) (2011).

¹⁰² *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 806 F.Supp.2d 942, 948 (W.D. Tex. 2011) (vacated in part by *Texas Med. Providers Performing Abortion Servs. V. Lakey*, 667 F.3d 570 (5th Cir. 2012)).

¹⁰³ *Id.* at 949.

and patients of all other medical services in the state without any basis, other than animus, in violation of the Equal Protection Clause.¹⁰⁴

On August 30, 2011, Judge Sparks granted a partial preliminary injunction, ruling that the provisions dealing with visualizing the ultrasound image of the embryo/fetus, the verbal descriptions of the ultrasound image, and the heart auscultation were unconstitutional violations of the First Amendment to be free of from compelled speech.¹⁰⁵ In addition, the U.S. District Court ruled that because three other provisions were unconstitutionally vague, the defendants were enjoined from penalizing a physician, criminally or otherwise, under the Act.¹⁰⁶ The U.S. District Court also denied the physicians' equal protection claim that the statute imposes intrusive burdens on the practice of medicine, stating the state has a legitimate interest in singling out abortion providers under *Casey* because those physicians and their patients pose a potential risk to a fetus.¹⁰⁷ Under rational basis review, the Court can "accept even tenuous rationales for the advancement of a legitimate government interest."¹⁰⁸

While Judge Sparks ruled that the provision defining "medical emergency" was not unconstitutionally vague, he opened the door to further argument that the challenge may have merit when he stated that the plaintiffs' challenge was more "to the constitutional sufficiency of the substance of the definition."¹⁰⁹ The underlying argument is that "the definition is not broad enough to provide an adequate exception to the informed consent requirement in cases where the life or health of the pregnant woman are [sic] threatened."¹¹⁰ However, the statute's provision for mandatory sonograms to be performed at least twenty-four hours before an abortion continues to stand.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 975.

¹⁰⁶ *Id.* at 977.

¹⁰⁷ *Id.* at 957 (quoting *Casey*, 505 U.S. 833 (1992)).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 960.

¹¹⁰ *Id.*

Within days of hearing oral arguments, a panel of the Fifth Circuit Court of Appeals vacated the preliminary injunction on January 10, 2012, concluding that the plaintiffs-appellees failed to establish a substantial likelihood of success on the merits of any of the claims on which the injunction was granted (First Amendment and vagueness claims).¹¹¹ Specifically, the panel ruled that the provisions requiring disclosures and written consent are sustainable under *Casey* and *Gonzales* because those cases allowed the state to regulate the practice of medicine by deciding what information about fetal development was important for a woman's informed consent.¹¹² While the statute's mode of delivery of the information constituting informed consent by way of ultrasound exams may be "direct and powerful," the method does not make a constitutionally significant difference when compared to the provisions requiring the "availability" of information upheld under *Casey*.¹¹³ Therefore, these requirements do not violate the First Amendment.¹¹⁴ According to the panel, the required disclosures of the sonogram and the fetal heart-beat, along with their descriptions, "are the epitome of truthful, nonmisleading information."¹¹⁵ With this ruling, the panel disregards the significance of the method mandated in obtaining information required for informed consent. It judicially justifies a diagnostic procedure as the means to the end – regulating abortion.

C. Equal Protection Analysis

As mentioned above, with regulation of the medical profession, as with any other social or economic legislation that does not impinge on a fundamental right, the state legislature is free to enact laws that are rationally related to a legitimate government purpose.¹¹⁶ Likewise, whenever the government passes a law that makes class-

¹¹¹ *Texas Med. Providers Performing Abortion Servs.*, 667 F.3d 570, 584 (5th Cir. 2012).

¹¹² *Id.* at 578.

¹¹³ *Id.* at 579 (stating that the context of the discussion is relevant since it involves the regulation of informed consent to a medical procedure).

¹¹⁴ *Id.* at 580.

¹¹⁵ *Id.* at 577-78.

