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Fulfilling the Promise of *Roe*: A Pathway for Meaningful Pre-Abortion Consultation

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Fulfilling the Promise of *Roe*: A Pathway for Meaningful Pre-Abortion Consultation

Cover Page Footnote

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FULFILLING THE PROMISE OF *ROE*: A PATHWAY FOR MEANINGFUL PRE-ABORTION CONSULTATION

Thomas J. Molony⁺

I. THE PROMISE OF <i>ROE</i> —AND REALITY	716
II. A PATH TOWARD MEANINGFUL PRE-ABORTION CONSULTATION	720
A. <i>The Pre-Abortion Consultation Enhancement Act</i>	720
B. <i>Benefits of the Model Statute</i>	722
C. <i>Enhancing Patient Autonomy</i>	726
III. A REQUIREMENT THAT RESPECTS A WOMAN’S CONSTITUTIONAL RIGHTS	728
A. <i>The Primary Care Consultation Requirement Does Not Create an Undue Burden on a Woman’s Right to Choose</i>	728
1. <i>Planned Parenthood v. Casey and Whole Woman’s Health v. Hellerstedt</i>	728
2. <i>Doe v. Bolton</i>	744
B. <i>The Primary Care Consultation Requirement Does Not Implicate a Woman’s First Amendment Right to Be Free from Compelled Speech</i>	747
IV. CONCLUSION	763
V. APPENDIX	763

New abortion regulations have been sweeping the nation, and the debate the U.S. Supreme Court had hoped to quell when it handed down its decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹ has raged on, with emotions running as high as ever.² The new regulations have been wide-ranging and, among other things, have included requirements that physicians who perform abortions have hospital admitting privileges, that abortion facilities

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1. 505 U.S. 833 (1992).

2. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844, 901 (1992) (noting that “[l]iberty finds no refuge in a jurisprudence of doubt” and claiming to have “define[d] the freedom guaranteed by the Constitution’s own promise . . .”); see also *State Policies on Abortion*, GUTTMACHER INSTITUTE, <https://www.guttmacher.org/united-states/abortion/state-policies-abortion> (last visited July 28, 2016) (indicating that 288 abortion restrictions were adopted between 2011 and 2015); Janet Reitman, *The Stealth War on Abortion*, ROLLING STONE, (Jan. 15, 2014), <http://www.rollingstone.com/politics/news/the-stealth-war-on-abortion-20140115> (noting that, since 2010, “30 states have passed 205 anti-abortion restrictions, more than in the previous decade,” and giving examples of new restrictions).

meet standards applicable to ambulatory surgery centers, that women see ultrasounds before choosing abortion, and, most recently, that physicians administer anesthesia to alleviate fetal pain.³ Not surprisingly, these measures have generated both praise and scorn. Abortion foes hail them as important steps to make abortion safer, to ensure that women make more informed decisions, and to protect the unborn.⁴ Pro-choice advocates, on the other hand, see the new directives as calculated attempts to restrict women's access to a procedure that has been legal for over 40 years.⁵

In *Whole Woman's Health v. Hellerstedt*,⁶ the Supreme Court's first major abortion decision in over two decades, the Court weighed in on two regulations adopted in the recent wave—Texas admitting privileges and ambulatory surgery center requirements—and declared that they unconstitutionally burdened a woman's right to choose.⁷ The *Hellerstedt* decision undoubtedly represents a significant legal victory for those who oppose abortion restrictions, but what it may mean for the many other regulations of recent vintage is far from clear.

Public sentiment about abortion regulation is similarly hard to gauge.⁸ There appears to be a widely-held belief that the abortion decision should be made by

3. See Reitman, *supra* note 2 (giving examples of new restrictions on abortion); Jack Healy, *When Can Fetuses Feel Pain? Utah Abortion Law and Doctors Are at Odds*, N.Y. TIMES (May 4, 2016), http://www.nytimes.com/2016/05/05/us/utah-abortion-law-fetal-anesthesia.html?_r=0 (discussing Utah's recent law requiring that a woman having an abortion at 20 weeks or more gestation receive anesthesia).

4. See, e.g., NATIONAL RIGHT TO LIFE, <http://www.nrlc.org/statelegislation/> (last visited Feb. 26, 2016) (recognizing ultrasound laws as informed consent measures and asserting that informed consent requirements “lower[] the abortion rate and protect[] unborn children because pregnant mothers are able to receive factual scientific information . . .”); Sandhya Somashekhar, *Admitting-privileges laws have created high hurdle for abortion providers to clear*, WASH. POST (Aug. 10, 2014), https://www.washingtonpost.com/national/2014/08/10/62554324-1d88-11e4-82f9-2cd6fa8da5c4_story.html (“[Clinics] need to provide the best of care and have a physician with admitting privileges” (quoting abortion opponent)); Healy, *supra* note 3 (indicating that, in supporting Utah's new law requiring the administration of anesthesia, “[a]nti-abortion groups and lawmakers in Utah said they were acting out of concern for the fetus”).

5. See, e.g., Reitman, *supra* note 2 (“The politicians [have] . . . come up with laws that are unnecessary, technical and hard to follow, which too often forces clinics to close” (quoting Nancy Northup of the Center for Reproductive Rights)); Somashekhar, *supra* note 4 (“Abortion rights proponents . . . argue that admitting privileges are medically unnecessary . . . They regard the bills as a back-door attempt to shut down clinics. . .”).

6. 136 S. Ct. 2292 (2016).

7. See *id.* at 2300 (striking down Texas laws requiring that a physician performing an abortion have admitting privileges at a local hospital and that abortion facilities meet the minimum standards applicable to Texas ambulatory surgery centers).

8. See Irin Carmon, *Why it's so hard to measure public opinion on abortion*, MSNBC (Jan. 1, 2016), <http://www.msnbc.com/msnbc/why-its-so-hard-measure-public-opinion-abortion> (noting the difficulty in assessing opinions about abortion).

a woman in consultation with her doctor.⁹ With polls indicating that the public also disfavors unrestricted access to abortion,¹⁰ though, one might ask how people envision abortion consultation and the doctor who helps a woman navigate the various considerations associated with what Justice Stevens described as “a difficult choice having serious and personal consequences of major importance to her own future—perhaps to the salvation of her own immortal soul”¹¹ It certainly is easy to imagine a scene in which a woman makes her choice after spending extensive time with her long-time ob/gyn¹² or family physician. And perhaps it is so easy to imagine this scene because it is one the Court’s opinion in *Roe v. Wade*¹³ evokes when it indicates that, before having an abortion, the woman and her doctor will have a discussion that “necessarily”¹⁴ will cover a multitude of critical factors.

Yet, this image likely does not reflect reality in most cases. The vast majority of ob/gyns are unwilling to perform abortions,¹⁵ so women typically must turn to specialists who may be unknown to them until they perform a Google search.¹⁶ These specialists may be very skilled in performing the abortion procedure itself, but one can question whether they are prepared to have the type of discussion *Roe* suggests, and there is evidence that—for whatever reason—robust consultations do not always occur.¹⁷ The absence of meaningful dialogue is cause for concern, as the Court in *Hellerstedt* highlighted when it struck down

9. See *Poll Results: Abortion*, YOUGov (Jan. 16, 2014, 1:26 PM), <https://today.yougov.com/news/2014/01/16/poll-results-abortion/> (indicating that, in a 2014 survey, 64% of adults believed “[d]ecisions on abortion should be made by a woman and her doctor”).

10. Gallup, *Abortion*, <http://www.gallup.com/poll/1576/abortion.aspx> (last visited July 28, 2016) (reflecting that, in polls taken from 2010 to 2016, between 69% and 73% of those responding thought that abortion either should be “legal only under certain circumstances” or “illegal in all circumstances”).

11. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 781 (1985) (Stevens, J., concurring).

12. The term “ob/gyn” refers to a physician trained in obstetrics and gynecology.

13. 410 U.S. 113 (1973).

14. *Id.* at 153.

15. See Debra B. Stulberg, Annie M. Dude, Irma Dahlquist, and Farr A. Curlin, *Abortion Provision Among Practicing Obstetricians-Gynecologists*, 118 *OBSTETRICS & GYNECOLOGY* 609, 609 (2011) (concluding based on a study of 1,800 physicians that, “[a]mong practicing ob-gyns, 97% encountered patients seeking abortions, whereas only 14% performed them”).

16. See Eyal Press, *A Botched Abortion*, *NEW YORKER* (Feb. 3, 2014), <http://www.newyorker.com/magazine/2014/02/03/a-botched-operation> (discussing experiences of women who used Google to find a physician to perform an abortion).

17. See DAVID C. REARDON, *ABORTED WOMEN SILENT NO MORE* 328, 335 (1975) (noting that, in a survey of 252 women across 42 States, 70% of those responding reported that they had not made their decision to have an abortion in consultation with a physician, 73% indicated that they believed information was withheld or that they received incorrect information, and 64% claimed that they were not encouraged to ask questions).

Texas's ambulatory surgical center requirement.¹⁸ Indeed, the inability to receive "individualized attention, serious conversation, and emotional support"¹⁹ increases "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."²⁰

This Article offers a means to mitigate this risk, proposing legislation that would require a woman, in a manner compatible with her constitutional rights, to consult with her regular ob/gyn or family physician before having an abortion. Part I of the Article describes *Roe*'s view of the physician's role in a woman's decision to have an abortion and the threats posed by a lack of meaningful pre-abortion counseling. Part II proposes a model statute designed to protect against these threats and details the benefits of requiring a woman to consult with her regular physician before choosing to terminate her pregnancy. Part III analyzes the constitutionality of the model legislation, explaining how it is consistent with a woman's constitutional rights. Part III first considers the implications of the proposed statute with respect to a woman's substantive due process rights under the Fourteenth Amendment. Then, it explores how requiring disclosure of a woman's decision to her primary ob/gyn or internist relates to her First Amendment right to be free from government-compelled speech. Finally, having confirmed the constitutionality of the model legislation, the Article urges states to adopt the proposed statute and suggests that both sides of the abortion debate ought to line up in support.

I. THE PROMISE OF *ROE*—AND REALITY

The Supreme Court in *Roe* presented a vivid picture of how a woman would arrive at a decision to have an abortion. Rather than deciding quickly or alone, she would make the decision to terminate her pregnancy only after a long and detailed discussion with her trusted physician. The discussion would cover a broad range of considerations relating to the possible detriments associated with the woman's continuing her pregnancy:

Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a

18. See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2318 (2016) (suggesting that, with the ambulatory surgery center requirement, women would be "less likely to get the kind of individualized attention, serious conversation, and emotional support" they otherwise might receive).

19. *Id.*

20. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

family already unable, psychologically and otherwise, to care for it. In [some] cases, . . . the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.²¹

Indeed, given the depth of knowledge required for a physician to provide meaningful guidance to a woman based on her particular circumstances, it seems that the Court in *Roe* expected that a woman considering abortion would turn to her long-time physician to perform the procedure.²²

If the image *Roe* suggested represented reality in the period immediately following the decision, it does not today.²³ Most ob/gyns are unwilling to perform abortions.²⁴ Therefore, doctors performing abortions tend to specialize in the procedure rather than devote their time to comprehensive gynecological care.²⁵

Specialization, of course, has its benefits. Physicians who focus on abortion have the opportunity to hone and perfect their technical skill and perhaps have the ability to enhance their understanding of how abortion affects women

21. *Roe v. Wade*, 410 U.S. 113, 153 (1973). Not long after *Roe*, the Court reinforced this view in *City of Akron v. Akron Center for Reproductive Health, Inc.*, stating that “in *Roe* and subsequent cases we have ‘stressed repeatedly the central role of the physician . . . in consulting with the woman about whether or not to have an abortion’” *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 447 (1983) (quoting *Colautti v. Franklin*, 439 U.S. 379, 387 (1979)); see also *id.* at 443 (“It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances.”). Mysteriously, though, the Court in *Acron* also eroded the view of the importance of the physician’s own personal involvement in the counseling process, concluding that requiring consultation with a physician—as opposed to some other person qualified to counsel a woman—was incompatible with a woman’s constitutional right to choose. *Id.* at 448 (“We are not convinced, however, that there is as vital a state need for insisting that the physician performing the abortion, or for that matter any physician, personally counsel the patient in the absence of a request.”). The Court in *Casey*, however, changed course and determined that a State can place the responsibility for counseling on a physician. See *Casey*, 505 U.S. at 885 (upholding the constitutionality of a requirement that a physician himself or herself provide information to a woman seeking an abortion).

22. See *Roe*, 410 U.S. at 153.

23. Emily Bazelon, *The New Abortion Providers*, N.Y. TIMES MAGAZINE (July 14, 2010), http://www.nytimes.com/2010/07/18/magazine/18abortion-t.html?_r=0 (“In 1973, hospitals made up 80 percent of the country’s abortion facilities . . . 15 years later, 90 percent of the abortions in the U.S. were performed at clinics.”).

24. See Stulberg, et al., *supra* note 15, at 609 (concluding based on a study of 1,800 physicians that, “[a]mong practicing ob-gyns, 97% encountered patients seeking abortions, whereas 14% performed them”).

25. According to a study by the Guttmacher Institute, 63% of the abortions in 2011 were performed in abortion clinics, a term defined as “nonhospital facilities in which half or more of patient visits are for abortion services,” and 60% of the abortions were completed in clinics that perform 1,000 or more abortions per year. Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability In the United States, 2011*, 46 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 3, 5, 6 (2014).

generally. In exchange for a deep understanding of the *procedure* and its *general effects*, however, the specialist sacrifices a deep understanding of *each woman* who comes to him or her seeking an abortion. Simply put, an intake form and a few questions are no substitute for the depth of information a physician providing comprehensive care will obtain during the course of a relationship that begins in less trying circumstances.

To be sure, the sacrifices associated with specialization are not unique to abortion. What is different, however, is how the relationship between a woman and an abortion specialist often comes about. It is hard to imagine, for example, that a person who suspects he or she has cancer or a heart problem would turn to the internet to select an oncologist or a cardiologist. Instead, except in an emergency situation, one would expect the person first to approach his or her regular physician, who would evaluate the patient's symptoms in light of his or her medical history, discuss the particular problem with the patient based on the physician's knowledge of the patient, and then refer the patient to a specialist for further evaluation or assistance if necessary. Indeed, the U.S. Department of Health and Human Services ("HHS") emphasizes the importance of having a person's regular physician involved in managing his or her healthcare in this way, stating that "[p]rimary care providers are critical for providing preventive care, ensuring coordinated care, and improving health outcomes for Americans,"²⁶ and Congress accordingly took a number of steps in the Affordable Care Act to increase access to primary care physicians.²⁷ Moreover, insurance companies sometimes condition coverage for specialists' services on obtaining referrals from primary care doctors.²⁸

Notwithstanding the seriousness of the decision,²⁹ however, a woman may not seek guidance from her regular ob/gyn or internist when considering abortion,

26. *Creating Primary Health Care Jobs by Addressing Primary Care Workforce Needs*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/creating-health-care-jobs-by-addressing-primary-care-workforce-needs/index.html> (last visited Feb. 26, 2016).

27. *See id.* (detailing measures in the Affordable Care Act to increase access to primary care physicians).

28. *Requirements Guide*, UNITEDHEALTHCARE, https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/enUS/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Referral_Requirements_Quick_Reference.pdf (last visited Mar. 5, 2016) (requiring submissions of referrals for certain specialists); *How do referrals work in my HMO plan?*, BLUE CROSS BLUE SHIELD BLUE CARE NETWORK OF MICHIGAN, <http://www.bcbsm.com/index/health-insurance-help/faqs/plan-types/hmo/how-do-referrals-work-in-my-hmo-plan.html> (last visited Feb. 26, 2016) ("For most, but not all, HMO plans, you'll need a referral from your primary care physician before you can see any other health care professional (except in an emergency).").

29. The Supreme Court has repeatedly recognized the seriousness of the abortion decision. *See* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 873 (1992) (noting that the decision to have an abortion "has such profound and lasting meaning"); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67 (1976) ("The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature

but instead may look to Google or a similar source to select an abortion specialist.³⁰ Unfortunately, when a woman chooses this course, she may be forfeiting the wisdom of a physician who may know her well, thereby increasing “the risk that [she] may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.”³¹ A woman also may be exposing herself to the threat of physical harm by a physician who may be unskilled or, worse, incompetent in performing abortions. As the story of Kermit Gosnell attests,³² this threat is not merely theoretical, and Gosnell’s story is not the only one about an abortion doctor who has placed women’s lives in jeopardy.³³ The risks associated with a woman’s bypassing her primary care physician and striking out on her own to obtain an abortion, therefore, are extremely serious, and they warrant governmental action.

and consequences.”); *Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 448 (1983) (“[W]e do not suggest that the State is powerless to vindicate its interest in making certain the ‘important’ and ‘stressful’ decision to abort ‘is made with full knowledge of its nature and consequences.’” (quoting *Danforth*, 428 U.S. at 67)); *Bellotti v. Baird*, 443 U.S. 622, 641 (1979) (describing as “very important” the “decision whether or not to bear a child” (quoting *Danforth*, 428 U.S. at 91 (Stewart, J., concurring))); *id.* at 642 (indicating that the abortion decision involves “consequences so grave and indelible”); *H.L. v. Matheson*, 450 U.S. 398, 411 (1980) (“The medical, emotional, and psychological consequences of an abortion are serious and can be lasting[.]”); *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (“Whether to have an abortion requires a difficult and painful moral decision The State has an interest in ensuring so grave a choice is well informed.”). *See also* *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 781 (1986) (Stevens, J., concurring) (suggesting that a woman deciding whether to have an abortion is “faced with the reality of a difficult choice having serious and personal consequences of major importance to her own future—perhaps to the salvation of her own immortal soul”); *Casey*, 505 U.S. at 919 (Steven, J., concurring in part and dissenting in part) (“Those who disagree vehemently about the legality and morality of abortion agree about one thing: The decision to terminate a pregnancy is profound and difficult.”); *Akron*, 462 U.S. at 474 (O’Connor, J., dissenting) (“As we acknowledged in *Danforth*, the decision to abort is ‘a stressful one,’ and the waiting period reasonably relates to the State’s interest in ensuring that a woman does not make this serious decision in undue haste.”) (citation omitted); *Thornburgh*, 476 U.S. at 783 (Burger, C.J., dissenting) (“[T]he decision is fraught with serious physical, psychological, and moral concerns of the highest order.”).

30. *See* Press, *supra* note 16 (discussing experiences of women who used Google to find a physician to perform an abortion).

31. *Casey*, 505 U.S. at 882.

32. *See* William Saletan, *What Happened to the Women*, SLATE (Feb. 16, 2011, 5:34 PM), http://www.slate.com/articles/news_and_politics/the_back_alley/2011/02/what_happened_to_the_women.html (indicating that a grand jury report in the case of Dr. Kermit Gosnell stated that Gosnell “used unlicensed workers to administer anesthesia, failed to obtain patients’ informed consent, gave them expired drugs; endangered their health with poor sanitation and broken equipment, and caused the deaths of at least two women.”).

33. *See* William Saletan, *The Next Gosnell*, SLATE, (Feb. 25, 2011, 7:16 AM), http://www.slate.com/articles/news_and_politics/the_back_alley/2011/02/the_next_gosnell.html (describing examples of misconduct by physicians who perform abortions); Press, *supra* note 16 (discussing Steven Brigham, a physician whose practices endangered women’s lives).

II. A PATH TOWARD MEANINGFUL PRE-ABORTION CONSULTATION

Of course, no regulation will offer absolute assurance that a woman's decision to have an abortion will be fully informed or that the physician who performs the procedure will be careful and competent. Nevertheless, states could take a significant step toward achieving these ends by taking *Roe* at its word and facilitating the type of consultation *Roe* contemplated.³⁴ The model statute included in the Appendix to this Article (the "model statute") attempts to do just that by requiring, in appropriate circumstances, that a woman seeking an abortion consult first with the ob/gyn or internist who provides her with comprehensive—or primary—care (her "primary care physician").³⁵

A. *The Pre-Abortion Consultation Enhancement Act*

To facilitate consultation between a woman and her primary care physician, the model statute, which is entitled the Pre-Abortion Consultation Enhancement Act, requires a doctor performing an abortion for a woman to verify³⁶ that the woman has consulted³⁷ with her primary care physician and has requested a referral from him or her to another physician who might perform the procedure. In addition, the statute specifies that the physician performing the abortion must (i) obtain evidence with respect to any recommendation the woman's primary care physician makes regarding the advisability of the woman's having an abortion and (ii) confirm that the woman's primary care physician made a referral or declined to do so.³⁸

While adding new requirements, the model statute preserves—as it must under the Court's decision in *Casey*—the woman's ability to make the "ultimate decision."³⁹ A woman need not follow her primary care physician's advice or have her abortion performed by the physician to whom her primary care

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

35. *See infra* note 315 and accompanying text (describing the practice areas that are considered primary care under North Carolina law). The model statute requires consultation with a woman's primary ob/gyn if she has one and can get an appointment with him or her within 72 hours. If the woman does not have a primary ob/gyn or cannot get an appointment within 72 hours, the model statute requires consultation with her primary internist. The legislation easily could be modified to require a woman to consult with one or the other or to give her the option to select the doctor to consult. *See Model Statute, infra* APPENDIX Sec. 3(b).

36. The model statute provides a safe harbor for meeting its evidentiary requirements. While not limiting the type of evidence that might satisfy the requirement, the statute includes a prescribed form that, if signed by the woman's primary care physician, will meet the statutory requirement. *See Model Statute, infra* APPENDIX Sec. 3(c).

37. *Id.* Sec. 3(a). As used in this Article, the term "primary care consultation requirement" refers collectively to the requirements set forth in Section 3 of the model statute.

38. If the primary care physician declines to make a referral, the model statute requires the physician performing the abortion to obtain evidence with respect to any reasons why the primary care physician declined to do so. *See id.* Sec. 3(a)(1)(E).

39. *Id.* Sec. 3(e). *See also Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992).

physician refers her, and a primary care physician's recommendation will not impede the physician who performs the abortion from exercising his or her professional judgment.⁴⁰

The model statute also provides relief from the consultation requirement under appropriate circumstances. First, the requirement does not apply in the case of a medical emergency.⁴¹ Second, the model statute provides an exemption if the woman certifies in writing that she has no primary care physician⁴² or has been unable to schedule an appointment within 72 hours of her first attempt to do so.⁴³ Finally, of course, the consultation requirement need not be satisfied when a woman's primary ob/gyn is the physician performing the abortion.⁴⁴

In addition to providing these reasonable exceptions, the model statute contains provisions designed to facilitate meaningful consultation between a woman and her primary care physician. First, to aid women in obtaining a consultation appointment quickly, the model statute requires primary care physicians to treat a woman's request for consultation as a request for urgent care and to schedule an appointment with the woman consistent with any prioritization policy the primary care physician has with respect to appointments for urgent care.⁴⁵ The statute thus aids women in obtaining consultations quickly and shortening any delay the consultation requirement otherwise might impose.⁴⁶ Second, the model statute requires a primary care physician to provide

40. See *Casey*, 505 U.S. at 879 (noting that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability").

41. See Model Statute, *infra* APPENDIX Sec. 3(a).

42. The model statute, of course, offers no benefit to a woman who has no primary care physician. As a result, low-income individuals may be less likely to receive the important assistance the statute offers. One would hope that increased funding of community health centers under the Affordable Care Act, however, will mitigate this problem. See *Health Center Program*, HEALTH RESOURCES & SERVICES ADMINISTRATION, <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf> (last visited July 28, 2016) (detailing the funding for community health centers under the Affordable Care Act and explaining that "health centers emphasize coordinated primary and preventive services or a 'medical home' that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and underserved populations").