¹¹⁶ See *Washington v. Glucksberg*, 521 U.S. 702, 788 (1997) (Souter, J., concurring); Joshua E. Perry, *Partial Birth Biopolitics*, 11 DEPAUL J. HEALTH CARE L. 247, 256-57 (2008).

ifications that are not subject to heightened scrutiny, it need only be justified in doing so with a legitimate purpose.¹¹⁷ With House Bill 15, the Texas legislature singled out physicians who provide abortion services and who are not a legally protected class. Therefore, for House Bill 15 to sustain an equal protection challenge, the state's classification and regulation of abortion doctors need only be reasonably related to a legitimate government purpose. Accordingly, the legislature included a provision outlining its purposes for enacting the statute,¹¹⁸ which on its face satisfies the goal requirement for rational review.

Under general equal protection analysis, whether a legislative classification is reasonable and whether it treats those similarly situated similarly depends on whether the legislative means sufficiently fit with the legislative purpose.¹¹⁹ If the fit is inadequate, it may occur because the classification is under-inclusive or over-inclusive in relation to the purpose.¹²⁰ Under-inclusion fails to include some members deserving to be burdened whereas over-inclusion includes those who do not deserve to be burdened.¹²¹ Put another way, under-inclusive laws do not regulate everyone who is similarly situated, while over-inclusive laws regulate individuals who are not similarly situated.¹²²

Many laws are either over-inclusive or under-inclusive, yet courts tend to be extremely deferential under rational basis review.¹²³

¹¹⁷ See, e.g., Robert C. Farrell, *Affirmative Action and the "Individual" Right to Equal Protection*, 71 U. PITT. L. REV. 241, 242 (2009); Nordlinger v. Hahn, 505 U.S. 1, 11 (1992) ("The appropriate standard of review is whether the difference in treatment . . . rationally furthers a legitimate state interest.").

¹¹⁸ H.R. 15, *supra* note 6 at § 12 (2011) ("(1) protecting the physical and psychological health and well-being of pregnant women; (2) providing pregnant women access to information that would allow her to consider the impact an abortion would have on her unborn child; and (3) protecting the integrity and ethical standards of the medical profession.").

¹¹⁹ Joseph Tussman & Jacobus tenBroek, *The Equal Protection of the Laws*, 37 CALIF. L. REV. 341, 346 (1949).

¹²⁰ Kenneth W. Simons, *Overinclusion and Underinclusion: A New Model*, 36 UCLA L. REV. 447, 458 (1989).

¹²¹ *Id.*

¹²² ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 686 (3d ed. 2006).

¹²³ *Id.* at 687.

In fact, the Supreme Court has declared that even if the classification is both under-inclusive and over-inclusive to some extent, then “perfection is by no means required.”¹²⁴ Furthermore, substantial over-inclusiveness by itself is tolerated under rational review.¹²⁵ However, a few laws failed rational basis review because they were deemed arbitrary and unreasonable.¹²⁶ Thus, laws sweeping too broadly may be struck down, such as when the means as written in the regulation do not coincide with the legislative justification.

In *Turner v. Safely*, the Supreme Court held that a Missouri prison regulation significantly restricting and effectively banning inmates’ marriages was not reasonably related to legitimate penological interests and, therefore, was unconstitutional.¹²⁷ The Court declared in the opinion that a prison regulation that impinges on an inmate’s constitutional rights is valid if it is reasonably related to legitimate penological interests.¹²⁸ Here, the state argued that the regulation prohibiting inmates from marrying other inmates or civilians unless the superintendent found compelling reasons to do so was reasonably related to legitimate security and rehabilitative concerns.¹²⁹ “Compelling reasons,” in practice, usually concerned only pregnancy

¹²⁴ *Vance v. Bradley*, 440 U.S. 93, 108 (1979) (quoting *Phillips Chem. Co. v. Dumas School Dist.*, 361 U.S. 376, 385 (1960)).

¹²⁵ *New York City Transit Authority v. Beazer*, 440 U.S. 568, 592–93 (1979) (upholding New York City regulation that prevented workers in methadone programs from holding jobs in the Transit Authority, even though the exclusion was over-inclusive in relation to public safety goal).