43. Model Statute, *infra* APPENDIX Sec. 3(b). Because the model statute requires consultation with a primary internist only if a woman has no primary ob/gyn or cannot get an appointment with her primary ob/gyn within 72 hours, to ensure that she can obtain an abortion with the shortest wait, she would want to try to set up an appointment with her primary ob/gyn and her primary internist contemporaneously. If she is able to get an appointment with her primary ob/gyn, she would cancel the appointment with her primary internist, and if she is unable to get an appointment with either, she could obtain the abortion after having waited only 72 hours.

44. *Id.*

45. *Id.* Sec. 4(a).

46. *Id.* Section 4(a) of the model statute would not help a woman whose physician is located in a jurisdiction that is different from the one in which she plans to have an abortion. If multiple jurisdictions adopt the model, however, the combination of statutes could facilitate the consultation requirement.

such consultation as he or she considers appropriate based on his or her professional judgment.⁴⁷ And third, in an attempt to curb the influence that financial compensation might have on the advice a primary care physician may offer, the model statute bars remuneration for making referrals for abortions.⁴⁸

B. Benefits of the Model Statute

By attempting to fulfill *Roe*'s promise, the model statute offers numerous benefits. Many of these are similar to the benefits associated with getting a second opinion. Others derive from having someone with a broad view of a woman's health involved in such an important decision.

Obtaining a second opinion is a practice that is widely acclaimed when one is considering a serious medical procedure.⁴⁹ The official U.S. Government website for Medicare, for example, recommends a second opinion "if your doctor says you need surgery to diagnose or treat a health problem that [is not] an emergency."⁵⁰ An invited guest on a 2012 NPR Talk of the Nation program about second opinions likewise emphasized that, "when you have a major procedure that's life-altering . . . you really . . . owe it to yourself . . . to get the best advice you can."⁵¹ Moreover, though largely driven by financial concerns rather than patient health, insurers, including Medicare, sometimes require a second opinion before covering certain procedures.⁵²

47. Model Statute, *infra* APPENDIX Sec. 4(c). Like the scheduling provision, this provision would not help a woman whose physician is located in a jurisdiction that is different from the one in which she plans to have an abortion. *See supra* note 46.

48. Model Statute, *infra* APPENDIX Sec. 5.

49. *See* Renée Bacher, *Half of Americans don't get a second opinion*, NBC NEWS (Feb. 4, 2008, 8:48 AM), http://www.nbcnews.com/id/22829371/ns/health-health_care/t/half-americans-dont-get-second-opinion/#.VYLnok_wvcu (indicating that "you must get a second opinion" when "[y]our doctor suggests surgery" and that "[y]ou should always question elective (planned, nonemergency) procedures"); Elizabeth Renter, *3 times you should get a second opinion about your health*, FOX NEWS (Sept. 24, 2014), <http://www.foxnews.com/health/2014/09/26/3-times-should-get-second-opinion-about-your-health/> (indicating that a second opinion is important "[w]hen your doctor recommends a serious but non-emergency surgery"); *Getting a Second Opinion*, CIGNA, <http://www.cigna.com/healthwellness/hw/medical-topics/getting-a-second-opinion-ug5094> (last visited Aug. 18, 2016) [hereinafter CIGNA] ("[A] second opinion may be a good idea if . . . [y]ou are deciding about a costly or risky test or treatment, like a surgery.").

50. *Getting a Second Opinion before Surgery*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.medicare.gov/what-medicare-covers/part-b/second-opinions-before-surgery.html> (last visited Feb. 23, 2016).

51. *Talk of the Nation: When, And How, To Ask For a Second Medical Opinion* (NPR radio broadcast Jan. 19, 2012) [hereinafter NPR Broadcast] (comments by Laura Landro, assistant managing editor of The Wall Street Journal, who had written an article entitled "What if The Doctor is Wrong?").

52. *See Second Surgical Opinion*, UNITEDHEALTHONE, <http://www.goldenrule.com/glossary-terms/second-surgical-opinion/> (last visited Dec. 26, 2016) ("Health insurance plans may require a second opinion about the appropriateness of a surgery before providing coverage for the procedure."); *Seeking a Second Opinion*, CANCER.NET, <http://www.cancer.net/navigating-cancer->

In most cases, abortion is an elective procedure, and the Supreme Court repeatedly has characterized it as a serious one.⁵³ A second opinion, therefore, makes sense when a woman is seeking an abortion, and by requiring her to consult with her primary care physician before having the procedure, the primary care consultation requirement will give her access to the numerous benefits attendant to second opinions generally.

First, the primary care consultation requirement gives a woman another opportunity to be heard⁵⁴ and to learn about her options.⁵⁵ During a consultation with her primary care physician, a woman has the chance to receive a new professional perspective on alternatives to abortion and on the impact of having an abortion in her particular circumstances and considering her history, and this new perspective could result in her choosing childbirth over abortion. In addition, she may receive information regarding her options as to abortion method—whether a particular chemical or surgical procedure might be more beneficial from the standpoint of safety or cost. The primary care consultation requirement, therefore, allows for a more informed decision, while still leaving the final decision to the woman.⁵⁶

Second, the primary physician consultation requirement may result in a woman's receiving better medical treatment. According to James Rohack, a trustee with the American Medical Association, a second opinion is "the key to getting the best diagnosis and treatment."⁵⁷ Doctors make mistakes,⁵⁸ and "[e]vidence is mounting that second opinions . . . can lead to significant changes

care/cancer-basics/cancer-care-team/seeking-second-opinion (last visited Feb. 26, 2016) ("Some insurance providers even require a second opinion before they will pay for cancer treatment."); Bacher, *supra* note 49 ("Insurance, including Medicare, frequently requires second opinions in [the case of elective procedures].").

53. See *supra* note 29 and accompanying text.

54. See Renter, *supra* note 49 (recommending a second opinion "[w]hen you don't feel like you are being heard").

55. See Bacher, *supra* note 49 ("[S]imply knowing your options and thinking through the pros and cons can improve your care."); Jacob Teitelbaum, M.D., *Trust Your Doctor? When to Get a Second Opinion*, HUFFINGTON POST (June 26, 2011), http://www.huffingtonpost.com/jacob-teitelbaum-md/doctor-second-opinion_b_853210.html ("[I]t is good to get a choice of treatment options."); *How to Get a Second Opinion*, NATIONAL WOMEN'S HEALTH INFORMATION CENTER, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, <https://www.womenshealth.gov/publications/our-publications/second-opinion-how-to.pdf> ("Getting a second opinion from a different doctor might give you a fresh perspective and new information. It could provide you with new options for treating your condition.").

56. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) ("What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so."); CIGNA, *supra* note 49 (discussing second opinions and emphasizing that "the final choice is yours").

57. Bacher, *supra* note 49.

58. *Id.* (quoting Gail Gazelle, MD, assistant clinical professor of medicine at Harvard Medical School, as stating "doctors can diagnose any problem incorrectly").

... in recommendations for treating a disease.”⁵⁹ Pregnancy is not a disease, of course, but a misdiagnosed ectopic pregnancy or a mistake in estimating the gestational age of a fetus could have a significant impact on the abortion method a doctor might choose and even on a woman’s decision to terminate her pregnancy.⁶⁰ The primary care consultation requirement helps to ensure that a woman’s abortion provider receives information critical to the woman’s care, thereby enhancing her medical treatment and decreasing the likelihood that she will suffer adverse health consequences as a result of errors a doctor might make because he or she does not have all of the significant facts.

Moreover, the primary care consultation requirement offers the added advantage of insight from a doctor who is particularly familiar with the woman, her medical history, and her particular circumstances. And this familiarity is vital: “An accurate diagnosis depends on you[r] being able to communicate your health history, symptoms and concerns.”⁶¹ In the midst of the trauma that may be associated with an unexpected pregnancy, such communication could prove difficult and a woman might fail to share critical information with the doctor she sees to perform an abortion. By requiring a consultation with an existing physician with whom a woman has a relationship, the primary care consultation requirement reduces the likelihood that a crucial piece of personal medical information will slip through the cracks and result in substandard care.

Third, the primary care consultation requirement protects against the inherent bias a physician has when recommending a procedure from which he or she will benefit financially.⁶² As one doctor points out:

59. Laura Landro, *What if the Doctor Is Wrong?*, WALL ST. J. (Jan. 17, 2012), <http://www.wsj.com/articles/SB10001424052970203721704577159280778957336>.

60. See *Common Questions and Myths, Is medical abortion or aspiration abortion better?*, NATIONAL ABORTION FEDERATION, <http://prochoice.org/think-youre-pregnant/common-questions-and-myths/> (last visited Feb. 26, 2016) (noting that “some women might have medical conditions that would result in her provider recommending one [type of procedure] over the other”); *Pregnancy: Unplanned Pregnancy – About Abortion*, CENTER FOR YOUNG WOMEN’S HEALTH, <http://youngwomenshealth.org/2014/09/05/pregnancy-abortion/> (last updated Sept. 5, 2014) (noting reasons when a medication abortion is not appropriate). In addition, it is not unheard of for a physician to perform an abortion procedure for a woman who is not pregnant. See REARDON, *supra* note 17, at 240 (“*Sun-Times* reporters witnessed dozens of cases in which abortions were performed on non-pregnant women.”).

61. Renter, *supra* note 49.

62. See Bacher, *supra* note 49 (quoting a physician as saying that “there may even be a financial incentive for a physician to recommend one treatment over another”); NPR Broadcast, *supra* note 51 (“[I]t was disappointing that my doctor didn’t want to educate me because he wanted to . . . send me down the mainstream pipeline that’s endorsed by . . . his insurance indemnification And it is the most profitable of things. So, . . . you have to bear in mind that that may be a motive for some large doctors—some large hospital groups.”); See Teitelbaum, *supra* note 55 (recommending that, “if the first opinion came from a doctor in a specific specialty area, consider getting the second opinion from someone of a different but related specialty”).

Unfortunately, medicine [is] a business and economic factors often cloud a practitioner's judgment. This is not because they mean to intentionally misguide you, but there are financial incentives involved If the procedure is done by the recommending physician and is a source of their income, then there is a *heavy* bias to believing that it is good for the patient.⁶³

While physicians who perform abortions may be well-intentioned, they are by no means immune from these biases.⁶⁴ A woman's decision to have an abortion certainly will have a financial impact on the physician whom she approaches to perform the procedure, and the fees the doctor will receive may depend on the method used.⁶⁵ For example, according to the Guttmacher Institute, the average cost in 2009 of a surgical abortion for a pregnancy at 10 weeks was \$451, while the average cost of a medication-induced abortion during that year was \$483.⁶⁶ Dr. LeRoy Carhart, one of the physicians who challenged the federal partial-birth abortion ban in *Gonzales v. Carhart*,⁶⁷ states that "the profit margin is huge" for a particular type of medical abortion and sums up well the risks a woman may face:

"Now you have two types of doctors doing abortions—the doctors who are totally committed to women's health and are going to do them even if they never get another dime, and the people that just want to take advantage of the [decrease in the number of abortion providers] and milk everything they can get out of it."⁶⁸

The primary care consultation requirement offers important protection against these financial biases—whether they are inherent or intentional.

The primary care consultation requirement also offers women benefits beyond those normally associated with second opinions. It may steer women away from unscrupulous doctors like Kermit Gosnell and to more competent ones. In addition, a woman's primary care physician may be able to recommend professionals to help with any psychological or other complications that could arise following an abortion.⁶⁹ Moreover, the requirement gives a woman an

63. Teitelbaum, *supra* note 55 (emphasis added).

64. See REARDON, *supra* note 17, at 235 ("Abortion is big business, as abortion clinic owners are the first to admit. And like other businesses, abortion clinics try to cut costs, increase productivity, and maximize profits."); RACHEL M. MACNAIR, PH.D., *ACHIEVING PEACE IN THE ABORTION WAR* 50–52 (2009) (providing testimony of former abortion counselors regarding marketing efforts by abortion providers).