¹²⁶ *See, e.g., Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869 (1985) (declaring a state law taxing out-of-state insurance companies unconstitutional because the state’s proffered purpose of improving the local economy was not a legitimate purpose); *City of Cleburne, Texas v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (declaring a city ordinance requiring a special permit to operate a group home for the mentally disabled unconstitutional because the city’s justifications were based on prejudices against the mentally disabled, and promoting prejudice is not a legitimate government purpose); *Allegheny Pittsburgh Coal Co. v. County Comm’n of Webster County, West Virginia*, 488 U.S. 336 (1989) (invalidating a tax assessor’s practice of valuing real property at fifty percent of its most recent sale price as arbitrary and not justified as an administrative decision under state law).

¹²⁷ *Turner v. Safely*, 482 U.S. 78, 99–100 (1987).

¹²⁸ *Id.* at 79.

¹²⁹ *Id.* at 95.

or the birth of a child.¹³⁰ Thus, a classification arose among those desiring to marry, yet the burden of requiring an official's approval to marry was shared by all.

While the state conceded that the right to marry is a fundamental right under *Zablocki v. Redhail*¹³¹ and *Loving v. Virginia*,¹³² whereby any burden on that right would ordinarily trigger strict scrutiny, it argued that within the prison forum a reasonableness standard of review is sufficient.¹³³ The Court, relying on its holding in *Pell v. Procunier*,¹³⁴ declared "[t]he right to marry, like many other rights, is subject to substantial restrictions as a result of incarceration."¹³⁵ After analyzing the various important attributes of marriage, the Court concluded that prisoners retained a constitutionally protected marital relationship in the prison context.¹³⁶ However, the Court determined that "even under the reasonable relationship test, the marriage regulation does not withstand scrutiny."¹³⁷

The Court based its rationale on the regulation's over-inclusive nature. The Court found the regulation to be an "exaggerated response to such security objectives" in preventing love triangles between inmates that might lead to violent confrontations.¹³⁸ It also found that the rule swept "much more broadly than can be explained" by the state's rehabilitative goal of developing female prisoners' skills of self-reliance, especially when marriages to civilians and marriages involving male inmates were routinely approved.¹³⁹ The Court pointed out that numerous, easy alternatives to the Missouri regulation existed to accommodate an inmate's right to

¹³⁰ *Id.* at 96-97.

¹³¹ *Zablocki v. Redhail*, 434 U.S. 374, 386 (1978).

¹³² *Loving v. Virginia*, 388 U.S. 1, 11-12 (1967).

¹³³ *Turner*, 482 U.S. at 95.

¹³⁴ *Pell v. Procunier*, 417 U.S. 817, 822 (1974) (stating that a prisoner retains those constitutional rights that are consistent with "the legitimate penological objectives of the corrections system.").

¹³⁵ *Turner*, 482 U.S. at 95.

¹³⁶ *Id.* at 96.

¹³⁷ *Id.* at 97.

¹³⁸ *Id.* at 98.

¹³⁹ *Id.* at 98-99.

marry while minimally burdening the goal of prison safety.¹⁴⁰ Thus, Justice O'Connor demonstrated how arbitrary and irrational the regulation was by focusing on its mismatched fit between the means and the end, which, in this case, was over-inclusion.

D. Over-inclusion of House Bill 15

Like the Missouri regulation in *Turner*, House Bill 15 sweeps too broadly in order to accomplish its goals of protecting both pregnant patients' health and well-being and the integrity of the medical profession. These goals are not attainable by classifying physicians into two groups—those who provide abortion care and those who do not. Nor are the goals of House Bill 15 accomplished by classifying pregnant patients into two groups—those who seek an abortion and those who do not. In addition, the required means to accomplish the goals are not realistic when utilized in day-to-day medical scenarios involving pregnant patients. While mandatory ultrasounds, waiting periods, and verbal explanations unnecessarily delay care within the sphere of elective abortion, they serve as immense hurdles to appropriate care when pregnant patients experiencing a miscarriage demand urgent treatment.

Much the same as the regulations addressed by *Turner*, this statute attempts to overregulate a constitutionally protected right that is already subject to substantial restrictions after *Casey*. By regulating the practice of those physicians who provide abortions, the state unwittingly ensnares both physicians who do not intend to perform an abortion and pregnant women experiencing medical complications who do not seek an abortion. Like *Turner*, House Bill 15 is over-inclusive because it encompasses more people than is necessary in order to accomplish its purpose. Physicians caring for pregnant patients with complications are not similarly situated as compared to physicians who perform abortions. Likewise, pregnant patients experiencing medical complications are not similarly situated to pregnant patients desiring an elective abortion.

¹⁴⁰ *Id.* at 98.

E. Medical Complications in Pregnancy

Approximately 1.21 million women obtained an abortion in the United States according to figures from 2008,¹⁴¹ and 82,056 Texas residents obtained abortions in 2006.¹⁴² Typically, a pregnant patient presents to a freestanding clinic or a private doctor's office for an abortion, which in Texas can only be performed by a licensed physician.¹⁴³ Thus, a doctor-patient relationship forms under the circumstances of an outpatient, elective procedure. However, when a patient who may or may not know that she is pregnant develops an acute medical problem, she may present for care at any number of facilities: her primary care physician's office, her local emergency room, a free-standing outpatient clinic, or a minor emergency clinic.

1. Miscarriages and Ectopic Pregnancies

Vaginal bleeding in the first trimester of pregnancy (threatened miscarriage) is one of the most common obstetrical emergencies.¹⁴⁴ In fact, vaginal bleeding will occur within the first trimester of pregnancy in approximately 15–25% of all pregnancies and is associated with an increased risk of miscarriage and other complications.¹⁴⁵ Transvaginal ultrasound is the method of choice for evaluation of the status of the pregnancy by way of the size of the gestational sac in pregnancies less than six weeks from the last menstrual period.¹⁴⁶ However, if a gestational sac is small, it is not possible to determine whether or not an embryo is developing within the sac unless a

¹⁴¹ *Facts on Induced Abortion in the United States*, GUTTMACHER INST. (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

¹⁴² *Induced Terminations of Pregnancy*, TEX. DEP'T OF STATE HEALTH SERVS., <http://www.dshs.state.tx.us/layouts/contentpagenonav.aspx?pageid=54030&id=67170&terms=abortion> (last updated Dec. 31, 2010). This number includes Texas residents who obtained an abortion out of state.

¹⁴³ Tex. Health & Safety Code § 171.003 (2011).

¹⁴⁴ Eric Jauniaux et al., *The Role of Ultrasound Imaging in Diagnosing and Investigating Early Pregnancy Failure*, 25 *ULTRASOUND OBSTETRICS GYNECOLOGY* 613, 617 (2005).

¹⁴⁵ P. Falco et al., *Sonography of Pregnancies with First Trimester Bleeding and a Small Intrauterine Gestational Sac Without a Demonstrable Embryo*, 21 *ULTRASOUND OBSTETRICS GYNECOLOGY* 62, 62 (2003).

¹⁴⁶ *Id.*

follow-up ultrasound is performed.¹⁴⁷ In addition, pseudosacs are false sacs visible with ultrasound that are easily confused with gestational sacs and occur in 10–20% of ectopic pregnancies.¹⁴⁸ Transabdominal ultrasound is less sensitive, so at least one more week is needed to show landmarks visible by vaginal ultrasound.¹⁴⁹ The speed of evaluation depends on the patient's history, signs, and symptoms.¹⁵⁰ If the patient is stable hemo-dynamically, if there is cardiac activity in an embryo that is more than 5 mm in length visible by vaginal ultrasound or fetal heart tones audible by Doppler, and if there is no tenderness in the pelvis to suggest an ectopic pregnancy, then "watchful waiting" is appropriate.¹⁵¹