65. See *infra* note 73 and accompanying text.

66. *Cost of Abortion Services in the United States*, GUTTMACHER INSTITUTE, <http://www.guttmacher.org/in-the-know/abortion-costs.html> (last visited Feb. 26, 2016).

67. 550 U.S. 124 (2007).

68. Press, *supra* note 16 (quoting Dr. Carhart).

69. See generally Catherine Anne Barnhard, Ph.D., *The Long-Term Psychosocial Effects of Abortion* (1991) (unpublished Ph.D. dissertation, Union Institute & University) (analyzing the

additional resource—one who already knows she might have an abortion—in the event complications arise following the procedure. Finally, the requirement will help to ensure that a woman’s primary care physician has information that may be critical to her ongoing care. As one abortion provider notes: “[I]t’s important to recognize that pregnancy and abortion are important parts of your medical history, and we encourage you to be honest with your doctor.”⁷⁰ By requiring a woman to share her decision to have an abortion with her primary care physician, the State thus helps to avoid the serious effects associated with excessive fragmentation in the health care system, effects a guest on NPR’s *Talk of the Nation* warned of: “[W]e’re having a fragmented [health care] system, highly specialized, people going off in different directions, and nobody . . . who’s bringing all of it together [O]ur health care in this country is going to suffer as a result of that.”⁷¹

C. Enhancing Patient Autonomy

Of course, one might argue that the primary care consultation requirement unnecessarily interferes with a woman’s autonomy and that, if a woman wants to consult with her primary care physician, she always can do so. Yet, this argument ignores the risk that a woman may be discouraged from talking with her primary care physician even when she really wants to consult with him or her. Indeed, despite the many benefits second opinions offer, a 2005 Gallup poll found that “almost 50% of Americans never get second opinions.”⁷² The most common reason was a fear of offending a physician,⁷³ and some patients

extent to which Posttraumatic Stress Disorder affects women who have had abortions); Teitelbaum, *supra* note 55.

70. *Abortion Clinics: Frequently Asked Questions*, SUMMIT MEDICAL CENTERS, <https://www.summitcenters.com/frequently-asked-questions.html> (last visited Mar. 4, 2016) [hereinafter *Questions*].

71. NPR Broadcast, *supra* note 51 (comments by Dr. Leonard Lichtenfeld, deputy chief medical officer for the American Cancer Society).

72. Bacher, *supra* note 49.

73. *See id.* (“Telling your doctor you want to see someone else for a second opinion can be awkward”); NPR Broadcast, *supra* note 51 (“[D]oesn’t asking a second opinion insult the doctor? How could it not? You’re saying that you don’t trust his opinion.”); Renter, *supra* note 49 (“Many people are nervous about getting a second opinion, worried their doctor will be angry.”); CIGNA, *supra* note 49 (indicating that a patient ought not worry about “offending [his or her] doctor”); Elizabeth Cohen, *Five diagnoses that call for a second opinion*, CNN (Aug. 30, 2007, 7:05 PM), <http://www.cnn.com/2007/HEALTH/08/30/ep.second.opinion/index.html> (“Even if it’s hard, patients need to question their doctors.”); *Should I Get a Second Opinion?*, CENTER FOR ADVANCING HEALTH, <http://www.cfah.org/prepared-patient/make-good-treatment-decisions/should-i-get-a-second-opinion/> (last visited Feb. 26, 2016) (“Others worry that their actions will be seen as a ‘betrayal’”); *How to Get a Second Opinion*, OFFICE OF WOMEN’S HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, <https://www.womenshealth.gov/publications/our-publications/second-opinion-how-to.pdf> (last updated Sept. 10, 2008) (“Don’t worry about hurting your doctor’s feelings.”).

expressed concern that “they [would] receive worse care if they appear to be pushy or difficult patients.”⁷⁴ Moreover, “[m]any people feel uncomfortable with questioning the authority or expertise of their physician.”⁷⁵ A woman seeking an abortion would not be insulated from these disincentives, and in fact, she may be more susceptible to them if she perceives her pregnancy to be a crisis.

When considering state-mandated measures designed to inform a woman’s choice about abortion, there is a tendency to make several common assumptions: all women seeking abortions are the same, all doctors providing abortion services are the same, all women know whether they want additional information and will not hesitate to seek it out, and all doctors will offer and deliver freely whatever additional information at their disposal a woman might request. But the universe of women seeking abortions and the universe of doctors performing them obviously are not so limited. Some women might be ambivalent about receiving certain information, but feel better after having it.⁷⁶ Others may want more information, but might not get it because a doctor is reluctant to provide the information⁷⁷ or has suggested implicitly that it would be a bother given his or her already busy schedule.

All situations will be different, and the primary care consultation requirement accommodates these many differences by ensuring that a woman who wants meaningful consultation has an opportunity to get it. The requirement, for example, will help a woman who is uncertain about her decision and wants to consult an already familiar physician, but is experiencing pressure—from spouses, boyfriends, parents, friends, or perhaps just societal expectations—not to do anything that would cause a delay. It likewise will assist a woman who wants meaningful consultation, but will not receive it from the doctor she approaches for the abortion. Indeed, the model statute’s “one-size-fits-all” approach, rather than impeding patient autonomy, enhances it.⁷⁸

74. *Should I Get a Second Opinion?*, CENTER FOR ADVANCING HEALTH, <http://www.cfah.org/prepared-patient/make-good-treatment-decisions/should-i-get-a-second-opinion> (last visited Feb. 26, 2016).

75. *Id.* See also Renter, *supra* note 49 (“If you’re like most Americans, you trust your physician to deliver an accurate diagnosis, and are reluctant to second-guess her judgment. After all, she’s the one in the white coat with the expensive degree under her belt.”).

76. See, e.g., Stephanie Pappas, *Abortion Debate: Little Evidence Sonograms Change Minds, Doctors Say*, LIVE SCIENCE (Feb. 16, 2011, 3:35 PM), <http://www.livescience.com/12886-abortion-sonogram-research.html> (noting that a 2009 study found that 86% of women who chose to view ultrasound images “said it was a positive experience”).

77. See *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (noting that “some doctors may prefer not to disclose precise details of the means that will be used [to perform an abortion], confining themselves to the required statement of risks the procedure entails”).

78. *Contra* *Stuart v. Camnitz*, 774 F.3d 238, 251–54 (4th Cir. 2014), *cert denied* 135 S. Ct. 2838 (2015) (stating that a patient’s autonomy with respect to informed consent is undermined when the state chooses the manner and script that the doctor employs when interacting with the patient).

To be sure, for women who are absolutely certain about their decision, the primary care consultation requirement may seem to be yet another box to check off, a measure that does nothing more than result in delay and additional expense. For a woman who is unsure, fearful, or under subtle or overt pressure, however, the requirement offers an important refuge, one that might “reduc[e] the risk that [she will] elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.”⁷⁹

III. A REQUIREMENT THAT RESPECTS A WOMAN’S CONSTITUTIONAL RIGHTS

The primary care consultation requirement offers women the many benefits described above, but to deliver these benefits, the requirement must respect women’s constitutional rights. And this it does. As the Supreme Court in *Casey* teaches, “[w]hat is at stake is the woman’s right to make the ultimate decision, not a right to be insulated from all others in doing so.”⁸⁰ The primary care consultation requirement attempts to break down the barriers that might insulate a woman from the necessary counsel that *Roe* contemplated,⁸¹ but the requirement always leaves to the woman the ultimate decision as to whether to have an abortion.

A. *The Primary Care Consultation Requirement Does Not Create an Undue Burden on a Woman’s Right to Choose*

1. *Planned Parenthood v. Casey and Whole Woman’s Health v. Hellerstedt*

Though one commonly thinks of *Roe* as providing the norm for assessing the constitutionality of abortion regulations under the Fourteenth Amendment, *Casey*—not *Roe*—now governs.⁸² Indeed, the Supreme Court in *Casey* discarded *Roe*’s “rigid trimester framework”⁸³ in favor of what the Court described as *Roe*’s essential holding, a holding consisting of three parts:

First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State’s interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman’s effective right to elect the procedure. Second is a confirmation of the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman’s life or health. And third is the principle that the State has legitimate interests from the outset of

79. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992).

80. *Id.* at 877.

81. See *supra* note 21 and accompanying text.

82. See *infra* notes 86–90 and accompanying text.

83. *Casey*, 505 U.S. at 873.

the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.⁸⁴

According to the *Casey* Court, the trimester framework departed from *Roe*'s essence by overemphasizing a woman's interest in choosing abortion and undervaluing the State's interest in protecting potential life,⁸⁵ an interest that *Roe* itself recognized as "important and legitimate."⁸⁶ Having identified this failing, the Court decided that it needed a new standard to restore the proper equilibrium.⁸⁷

The Court accordingly adopted what it described as the "undue burden" standard and, in so doing, sought to achieve the appropriate balance by measuring the degree to which an abortion regulation interferes with a woman's right to choose abortion before viability.⁸⁸ Under its new standard, the Court explained, a law impermissibly interferes with a woman's right to choose if the law's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."⁸⁹ Absent such a purpose or effect, however, reasonable laws aimed at protecting potential life and "regulations designed to foster the health of a woman" will be upheld.⁹⁰

Having articulated the standard, the *Casey* Court then applied it to the Pennsylvania statute at issue in the case, a law that specified what information a

84. *Id.* at 846.

85. *See id.* at 873 (holding that "[t]he trimester framework suffers from these basic flaws: in its formulation it 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*.").

86. *Roe v. Wade*, 410 U.S. 113, 162 (1973). *See Casey*, 505 U.S. at 873 (indicating that *Roe* had recognized the State's interest in protecting potential life).

87. *See Casey*, 505 U.S. at 873.

88. *See id.* at 876 (stating "[i]n our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty.>").

89. *Id.* at 878.

90. *Id.* Justice O'Connor's dissent in *Akron* suggests that *Casey*'s reference to reasonableness connotes rational basis review for regulations that do not pose an undue burden. *See City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 453 (1983) (O'Connor, J., dissenting) ("If the particular regulation does not 'unduly burden' the fundamental right, then our evaluation of that regulation is limited to our determination that the regulation rationally relates to a legitimate state purpose." (internal citation omitted)). The Court's decision in *Hellerstedt*, however, rejects this interpretation and indicates that *Casey* requires a more searching review. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (indicating that the Fifth Circuit Court of Appeals, in applying the second part of *Casey*'s test, was "wrong to equate the judicial review applicable to the regulation of a constitutionally protected liberty with the less strict review applicable where, for example, economic legislation is at issue").