In addition to performing ultrasounds when a pregnant patient presents with acute vaginal bleeding, most healthcare providers will measure the serum level of the pregnancy hormone, human chorionic gonadotropin (HCG).¹⁵² When HCG levels are between 1,500 and 2000 mIU per ml, transvaginal ultrasound can demonstrate an intrauterine gestational sac with 100 percent sensitivity.¹⁵³ However, if no gestational sac is visible and the HCG level is above the 1500–2000 level, then an ectopic pregnancy is highly likely.¹⁵⁴

Approximately two percent of all pregnancies in the U.S. are ectopic, with ninety-seven percent of them located in the fallopian tube.¹⁵⁵ An embryo with cardiac activity found outside of the uterus proves an ectopic pregnancy.¹⁵⁶ Since these pregnancies have the potential to rupture, early diagnosis is important in preventing mor-

¹⁴⁷ *Id.*

¹⁴⁸ Chris Feier, *Clinical Emergency Medicine Algorithms: Vaginal Bleeding in Early Pregnancy (Less than 20 Weeks)*, 9 W. J. OF EMERGENCY MED. 47, 49 (2008).

¹⁴⁹ Mark Deutchman et al., *First Trimester Bleeding*, 79 AM. FAM. PHYSICIAN 985, 988 (2009).

¹⁵⁰ *Id.* at 985.

¹⁵¹ *Id.*

¹⁵² *Id.* at 987.

¹⁵³ *Id.* at 988.

¹⁵⁴ *Id.*

¹⁵⁵ Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management?*, 21 WOMEN'S HEALTH ISSUES 104, 104 (2011).

¹⁵⁶ Deutchman et al., *supra* note 149, at 988.

tality and complications, such as hemorrhage and infertility.¹⁵⁷ A medical emergency is not declared until the patient exhibits signs that the ectopic pregnancy is actually rupturing. However, physicians typically intervene surgically or with medications as soon as they reach a diagnosis, even though the pregnancy is technically alive, in order to *prevent* tubal damage, hemorrhage, or death.¹⁵⁸

2. *Definition of Medical Emergency in House Bill 15*

While House Bill 15 permits a physician to perform an abortion without obtaining informed consent in a medical emergency, the definition of medical emergency (in danger of death or serious risk of substantial impairment of a major bodily function) is highly restrictive. Like in *Gonzales*, it is essentially a life exception and not a health exception. Thus, in Texas, an abortion may be performed without the expansive, abortion-specific informed consent only under extremely dire medical circumstance and by a physician who certifies that an abortion is medically indicated and who is trained to perform an abortion.

As a result, this definition is not broad enough to provide an adequate exception to the informed consent requirement in cases where a pregnant woman's overall physical health or well-being is jeopardized by a medical complication, such as excessive bleeding or an ectopic pregnancy. Due to the severity of the penalties for performing an abortion without proper informed consent under the current law, many physicians will be understandably reluctant to perform a D&C or a laparoscopy when a pregnant patient presents for care with a miscarriage or a tubal pregnancy for fear that someone will second-guess their diagnosis as non-life-threatening or devoid of serious risk of impairment of a major bodily function.

The definition for medical emergency in House Bill 15 is substantially similar to the definition that the Supreme Court upheld in *Casey*.¹⁵⁹ There, the Court concluded that Pennsylvania's medical

¹⁵⁷ *Id.* (stating that ectopic pregnancies are responsible for six percent of all U.S. maternal deaths).

¹⁵⁸ Foster et al., *supra* note 155, at 105.

¹⁵⁹ *Casey*, 505 U.S. 833, 879 (1992) (quoting 18 Pa. Cons. Stat. §3203 (1990): "[t]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the

emergency definition did not create an undue burden on a woman's right to an abortion.¹⁶⁰ The Court deferred to the U.S. Court of Appeals for the Third Circuit's construction of the provision, which encompassed numerous medical complications, such as inevitable miscarriage and preeclampsia, under the phrase "serious risk."¹⁶¹ As the Court had stated in *Brockett v. Spokane Arcades, Inc.*,¹⁶² it was reasonable and customary for the Court to defer to a lower federal court's interpretation of a state law.¹⁶³ Again, in *Frisby v. Schultz*, the Court declared that "district courts and courts of appeals are better schooled in and more able to interpret the laws of their respective States."¹⁶⁴

The Third Circuit, in turn, relied on the intention of the Pennsylvania legislature as assurance that compliance with the regulation "would not in any way pose a significant threat to the life or health of a woman."¹⁶⁵ However, without this double deference, the Court conceded that the definition could be "interpreted in an unconstitutional manner."¹⁶⁶ Thus, House Bill 15's medical emergency definition, even as a life exception, has the aura of unconstitutionality.

3. Medical Providers Affected by House Bill 15

As written, House Bill 15 applies not only to those providers who perform abortions routinely but also to those who treat pregnant women in general and to those who have the potential on a daily basis to treat them, whether the physician is an obstetrician/gynecologist, a family practice physician, an internist, a pediatrician, or an emergency room physician. Denial or revocation of a medical

medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which delay will create serious risk of substantial and irreversible impairment of a major bodily function.").

¹⁶⁰ *Id.* at 880.

¹⁶¹ *Id.*

¹⁶² *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 499 (1985).

¹⁶³ *Casey*, 505 U.S. at 880 (quoting 472 U.S. 491, 499-500 (1985)).

¹⁶⁴ *Frisby v. Schultz*, 487 U.S. 474, 482 (1988).

¹⁶⁵ *Casey*, 505 U.S. at 880.

¹⁶⁶ *Id.*

license will apply to any physician who violates either the WRTK Act with its attendant, scripted information or House Bill 15 with its mandatory sonogram and attendant explanations and certifications, regardless of any intention of performing an abortion.¹⁶⁷ Therefore, any physician who sees a pregnant woman needing an emergency D&C will have to alter substantially their practice of medicine due to the immediate threat of losing his or her license. Choosing between what is best for the patient versus what is best for the physician's career is certainly not conducive to optimal care for the patient.

Consider the situation where a pregnant woman presents for care to a local emergency room belonging to a Catholic hospital because she has suddenly started to bleed vaginally. The staff will immediately assess her bleeding by physical exam and her pregnancy status by ultrasound and serum quantitative HCG level.¹⁶⁸ If there is any indication by ultrasound that the pregnancy is viable, such as detecting any rudimentary blood flow within the embryo or any cardiac motion in the fetus, she will have the diagnosis of threatened miscarriage.¹⁶⁹ Because she is still pregnant, she can only be observed emergently. No procedure (e.g., D&C) can be performed to empty the uterus in order to stop the excessive bleeding because 1) she is being cared for in a Catholic hospital that expressly prohibits abortions for any reason¹⁷⁰ and 2) the patient's condition is not considered a medical emergency (i.e., not in danger of death or of a serious risk of substantial impairment of a major bodily function).¹⁷¹ She likely will be sent home with the instructions to follow up the next day with her primary care physician.

If this same pregnant patient presents to a secular hospital where abortions are permitted, once again, no procedure can be performed. In this case, the physician "who is to perform the abortion" probably

¹⁶⁷ H.R. 15, *supra* note 6 at § 10.

¹⁶⁸ Feir, *supra* note 148, at 47.

¹⁶⁹ Deutchman et al., *supra* note 149, at 985.

¹⁷⁰ Foster et al., *supra* note 155, at 105; *The Ethical and Religious Directives for Catholic Health Care Services*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (USCCB) (2009), available at [http://www.usccb.org/about/doctrine/ethical-and-religious-directives/\(follow hyperlink to pdf\)\[hereinafter *Directives*\]](http://www.usccb.org/about/doctrine/ethical-and-religious-directives/(follow%20hyperlink%20to%20pdf)[hereinafter%20Directives]).