As to post-viability measures, *Casey* retained *Roe*'s standard, which allows States to regulate or ban abortion, so long as exceptions are made in circumstances when a woman's life or health is in danger. *See Casey*, 505 U.S. at 879 ("We also reaffirm *Roe*'s holding that 'subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'" (quoting *Roe*, 410 U.S. at 164–65)).

woman must receive as a prerequisite to obtaining her informed consent and that included a mandatory 24-hour waiting period, a spousal notification requirement, and a parental consent requirement.⁹¹ With the exception of the spousal notification provision, the Court concluded that none of these measures posed an undue burden on a woman's right to choose abortion before viability and therefore they were consistent with a woman's rights under the Fourteenth Amendment.⁹²

Pennsylvania's informed consent provision charged a physician who was to perform an abortion with the responsibility to "inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the 'probable gestational age of the unborn child.'"⁹³ In addition, the provision required the physician or another qualified person to tell the woman about the availability of State-prepared information regarding abortion alternatives, medical assistance, the father's obligations, and the development of an unborn child.⁹⁴ According to the Court, neither aspect of Pennsylvania's informed consent mandate imposed an undue burden.⁹⁵

In reaching its conclusion that the informed consent provisions passed muster, the Court overruled its previous decisions in *City of Akron v. Akron Center for Reproductive Health, Inc.*⁹⁶ and *Thornburgh v. American College of Obstetricians and Gynecologists*⁹⁷ to the extent that those decisions applied *Roe*'s trimester framework to strike down requirements that a woman be given a specific body of information before an abortion.⁹⁸ The Court explained that, in *Akron* and *Thornburgh*, it had attached insufficient weight to the State's important interest in protecting potential life:

It cannot be questioned that psychological well-being is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.⁹⁹

91. See *Casey*, 505 U.S. at 844 (describing the components of the Pennsylvania statute).

92. See *id.* at 881–900 (upholding the informed consent, waiting period, and parental consent provisions and striking down the spousal notification requirement).

93. *Id.* at 881.

94. *Id.*

95. *Id.* at 881–900.

96. 462 U.S. 416 (1983).

97. 476 U.S. 747 (1986).

98. *Casey*, 505 U.S. at 882.

99. *Id.*

Moreover, the Court emphasized that a State may “enact[] legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.”¹⁰⁰

The Court in *Casey* likewise upheld Pennsylvania’s 24-hour waiting period under the undue burden standard, finding that the waiting period afforded a woman a reasonable amount of time to consider her decision: “the idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision.”¹⁰¹ The Court was unconvinced that the practical effects of the 24-hour waiting period—that women who live some distance away from the abortion facility may need to make two trips, resulting in a longer effective waiting period, and that women would be subject to harassment by abortion protesters twice—gave rise to a substantial obstacle.¹⁰² Moreover, the Court explained that increased costs and delays do not, in and of themselves, create a substantial obstacle.¹⁰³ Finally, while acknowledging that the waiting period infringed upon on the physician’s ability to exercise judgment, the waiting period did not present a serious health risk for the woman because it did not apply in the case of medical emergencies.¹⁰⁴

The Court easily concluded that Pennsylvania’s parental consent requirement was constitutional, noting that the Court had approved similar measures in the past¹⁰⁵ and stating that “[r]egulations which do no more than create a structural mechanism by which . . . [a] parent or guardian . . . may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman’s exercise of the right to choose.”¹⁰⁶ On the other hand, the Court found that Pennsylvania’s spousal notification requirement impermissibly encroached on a woman’s right to choose because, “in a large fraction of the cases in which [the spousal notification provision was] relevant, it [would] operate as a substantial obstacle.”¹⁰⁷ Defining the relevant population as “married women . . . who do not wish to notify their husbands of their intentions”

100. *Id.* at 883.

101. *Id.* at 885.

102. *Id.* at 885–86.

103. *Id.* at 886 (“We do not doubt that, as the District Court held, the waiting period has the effect of ‘increasing the cost and risk of delay of abortions,’ but the District Court did not conclude that the increased costs and potential delays amount to substantial obstacles.”) (citation omitted).

104. *Id.*

105. *See id.* at 899 (“Our cases establish, and we reaffirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure.”).

106. *Id.* at 877.

107. *Id.* at 895.

and who would not qualify for an exception to the notification requirement,¹⁰⁸ the Court cited detailed district court findings regarding the risks of abuse to a large fraction of these women and their children.¹⁰⁹ For these women, according to the Court, the spousal notification requirement in substance constituted an abortion ban.¹¹⁰

Now, almost 25 years later, the Court in *Hellerstedt* has employed the undue standard to strike down Texas regulations that required physicians performing abortions to have admitting privileges at nearby hospitals and that required abortion facilities to meet the minimum standards applicable to ambulatory surgery centers.¹¹¹ Purporting to be faithful to *Casey*, the Court indicated that the undue burden standard is a balancing test that requires a court to weigh the burdens of an abortion regulation against its benefits¹¹² and not merely to consider whether the regulation “ha[s] the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus,” with deference to the legislature if it does not have that purpose or effect.¹¹³ According to the Court, under this balancing test, Texas’s admitting privileges and ambulatory surgery center requirements were invalid.¹¹⁴

In applying the undue burden test, the Court in *Hellerstedt* assumed that both Texas regulations were aimed at protecting maternal health,¹¹⁵ which both *Roe* and *Casey* identified as a legitimate state interest.¹¹⁶ The Court determined, however, that neither regulation conferred appreciable health benefits to women who have abortions. In reaching this conclusion, the Court credited detailed findings by the district court indicating that performing an abortion was a safe procedure in Texas already.¹¹⁷ Moreover, with respect to the ambulatory surgery center requirement, the Court pointed to record evidence that other

108. *Id.*

109. *Id.* at 888–95 (citing district court findings and several studies as to the risk of abuse).

110. *See id.* at 894 (“[T]he significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases.”).

111. *See Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (describing the Texas regulations and concluding that they could not satisfy *Casey*’s undue burden test).

112. *See id.* at 2309 (indicating that the undue burden test is not a deferential standard, but requires a court to consider a regulation’s benefits and burdens).

113. *Id.*

114. *See id.* at 2309 (striking down each of the Texas regulations as unduly burdensome).

115. *See id.* at 2310 (inferring the relevant state interest).

116. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (referencing *Roe* and indicating that a state has a legitimate interest in “protecting the health of the woman”).

117. *See Hellerstedt*, 136 S. Ct. at 2311–12 (indicating that “there was no significant health-related problem that the [admitting privileges requirement] helped to cure” and summarizing detailed evidence supporting that conclusion); *id.* at 2315 (“There is considerable evidence in the record supporting the District Court’s findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary.”).

procedures—including childbirth, colonoscopies, and liposuction—pose greater health risks than abortion, but nevertheless may be performed in facilities that do not meet Texas’s ambulatory surgical center standards.¹¹⁸ Finally, the Court rejected the suggestion that the admitting privileges and ambulatory surgery center requirements would cause unsafe facilities to shut down.¹¹⁹ According to the Court, “[d]etermined wrongdoers, already ignoring existing statutes and safety measures, are unlikely to be convinced to adopt safe practices by a new overlay of regulations.”¹²⁰

The *Hellerstedt* Court also decided that the Texas admitting privileges and ambulatory surgery center requirements imposed a number of burdens on—or substantial obstacles in the path of—women seeking abortions pre-viability.¹²¹ In this regard, the Court credited evidence suggesting that the requirements both individually and collectively caused the number of abortion facilities to decrease dramatically.¹²² The closures resulting from the admitting privileges requirement, the Court asserted, would result in “fewer doctors, longer waiting times, and increased crowding” and would require women to drive longer distances for abortion services.¹²³ Furthermore, the Court insisted, the record included ample evidence that the ambulatory surgery center requirement would leave an insufficient number of clinics to meet the demand for abortions in Texas.¹²⁴ Moreover, the Court was concerned that the clinic closures would “force women to travel long distances to get abortions in crammed-to-capacity superfacilities” in which women are “less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered.”¹²⁵

The “individualized attention, serious conversation, and emotional support” that the *Hellerstedt* Court identified as so important are precisely what the primary care consultation requirement is designed to achieve. Nevertheless, because the Court considered the Texas regulations at issue in *Hellerstedt* only in relation to the state’s interest in maternal health, it is unclear how the undue

118. *See id.* at 2315 (comparing the safety of abortion to that of other procedures).

119. *See id.* at 2313 (rejecting a benefit the dissent cited).

120. *Id.* at 2313–14.

121. *See id.* at 2312, 2316 (indicating that both Texas regulations represented substantial obstacles).

122. *See Hellerstedt*, 136 S. Ct. at 2312, 2316 (noting that the lower court had found that, “as of the time the admitting-privileges requirement began to be enforced, the number of facilities . . . dropped in half, from about 40 to about 20” and that the parties agreed that the ambulatory surgery requirement would further reduce the number of facilities to seven or eight).

123. *Id.* at 2313. While the Court acknowledged that increased driving distances alone would not represent an unconstitutional burden, it stated that it was “one additional burden” that would weigh against the lack of any health benefit. *Id.*

124. *See id.* at 2316 (discussing the district court’s conclusion regarding the ability of the remaining Texas clinics to meet demand).

125. *Id.* at 2318.

burden test applies to informed consent measures (like the primary care consultation requirement) that advances both the state's interest in protecting the unborn and its interest in safeguarding maternal health. In describing what *Casey* requires, the Court in *Hellerstedt* indicated only that *Casey* employed a balancing test in assessing Pennsylvania's parental consent and spousal notification laws; the *Hellerstedt* opinion says nothing of *Casey*'s treatment of Pennsylvania's informed consent and waiting period provisions.¹²⁶ Therefore, one reasonably might argue that the undue burden test does not require balancing with respect to a regulation like the primary care consultation requirement.¹²⁷ Nevertheless, even if the balancing test described in *Hellerstedt* would apply, the primary care consultation requirement satisfies the test because the requirement shares the characteristics of the Pennsylvania informed consent and waiting period provisions at issue in *Casey*, and in some respects, imposes fewer burdens than the Pennsylvania regulations.

The model statute fits neatly within the bounds of *Casey*'s rationale for upholding the Pennsylvania informed consent and waiting period requirements for a number of reasons. First, the primary care consultation requirement is "aimed at ensuring a decision that is mature and informed,"¹²⁸ thereby reducing the "risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."¹²⁹ Through the primary care consultation requirement, a woman should receive valuable information from a physician who knows her well, information that a physician who sees a woman only for the purpose of having an abortion may not have and information that an abortion provider may be reluctant to provide given his or her financial interest in a woman's decision to choose abortion. Moreover, the primary care consultation requirement yields the numerous other benefits detailed in Section II.B of this Article, including the likelihood of receiving better medical care. Though an abortion provider may

126. *Id.* at 2309 (referencing only Pennsylvania's parental consent and spousal notification provisions in support of the assertion that *Casey* "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer").

127. The Court in *Casey* nowhere uses the word "benefit" in its discussion of Pennsylvania's informed consent and waiting period provisions. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 881–87 (1992) (addressing the informed consent and waiting period requirements). And in assessing the spousal notification and parental consent provisions, the Court only uses the term "benefit" in relation to the interest of a woman's spouse in participating in the choice to have an abortion and the state's interest in protecting minors. See *id.* at 887–900 (discussing the spousal notification and parental consent provisions). Thus, it seemed that the *Casey* Court's undue burden test itself struck the balance with respect to the states' interests in protecting women's health and unborn life and that the test only required additional balancing when interests other those considered in *Roe* were at play. See Thomas J. Molony, *Roe, Casey, and Sex-Selection Abortion Bans*, 71 WASH. & LEE L. REV. 1089, 1109–29 (suggesting that a sex-selection abortion ban might survive *Casey*'s undue burden test because such a ban serves other interests).

128. *Casey*, 505 U.S. at 883.

129. *Id.* at 882.

ask about a woman's medical history, it seems rather unremarkable to say that the abortion provider will have a much more superficial understanding of a woman and her health than her primary care physician will. Furthermore, amidst the trauma of an unplanned pregnancy, a woman may forget to share with the abortion provider important health information relevant to the woman's decision and the abortion method the physician may choose.

Second, the primary care consultation requirement imposes no burden on a physician's ability to exercise his or her medical judgment.¹³⁰ The requirement, like the Pennsylvania informed consent and waiting period provisions, does not apply in the case of medical emergencies.¹³¹ In addition, it specifically provides that it does not limit the right of a physician to perform an abortion.¹³² Furthermore, nothing in the statute dictates what information either a primary care physician or an abortion provider must provide a woman.¹³³ While the statute requires a primary care physician to consult with a woman who secures an appointment for consultation as contemplated by the law, the physician is free to determine, based on each particular woman's circumstances, what information might be beneficial to her in her decision-making process and what may pose a danger to her health.¹³⁴ In many (if not most) cases, a primary care physician possesses a deeper understanding of a patient's health and circumstances. Therefore, a woman's primary care physician may be better able to assess how providing certain information might affect her, and the physician is free to share this assessment with the abortion provider, further advancing the state's interest in protecting a woman's health.

Third, the primary care consultation requirement is consistent with customary medical practice in some contexts. For example, it is not unusual for insurance plans to require a referral from a primary care doctor before one sees a specialist.¹³⁵ As one abortion provider notes, "[d]epending on your policy, it may be necessary to obtain a referral from a primary care physician before setting up an abortion appointment."¹³⁶ Even when a referral is not required by an insurance plan, seeing a primary care physician before seeing a specialist is a

130. See Model Statute, *infra* APPENDIX Sec. 3.

131. *Id.* Sec. 3(a) ("Except in the case of a medical emergency, no abortion shall be performed upon a woman in this State unless, before the performance of the abortion, the physician who will perform the abortion has received . . .").

132. *Id.* Sec. 3(e)(ii) (stating "neither the recommendation of a woman's primary care physician nor any referral by such person shall limit . . . the ability of a physician to perform an abortion for the woman.>").

133. See generally *id.* Sec. 3. See also *Casey*, 505 U.S. at 883–84.

134. See generally Model Statute, *infra* APPENDIX Sec. 4.

135. See *supra* note 28 and accompanying text (noting that insurance plans may condition coverage of the costs of seeing specialist on a referral from a person's primary care physician).

136. *Abortion FAQs, Does my insurance cover the cost of an abortion?*, FEMINIST WOMEN'S HEALTH CENTER, <http://www.feministcenter.org/abortion-care/faqs-about-abortion> (last visited Mar. 5, 2016).

common practice.¹³⁷ Therefore, though the law may not require a primary care consultation in other circumstances, it certainly is not outside the norm of medical practice and it aligns with what one would expect when considering a serious medical procedure.¹³⁸ Moreover, the Supreme Court determined in *Planned Parenthood of Central Missouri v. Danforth*¹³⁹ that a State has flexibility to adopt different requirements for different types of procedures.¹⁴⁰ And even if the abortion procedure is safer than a diagnostic procedure like a colonoscopy or liposuction as the Court in *Hellerstedt* asserted,¹⁴¹ the abortion decision is different in kind from those other procedures because it implicates the unborn, whom the state has an important interest in protecting.

Fourth, the fact that the primary care consultation requirement could impose additional costs and delays does not mean that it imposes an undue burden under *Casey*.¹⁴² To be sure, the primary care consultation requirement will impose an additional cost on a woman seeking an abortion—the cost of an additional doctor’s visit¹⁴³—but, as the Court in *Casey* determined, additional costs alone are not sufficient to invalidate an abortion regulation:

137. See Barbara Starfield, Leiyu Shi, & James Macinko, *Contribution of Primary Care to Health Systems and Health*, 83 THE MILBANK Q. 457, 464 (2005), http://www.commonwealth.fund.org/usr_doc/Starfield_Milbank.pdf (“In some health systems, both in the United States and abroad, people normally go to their primary care physician before seeking care elsewhere (such as from another type of physician).”).

138. See *Casey*, 505 U.S. at 846 (discussing a state’s interest in protecting unborn life).

139. 428 U.S. 52 (1976).

140. See *id.* at 67 (“[W]e see no constitutional defect in requiring [informed consent] only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions.”); see also *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 430 (1983) (“In *Danforth*, . . . we unanimously upheld two Missouri statutory provisions, applicable to the first trimester, requiring the woman to provide her informed written consent to the abortion and the physician to keep certain records, *even though comparable requirements were not imposed on most other medical procedures.*” (emphasis added)).

141. See *Hellerstedt*, 136 S. Ct. at 2315 (describing the risks of other procedures). The *Hellerstedt* opinion also indicates that the risks of childbirth are higher than the risk of abortion, but a woman giving birth very likely will involve her primary ob/gyn at least in some respects. See *id.* (indicating the risk of childbirth in comparison to abortion); *What Type of Practitioner is Right for Your Pregnancy*, WHAT TO EXPECT, <http://www.whattoexpect.com/pregnancy/doctor-type/> (last visited July 28, 2016) (“More than 90 percent of women choose an . . . [OB-GYN to guide them through pregnancy] . . . Because your OB-GYN can function as your primary care physician, he or she can make an excellent partner even after baby arrives.”).

142. See *Casey*, 505 U.S. at 886.

143. According to Healthcare Bluebook, \$278 is a fair price for a 40-minute consultation with respect to a complex medical problem. *Office Visit, Established Patient (40 min.)*, HEALTHCARE BLUEBOOK, https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=227&dataset=MD&g=Office+Visit%2c+Established+Patient%2c+Level+5 (last visited Feb. 26, 2016). The cost of the additional doctor’s visit, however, should be the sole additional cost. One would expect that, in most cases, a woman’s primary care physician will be located near the woman’s residence. Therefore, the consultation requirement typically should not result in any significant travel costs.

Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.¹⁴⁴

Moreover, the cost of an additional doctor's visit is minimal when weighed against the seriousness of woman's decision regarding abortion,¹⁴⁵ the benefits of robust consultation, and the "risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."¹⁴⁶

And while the primary care consultation requirement could result in some delay in a woman's being able to have an abortion, the Court in *Casey* determined that a delay that allows a woman to consider important information is constitutional: "The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision."¹⁴⁷ Importantly, the primary care consultation requirement facilitates a woman's receipt of information tailored to her unique circumstances, thereby adding to the reasonableness of any delay. Furthermore, the model statute contains measures designed to obviate inherent difficulties a woman may have in getting a consultation with her primary care physician: (i) it requires physicians to treat a woman's request for consultation as a request for urgent care, perhaps facilitating a woman's ability to get in to see her doctor on short notice and (ii) it places a 72-hour limit on the time in which a woman must seek a consultation. If a woman makes a diligent effort to schedule an appointment with her primary care physician and is unable to do so within 72 hours, the consultation provision does not apply if the woman so certifies.¹⁴⁸ Of course, some women may be able to get in to see their doctors more quickly, but for those who cannot do so, the model statute offers a reasonable limit.¹⁴⁹

144. *Casey*, 505 U.S. at 874.

145. *Id.* at 873 (describing the decision to have an abortion as one that has "profound and lasting meaning").

146. *Id.* at 882.

147. *Id.* at 885.

148. See Model Statute, *infra* APPENDIX Sec. 3(b) ("The requirements under Section 3(a)(i) shall not apply if, prior to the abortion, the physician who will perform the abortion receives from the woman a written certification that the woman . . . has been unable to schedule an appointment for urgent care with her primary ob/gyn for a time within 72 hours of her first attempt to schedule of her first attempt to schedule such an appointment.").

149. The 72-hour limit is consistent with waiting period recently adopted in some states. See *State Policies in Brief, Counseling and Waiting Periods for Abortion*, GUTTMACHER INSTITUTE (Feb. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (indicating that

Fifth, while imposing the consultation requirement may express a preference for childbirth over abortion, *Casey* permits expression of this preference based on the State's interest in protecting potential life: "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest."¹⁵⁰ In this respect, the primary care consultation requirement is less burdensome than the Pennsylvania informed consent provision at issue in *Casey*¹⁵¹ because, unlike the Pennsylvania law, the model statute does not control what a physician shares with a woman, and as one abortion provider states, "most OB/GYN[s] are supportive of all reproduction choices, including abortion."¹⁵² Moreover, because of the anti-kickback provision in the model statute, a woman is more likely to receive medical advice free from any underlying financial bias in favor of abortion.¹⁵³

Finally, and perhaps most importantly for abortion rights advocates, the primary care consultation requirement does not prevent a woman from making "the ultimate decision."¹⁵⁴ The requirement is designed to inform a woman's choice, not to impede it—the model statute is explicit that a woman remains free to choose abortion against her primary care physician's advice and to have an abortion performed by a doctor of her choosing.¹⁵⁵ Thus, like the informed

Missouri, North Carolina, South Dakota, and Utah require a 72-hour waiting period before a woman has an abortion). And in a 2011 lawsuit, the plaintiffs dropped their challenge with respect to South Dakota's 72-hour waiting period. See Order Dissolving in Part and Continuing in Part the Modified Preliminary Injunction, *Planned Parenthood Minnesota, North Dakota, South Dakota v. Daugaard*, Civ. 11-4071-KES, at 2 (D.S.D. June 11, 2013) (indicating that the plaintiffs dismissed their claim with respect to South Dakota's 72-hour waiting period).

150. *Casey*, 505 U.S. at 886. See also *id.* at 878 (noting that, unless it imposes an undue burden, "a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal"), 883 ("[W]e permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the State expresses a preference for childbirth over abortion.").

151. See *id.* at 844.

152. *Questions*, *supra* note 70. See also Amy Norton, *Few U.S. ob-gyns provide abortions: study*, REUTERS (Sept. 1, 2011, 1:12pm), <http://www.reuters.com/article/2011/09/01/us-abortion-issues-idUSTRE7804JN20110901> (indicating that the issue is "not that large numbers of doctors 'don't believe in abortion'").

153. Of course, a primary care physician may not be immune entirely from financial incentives because, in the course of the consultation, the physician might propose that the physician himself or herself perform the abortion. But evidence indicates that most ob/gyns who provide comprehensive services do not perform abortions. See Norton, *supra* note 152 ("Only a small percentage of ob-gyns offer abortion services, despite a high demand for them.").

154. *Casey*, 505 U.S. at 877.

155. See *Casey*, 505 U.S. at 877 ("A statute [whose purpose is to create a substantial obstacle] is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it."). See also Model Statute, *infra* APPENDIX Sec. 3.

consent provision in *Casey*,¹⁵⁶ the primary care consultation requirement offers a woman the opportunity to be better informed, while respecting the freedom to choose that the Court recognized in *Roe* and *Casey*.¹⁵⁷

Therefore, the primary care consultation requirement and the informed consent and waiting period provisions in *Casey* share similar attributes.¹⁵⁸ At the same time, the consultation requirement is markedly different from the spousal notification provision that the *Casey* Court struck down and the admitting privileges and ambulatory surgery center requirements the *Hellerstedt* Court declared unconstitutional.

In *Casey*, the Court determined that the spousal notification requirement imposed an undue burden because of the specter that a woman would choose not to have abortion because she feared that she would be abused, that her children would be abused, or that her decision would be shared with others.¹⁵⁹ These concerns are virtually non-existent with respect to the primary care consultation requirement. It would seem extremely rare for a woman to fear physical or psychological abuse from her primary care physician. And given the ethical obligations of doctors to maintain patient confidentiality¹⁶⁰ and the significant legal limitations on disclosing personal health information,¹⁶¹ it is very unlikely that a woman would have a reasonable fear that her decision would be disclosed to others without her consent. Moreover, mindful of confidentiality concerns, the model statute requires primary care physicians to notify women of their right to revoke any consent they previously provided regarding the disclosure of personal health information and to facilitate the process of revoking any such

156. *Casey*, 505 U.S. at 844.

157. *Roe v. Wade*, 410 U.S. 113, 153 (1973); *Casey*, 505 U.S. at 859.

158. *See Casey*, 505 U.S. at 844; Model Statute, *infra* APPENDIX Sec. 3.

159. *See Casey*, 505 U.S. at 893 (“Many may have justifiable fears of physical abuse Many may have a reasonable fear that notifying their husbands will provoke further instances of child abuse Many may fear devastating forms of psychological abuse from their husbands, including . . . disclosure of the abortion to family and friends.”).

160. *See AMA Code of Medical Ethics, Opinion 10.01 – Fundamental Elements of the Patient-Physician Relationship*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page> (last visited Mar. 5, 2016) (“The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.”).