¹⁷¹ Tex. Health & Safety Code §171.002(3) (2011).

is not the person performing the initial sonogram in the emergency room. Even so, the patient would have to wait twenty-four hours between sonogram and procedure. In addition, she would have to view images and listen to the heart auscultation or decline viewing and listening, but still listen to the explanation of embryonic/fetal development at the time of the initial sonogram. Again, she would likely be sent home because her condition does not fit the definition of medical emergency to justify an immediate D&C, which would be the equivalent of an abortion.

What happens to the family practitioner practicing in a rural setting who evaluates a pregnant patient who is actively bleeding? These physicians may not have ultrasound equipment in their offices due to lack of training in prenatal ultrasound,¹⁷² or they may not even provide obstetrical care.¹⁷³ Transport by ambulance to the nearest hospital is likely in order to obtain a sonogram. As above, several factors will influence the patient's care, although not necessarily for medical reasons: the hospital's religious affiliation, the patient's physical exam, the immediate availability of the sonogram, the performance of a sonogram by a physician or certified sonographer, and the interpretation of the sonogram. Again, the patient's care will be dictated by a diagnosis of a viable pregnancy to the exclusion of other medical issues, such as blood loss and infection.

4. Analogy to Care in Catholic Hospitals

Catholic hospitals comprise approximately twelve percent of all hospitals in the U.S.¹⁷⁴ and are the sole providers of emergency services for many communities.¹⁷⁵ Looking at how they manage threatened miscarriages and ectopic pregnancies gives some insight as to the rocky road ahead under House Bill 15. Governing the provision of care in Catholic-affiliated hospitals, the *Ethical and*

¹⁷² Lee T. Dresang et al., *Prenatal Ultrasound: A Tale of Two Cities*, 98 J. OF NAT'L MED. ASS'N 167, 170 (2006).

¹⁷³ Thomas S. Nesbitt, *Obstetrics in Family Medicine: Can It Survive?*, 15 J. AM. BD. FAM. MED. 77, 77 (2002).

¹⁷⁴ Foster et al., *supra* note 155, at 105.

¹⁷⁵ *Id.* at 108.

Religious Directives for Catholic Health Care Services prohibit abortions within the institutions and prohibit healthcare providers “from taking ‘direct’ action against the embryo.”¹⁷⁶ For some Catholic ethicists and clinicians, this direct action includes two standard regimens for ectopic pregnancies: (1) the administration of methotrexate as a medical treatment and (2) a salpingostomy with the removal of the embryo from the fallopian tube as a surgical treatment.¹⁷⁷

When patients present to Catholic hospitals with a threatened miscarriage, physicians typically conduct additional clinical tests and imaging studies in order to establish and document non-viability.¹⁷⁸ This process invariably leads to delays in care as well as increases in medical expenses.¹⁷⁹ Anemia, hemorrhage, transfusions, infections, sepsis, and disseminated intravascular coagulopathy are just a few of the possible consequences of delaying a medically necessary uterine evacuation.¹⁸⁰ In order to inform patients of their options and to provide them with appropriate care, some physicians circumnavigate the *Directives* by referring patients to other facilities, treating them offsite, counseling behind closed doors, or quietly violating hospital protocols.¹⁸¹

¹⁷⁶ *Id.* at 105; *Directives*, *supra* note 170, at 26–27. See also Lynn Wardle, *Access and Conscience: Principles of Practical Reconciliation*, 11 AM. MED. ASSN. J. OF ETHICS 783, 785 (2009) (reporting that nearly all states have variations of conscience-protection provisions except Alabama, New Hampshire, and Vermont which currently lack explicit conscience protection covering at least abortion services).

¹⁷⁷ Foster et al., *supra* note 155, at 105.

¹⁷⁸ See *id.* at 106.