161. *See, e.g.*, Health Insurance Portability and Accountability Act of 1996 § 1177, 42 U.S.C. § 1320d-6 (2012) (imposing penalties for disclosing “individually identifiable health information”).

consent.¹⁶² Therefore, the primary care consultation requirement hardly represents an “effective veto” over the woman’s decision to choose abortion.¹⁶³

The model statute likewise is free from the problems the Court identified in *Hellerstedt*. The *Hellerstedt* Court determined that Texas’s admitting privileges and ambulatory surgery center requirements conferred no benefit with respect to maternal health because they would not make abortion any safer and that they imposed significant burdens by causing abortion facilities to close, thereby leaving an insufficient number of clinics to meet demand, causing overcrowded facilities and increased waiting times, and denying women the ability to receive meaningful consultation.¹⁶⁴ Even if one concluded that the health-related benefits of the primary care consultation requirement were merely speculative, the consultation requirement nevertheless advances the state’s interest in protecting unborn life by assisting a woman in making an informed decision, a benefit sufficient to support the informed consent and waiting period provisions in *Casey*.¹⁶⁵ Moreover, the primary care consultation requirement will not result in any clinic closures (except perhaps those that are unsafe, if primary care physicians regularly steer women away from them), and rather than denying women individual attention and care, the requirement facilitates those things.¹⁶⁶ Indeed, the only burdens the requirement imposes are those that the Court in *Casey* determined were not undue.¹⁶⁷

Before *Hellerstedt*, however, the U.S. District Court for the District of South Dakota in *Planned Parenthood Minnesota, North Dakota, South Dakota v. Daugaard*¹⁶⁸ invoked *Casey*’s undue burden standard to enjoin a consultation requirement of a different sort—one that required a visit to a “pregnancy help center.”¹⁶⁹ *Daugaard* involved a South Dakota statute that barred a physician from performing an abortion for a woman unless the physician first obtained the

162. See Model Statute, *infra* APPENDIX Sec. 4(b) (providing that a doctor “shall inform the woman of her right to withhold consent to disclosure to third parties of the substance of any information discussed during the course of the consultation and shall provide the woman with such forms as may be necessary to revoke any consent previously given that otherwise would authorize the physician to make such disclosures.”). Of course, this provision would not apply to primary care physicians located outside the State imposing the consultation obligation, but it seems likely that physicians on their own—and mindful of patient concerns—would remind women of their ability to revoke consent.

163. *Casey*, 505 U.S. at 897.

164. See *supra* notes 121–25 and accompanying text (discussing *Hellerstedt*).

165. See *Casey*, 505 U.S. at 885 (indicating that requiring time for reflection is reasonable, particularly when important information is made available).

166. See *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2312–14, 2316–18 (2016) (discussing evidence that the Texas regulations caused clinic closures and the burdens associated with such closures).

167. See *supra* notes 88–90 and accompanying text (discussing the costs and delay associated with the primary care consultation requirement).

168. 799 F. Supp. 2d 1048 (D.S.D. 2011).

169. *Id.* at 1063.

woman's written certification that she had consulted with a "pregnancy help center," a term the law defined to mean an entity that offers services to encourage pregnancy over abortion, does not itself perform abortions, is not affiliated with an abortion provider, and does not make referrals for abortions.¹⁷⁰ Planned Parenthood and a physician challenged the law, claiming that it posed an undue burden on a woman's right to choose and therefore was invalid under *Casey*.¹⁷¹

The district court agreed, finding that the pregnancy help center consultation requirement was relevant only to those women "who have chosen to undergo an abortion and would otherwise not consult with a pregnancy help center,"¹⁷² and that for a "large fraction" of those women, the requirement constituted a substantial obstacle to choosing abortion.¹⁷³ According to the court:

Forcing a woman to divulge to a stranger at a pregnancy help center the fact that she has chosen to undergo an abortion humiliates and degrades her as a human being. The woman will feel degraded by the compulsive nature of the Pregnancy Help Center Requirements, which suggest that she has made the "wrong" decision, has not really "thought" about her decision to undergo an abortion, or is "not intelligent enough" to make the decision with the advice of a physician. . . . Furthermore, these women are forced into a hostile environment. . . . [S]he will fear being ridiculed, labeled a murderer, subjected to anti-abortion ideology, and repeatedly contacted by the pregnancy help center. Moreover, a woman may likely believe . . . that her decision to have abortion could become public information.¹⁷⁴

While the district court's analysis may hold some appeal, the court missed the mark in a number of significant respects. First, by taking into account only those women who have "chosen to undergo an abortion,"¹⁷⁵ the court defined the relevant class of women more narrowly than is appropriate under *Casey*. *Casey* included those women "seeking abortion"¹⁷⁶ and thus included women who may be planning to have an abortion, but who have not yet made up their minds. Second, the court in *Daugaard* relies on assumptions about what women will experience and fear from the pregnancy help center consultation requirement,¹⁷⁷

170. *See id.* at 1053–54 (detailing the requirements of the South Dakota statute).

171. *Id.* at 1054.

172. *Id.* at 1060.

173. *See id.* at 1063 (concluding that the pregnancy help center consultation requirement would represent a substantial obstacle to abortion and would do so with respect to a "large fraction" of women to whom it was relevant).

174. *Id.* at 1060.

175. *Id.* at 1059.

176. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 894 (1992) (emphasis added). The *Daugaard* opinion even acknowledges the broader scope employed by *Casey*. *See Daugaard*, 799 F. Supp. 2d at 1062 (quoting *Casey*'s description of the relevant class).

177. *Daugaard*, 799 F. Supp. 2d at 1060.

rather than on extensive evidence of the type that the *Casey* Court considered in striking down Pennsylvania's spousal notification requirement and that the Court in *Hellerstedt* detailed when it invalidated Texas's admitting privileges and ambulatory surgery center requirements.¹⁷⁸ Moreover, the degradation that the court posits in *Daugaard* is not of the same magnitude as the risk of abuse the Court in *Casey* emphasized.¹⁷⁹ Third, the *Daugaard* court ignores the important distinction between spousal notification and parental consent requirements, which have implications for continuing relationships with inherent power disparities that realistically could transform a condition into an effective ban,¹⁸⁰ and the pregnancy help center consultation requirement, which (except in rare cases) involves third parties a woman may never see again. Fourth, the court does not consider the financial incentives a physician has when recommending a procedure he or she will perform¹⁸¹ and the subtle pressure a woman therefore may experience when she approaches a physician to perform an abortion for her. A consultation with a pregnancy help center—which the South Dakota law required to be staffed with a physician subject to his or her own ethical duties¹⁸² and who would not have the financial incentives an abortion specialist would—could serve as important countermeasure against this pressure. Finally, in determining that the pregnancy help center consultation requirement would affect a large fraction of women to whom it is relevant, the court in *Daugaard* merely repeats the concerns underlying its conclusion that the South Dakota statute would create a substantial obstacle, asserts that those concerns affect nearly all of the women in the relevant class, and then summarily concludes: “As a result, women will delay or refrain from consulting with the pregnancy help centers, which will prevent them from being able to carry out their decision to undergo an abortion.”¹⁸³ Put simply, the district court in *Daugaard* does not engage in the detailed analysis above regarding the primary care consultation requirement in the model statute, analysis that in large measure applies equally to the pregnancy help center consultation requirement.

Nevertheless, even if the district court's conclusion regarding the South Dakota statute were correct, the primary care consultation requirement is

178. See *Casey*, 505 U.S. at 888–94 (describing extensive district court findings and supporting evidence); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310–18 (2016) (same).

179. See *Casey*, 505 U.S. at 893.

180. See *id.* at 894 (indicating that the Court “must not blind [itself] to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases.”).

181. See *supra* notes 62–68 and accompanying text (discussing the inherent financial bias present when a physician proposes a procedure from which the physician will profit).

182. See *Daugaard*, 799 F. Supp. 2d at 1053 (defining the term “pregnancy help center” to include an entity that is staffed by a “medical director who is licensed to practice medicine in the state of South Dakota”).

183. *Id.* at 1063.

different from South Dakota's pregnancy help center consultation requirement in important respects. First, under the primary care consultation requirement, a woman is not required to divulge information about her pregnancy and her plan to have an abortion to a stranger, but instead to a physician known to her and in whom she presumably has placed some measure of trust with respect to her health. Second, while the South Dakota law contained specific parameters for the required consultation and contemplated the delivery of information about assistance she might obtain if she were to choose to maintain her pregnancy,¹⁸⁴ the primary care consultation requirement does not dictate what views a primary care physician must have or what information he or she must share.¹⁸⁵ Thus, the primary care consultation requirement would not suggest anything about a woman's intelligence or her decision to have an abortion. Third, it is hard to see how the primary care consultation requirement would subject a woman to hostility or cause her reasonably to fear "being ridiculed, labeled a murderer, subjected to anti-abortion ideology, [or] repeatedly contacted"¹⁸⁶ by her primary care physician. Medical ethics standards require physicians to treat patients with "courtesy, respect, [and] dignity,"¹⁸⁷ and as the Court asserted in *Doe*, "the good physician . . . will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling."¹⁸⁸ In addition, if one can rely on State licensing requirements to ensure that abortion providers exercise an appropriate level of judgment,¹⁸⁹ one should be able to rely on these very same requirements to protect a woman from hostility, ridicule, or other inappropriate behavior by her primary care physician. Fourth, even if a woman might be concerned about the sufficiency of the confidentiality protections included in South Dakota's pregnancy help center consultation requirement,¹⁹⁰ she should have little fear of public disclosure by

184. *See id.* at 1053–54 (quoting Section 3(a) of the South Dakota statute, which specifies the content of the required consultation).

185. *See* Model Statute, *infra* APPENDIX Sec. 3.

186. *Daugaard*, 799 F. Supp. 2d at 1060.

187. *Opinion 10.01 – Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page> (last visited Mar. 5, 2016) [hereinafter *Fundamental Elements*].

188. *Doe v. Bolton*, 410 U.S. 179, 197 (1973).

189. *See id.* at 199 ("If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies.")

190. While the South Dakota statute permitted a pregnancy help center to forward to the abortion provider any assessment it might have made in connection with the consultation, it otherwise prohibited disclosure of information as to the consultation unless authorized by the woman or required by law. *See Daugaard*, 799 F. Supp. 2d at 1054 (describing the provision of the South Dakota statute governing disclosure of information).

her physician in light of the ethical and legal obligations physicians have with respect to confidential medical information.¹⁹¹

The primary care consultation requirement, therefore, does not raise the same issues the flawed *Daugaard* decision highlighted. Absent also are concerns of the type the Supreme Court in *Casey* and *Hellerstedt* expressed with respect to Pennsylvania's spousal notification requirement and Texas's admitting privileges and ambulatory surgery center requirements.¹⁹² Instead, the primary care consultation requirement shares common ground with the informed consent and waiting period provisions at issue in *Casey*.¹⁹³ Consequently, it fits firmly within the constitutional bounds established by the Supreme Court.

2. Doe v. Bolton

Despite *Casey*'s abandonment of *Roe*'s trimester framework in favor of an undue burden standard for pre-viability abortion regulations,¹⁹⁴ the U.S. District Court for the Southern District of Ohio in a post-*Casey* opinion looked to *Doe v. Bolton*,¹⁹⁵ *Roe*'s companion case,¹⁹⁶ when the district court enjoined an Ohio law that required a second physician to concur in a determination of the necessity of a post-viability abortion.¹⁹⁷ Therefore, a thorough constitutional analysis of the primary care consultation requirement must consider the continuing vitality of *Doe* and its treatment of a physician concurrence requirement that was similar to Ohio's, but applied throughout a woman's pregnancy.