¹⁷⁹ *Id.*

¹⁸⁰ See Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1776–1777 (2008); *Disseminated Intravascular Coagulation (DIC)*, MEDLINE PLUS (Mar. 19, 2012), <http://www.nlm.nih.gov/medlineplus/ency/article/000573.htm> (Disseminated intravascular coagulopathy is a condition in which clotting proteins are consumed in response to infection, sepsis, trauma, cancer, hemorrhage, etc. which causes serious bleeding).

¹⁸¹ Foster et al., *supra* note 155, at 108; Freedman et al., *supra* note 175, at 1777.

IV. CONCLUSION

Looking at the big picture of healthcare policy, House Bill 15 will create barriers to proper and reasonable care for pregnant women, including those who do not desire or seek an abortion. Highly sensitive urine pregnancy tests now allow patients to present earlier for evaluation.¹⁸² As a result, this has increased the number of inconclusive ultrasound scans and increased the need for repeat assessments to establish both pregnancy location and viability.¹⁸³ The costs of serial obstetrical sonograms¹⁸⁴ and serum HCG levels, along with the time devoted to performing physical examinations by the physician, can add up to a sizeable amount of money expended merely to determine whether an embryo is developing or not. Consequently, healthcare providers will need to be knowledgeable and proficient in using ultrasound to diagnose early pregnancies and to avoid the pitfalls associated with ultrasound in diagnosing early pregnancy failure.¹⁸⁵

Unfortunately, in Texas, in the wake of severe budget cuts that occurred in the 2011 legislative session, approximately 180,000 women will face significantly increased healthcare costs.¹⁸⁶ Lawmakers cut \$73.6 million from the \$111.5 million budget that the Department of State Health Services uses to fund women's health and family planning services.¹⁸⁷ As a result, it is anticipated that more women will forego routine prenatal care, and more unplanned

¹⁸² Jauniaux et al., *supra* note 144, at 617.

¹⁸³ *Id.*

¹⁸⁴ *Reimbursement Information for Diagnostic Ultrasound Procedures Completed by Obstetricians*, GE HEALTHCARE (Jan. 1, 2011), http://www3.gehealthcare.com/~media/Downloads/us/Product/Product-Categories/Ultrasound/GEHealthcare-Brochure_Reimbursement-Info-Obstetricians.pdf. According to 2011 Medicare reimbursement rates, obstetrical ultrasound charges ranged from approximately \$62 to \$562, depending on gestational age and complexity of exam.

¹⁸⁵ Jauniaux et al., *supra* note 144, at 617.

¹⁸⁶ Audrey White, *Local Clinic Finding Ways to Continue Services Amid State Funding Cuts*, AUSTIN AM. STATESMAN (Feb. 5, 2012, 9:58 PM), www.statesman.com/news/local/local-clinic-finding-ways-to-continue-services-amid-2152757.html.

¹⁸⁷ *Id.*

pregnancies will occur among poor women and teenagers.¹⁸⁸ Invariably, this dynamic will place significant fiscal pressure on providers who see pregnant patients emergently to treat expeditiously or to transfer care elsewhere.

On February 6, 2012, the U.S. Court for the Western District of Texas, Austin Division, granted summary judgment for the defendants, thus ending the facial challenge.¹⁸⁹ The unintended consequences of House Bill 15 will be far-reaching and predictable. Many physicians will play it safe by withholding proper treatment when pregnant patients present with bleeding complications. Those physicians who are inexperienced in diagnosing early pregnancies or who do not have access to state-of-the-art ultrasound equipment will be at risk for performing a D&C on a pregnancy that is still “alive.” Many pregnant patients will be destined to languish in the limbo land of needing a D&C even though their pregnancy is still technically “alive.” Perhaps one option remains for physicians and patient advocates, as suggested in *Gonzales*: Mount an as-applied constitutional challenge to House Bill 15 with a patient as plaintiff. Unfortunately, for this to occur, medical harm will have been done.

¹⁸⁸ *Id.*

¹⁸⁹ *Texas Med. Providers of Abortion Servs. v. Lakey*, No. A-11-CA-486-SS, 2012 WL373132, at *6, (W.D. Tex. Feb. 6, 2012).