In *Doe*, the Court addressed the constitutionality of a Georgia statute that prohibited a physician from performing an abortion for a woman unless two other physicians examined the woman and confirmed the medical judgment of the physician who was to perform the abortion.¹⁹⁸ Striking down the law, the Court determined that the concurrence requirement did not serve the needs of a woman seeking an abortion and impermissibly interfered with the exercise of

191. See *Fundamental Elements*, *supra* note 187 ("The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest."); Health Insurance Portability and Accountability Act of 1996 § 1177, 42 U.S.C. § 1320d-6 (2012) (imposing penalties for disclosing "individually identifiable health information").

192. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887–98 (1992); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310–18 (2016).

193. See *id.* at 887.

194. *Id.* at 873, 876.

195. 410 U.S. 179 (1973).

196. See *Roe v. Wade*, 410 U.S. 113, 165 (1973) (indicating that *Roe* and *Doe* "are to be read together.").

197. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1087–88 (S.D. Ohio 1995) *aff'd* 130 F.3d 187 (6th Cir. 1997) (applying *Doe* and finding substantial likelihood that physician concurrence requirement was unconstitutional).

198. *Doe*, 410 U.S. at 192.

the physician's medical judgment.¹⁹⁹ According to the Court, a physician's license testified to his or her ability to exercise sound medical judgment, and should the physician fail to do so, "professional censure and deprivation of his license are available remedies."²⁰⁰

In deciding *Doe*, it is apparent that the Court applied *Roe*'s trimester framework. The Court intended that *Roe* and *Doe* "be read together,"²⁰¹ and *Roe* made this point explicitly right after summarizing its trimester framework.²⁰² Indeed, in striking down a Georgia requirement that abortions be performed in an accredited hospital, the Court in *Doe* cited its inconsistency with the trimester framework,²⁰³ and while not mentioning the framework by name when discussing the physician concurrence requirement, the Court noted that the "[r]isks during the first trimester of pregnancy are admittedly lower than during later months."²⁰⁴ If *Casey* discarded *Roe*'s trimester framework, then, it is *Casey*'s undue burden standard that now would apply when determining the constitutionality of a physician concurrence requirement,²⁰⁵ and it is this standard that would apply to the primary care consultation requirement as well.

199. *See id.* at 199.

200. *Id.*

201. *Doe v. Deschamps*, 461 F. Supp. 682, 688 (D. Mont. 1976).

202. *See Roe*, 410 U.S. at 165 ("In *Doe* . . . procedural requirements contained in one of the modern abortion statutes are considered. That opinion and this one, of course, are to be read together.").

203. *See Doe*, 410 U.S. at 195 ("We hold that the hospital requirement of the Georgia law, because it fails to exclude the first trimester of pregnancy . . . is also invalid." (citing *Roe*, 410 U.S. at 163)).

204. *Id.* at 198.

205. Given that *Casey* preserved *Roe*'s standard for post-viability abortion regulations, *see Casey*, 505 U.S. at 879 ("We also reaffirm *Roe*'s holding that 'subsequent to viability, the State . . . may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'" (quoting *Roe*, 410 U.S. at 164–65)), the district court in *Voinovich* was not unreasonable in considering *Doe* post-*Casey*. The district court in *Voinovich* erred, however, by failing to appreciate the fact that the Court in *Doe* struck down a physician concurrence requirement that applied throughout a woman's pregnancy and not one, like the Ohio statute, that only applied post-viability, when a State has wide latitude to regulate abortion and even can adopt a ban so long as appropriate exceptions are made. In reaching its decision, the court in *Voinovich* did not even mention the U.S. District Court for the District of Montana's 1976 decision in *Doe v. Deschamps* to uphold a Montana statute that required two additional physicians to concur before a doctor could perform a post-viability abortion aimed at preserving a woman's life or health. *See Deschamps*, 461 F. Supp. at 687, 687–88 (describing the Montana law and concluding that it was valid). While it considered the Missouri law's constitutionality "a close question," the court in *Deschamps* was persuaded to sustain the law based on the prominence of the State's interest in potential life post-viability and the fact that, for post-viability bans, *Roe*'s exceptions for circumstances when a woman's life or health relied on "appropriate medical judgment"—presumably an objective standard—while first-trimester abortions were left to the subjective judgment of the physician performing the abortion. *See Deschamps*, 461 F. Supp. at 688 (distinguishing *Roe*'s treatment of regulations during different stages of pregnancy); *but see Margaret S. v. Edwards*, 488 F. Supp. 181, 196–97 (E.D. La. 1980).

Admittedly, when invalidating a statute requiring the approval of a hospital committee before a physician could perform an abortion, *Doe* almost foreshadowed the *Casey* standard by describing the approval requirement as “unduly restrictive of the patient’s rights.”²⁰⁶ Similarly, the Court in *Whalen v. Roe* suggests that, in applying *Roe*’s trimester framework, *Doe* may have employed an undue burden-like standard:

The statutory restrictions on the abortion procedures [at issue in *Doe*] were invalid because they encumbered the woman’s exercise of that constitutionally protected right by placing *obstacles* in the path of the doctor upon whom she was entitled to rely for advice in connection with her decision. If those *obstacles had not impacted upon the woman’s freedom* to make a constitutionally protected decision, if they had merely made the physician’s work more laborious or less independent without any impact on the patient, they would not have violated the Constitution.²⁰⁷

A physician concurrence requirement similar to the one at issue in *Doe*, therefore, may not survive *Casey*’s undue burden standard.²⁰⁸

This conclusion, however, does not spell doom for the primary care consultation requirement, which is fundamentally different from a requirement that another physician concur in the decision to perform an abortion. First, the consultation requirement is designed not to inform the physician performing an abortion, but the woman based on her particular circumstances—a concern that lies at the very heart of *Casey*.²⁰⁹ Second, unlike a physician concurrence requirement, which gives another person an effective veto over a woman’s decision, the primary care consultation requirement in the model statute explicitly preserves a woman’s right to make the ultimate decision.²¹⁰ Third, the consultation requirement does not affect a physician’s discretion. While the

(striking down a physician concurrence requirement based on *Doe*). Before *Casey*, the U.S. District Court for the Northern District of Illinois in *Wynn v. Scott* engaged *Deschamps*, but disagreed, finding that an Illinois statute that required consultation with two other physicians “ha[d] no rational connection to either the patient’s or the fetus’s needs.” *Wynn v. Scott*, 449 F. Supp. 1302, 1320 (N.D. Ill. 1978). In reaching this decision, the court indicated that “it [was] necessary to scrutinize [the statute] to determine whether it [was] narrowly drawn,” *id.* at 1319, an exacting standard of review that seems inconsistent with a State’s right to ban abortion post-viability. If a State can ban abortion entirely based on its interest in protecting potential life, however, it is hard to see why necessity would be required for lesser regulations.

206. *Doe v. Bolton*, 410 U.S. 179, 198 (1973) (emphasis added).

207. *Whalen v. Roe*, 429 U.S. 589, 604–05 n.33 (1976) (emphasis added).

208. *See Casey*, 505 U.S. at 874–75.

209. *See id.* at 873 (“States are free to enact laws to provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning.”).

210. *See supra* notes 39–40 and accompanying text (describing the model statute’s specific provision acknowledging that a woman retains the right to choose abortion notwithstanding contrary advice from her primary care physician).

Georgia statute at issue in *Doe* prohibited a physician from performing an abortion unless two other physicians concurred,²¹¹ under the model statute, an abortion provider need not pay heed to a recommendation the woman's primary care physician might offer. Just as a woman can decide to have an abortion against the advice of her primary care physician, a physician can perform an abortion for a woman even if the woman's primary care physician considers the procedure ill-advised. Thus, the primary care consultation requirement presents none of the issues that caused the Court in *Doe* to strike down Georgia's physician concurrence requirement.²¹² Instead, the consultation requirement falls squarely within the bounds of *Casey* and, consequently, on solid constitutional ground.²¹³

B. The Primary Care Consultation Requirement Does Not Implicate a Woman's First Amendment Right to Be Free from Compelled Speech

As the Supreme Court pointed out in *Wooley v. Maynard*,²¹⁴ "the right of freedom of thought protected by the First Amendment against state action includes . . . the right to refrain from speaking."²¹⁵ The plaintiffs in *Daugaard* challenged South Dakota's pregnancy help center consultation requirement on this basis as well,²¹⁶ and as an alternative to its decision regarding the plaintiffs' Fourteenth Amendment claim, the district court enjoined the requirement on First Amendment grounds, finding that the requirement impermissibly compelled a woman to disclose to a stranger that the woman is pregnant, that she is going to have an abortion, that she has spoken with a physician about performing the abortion, and the name of that physician.²¹⁷ Given that the primary care consultation requirement under the model statute implicitly would require a woman to speak in similar ways—to set up an appointment with her doctor, to tell her doctor that she is pregnant and considering an abortion, and to request that the doctor give her a referral to a doctor to perform the procedure—one might anticipate a similar First Amendment challenge. Yet, once again, the district court in *Daugaard* missed the mark in its constitutional analysis, and even if the court were correct, the primary care consultation requirement and the

211. *Doe*, 410 U.S. at 183–84.

212. *See id.* at 199–200 (reasoning that no other surgical procedure required confirmation by two other physicians in Georgia and that the concurrence infringed on the physician's right to practice and was unrelated to the patient's needs).

213. *See* discussion, *supra* Section II.A.1 (discussing application of the undue burden standard in *Casey* in the context of the model statute).

214. 420 U.S. 705 (1977).

215. *Id.* at 714.

216. *Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1054–55 (D.S.D. 2011).

217. *Id.* at 1056. The court also suggested that the consultation requirement impermissibly compelled a woman to speak by requiring a woman to participate in an interview, which by its very nature requires a person to answer questions. *Id.*

South Dakota pregnancy health center consultation requirement are different in constitutionally significant ways. The primary care consultation requirement, therefore, would withstand a First Amendment challenge.

To analyze the constitutionality of compelled statements under the First Amendment, a court must engage in a two-step process.²¹⁸ First, the court must determine whether the First Amendment is implicated.²¹⁹ Second, if the First Amendment is implicated, the court must then determine the proper standard of

218. See *Daugaard*, 799 F. Supp. 2d at 1055 (recognizing the two-step process for considering compelled speech). The Court in *Casey* applied this two-step process in upholding the Pennsylvania informed consent requirements against a First Amendment challenge brought by physicians:

To be sure, the physician's First Amendment rights not to speak are implicated, but only as part of the practice of medicine, subject to reasonable licensing and regulation by the State. We see no constitutional infirmity in the requirement that the physician provide the information mandated by the State here.

Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884–85 (1992) (citations omitted). Thus, the Court first determined that the informed consent requirements implicated the First Amendment and then concluded that the requirements satisfied the applicable standard of review.

Federal circuit courts have disagreed as to the standard of review the *Casey* Court applied. Compare *Stuart v. Camnitz*, 774 F.3d 238, 249 (4th Cir. 2014), *cert denied* 135 S. Ct. 2838 (2015) (asserting that “*Casey* does not . . . announce the proper level of scrutiny to be applied to abortion regulations that compel speech to the extraordinary extent present here . . . [and] did not hold sweepingly that all regulation of speech in the medical context merely receives rational basis review”), with *Texas Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 575 (5th Cir. 2012) (indicating that “[t]he plurality response to the compelled speech claim is clearly not a strict scrutiny analysis[;] . . . [t]he three sentences with which the Court disposed of the First Amendment claims are, if anything, the antithesis of strict scrutiny”); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 733–34 (8th Cir. 2008) (discussing how in *Casey*, “the Court found no violation of the physician’s right not to speak, without need for further analysis of whether the requirements were narrowly tailored to serve a compelling state interest, where physicians merely were required to give ‘truthful, non-misleading information’ relevant to the patient’s decision”), and *Pickup v. Brown*, 740 F.3d 1208, 1231 (9th Cir. 2013) (applying rational basis review and citing *Casey* as support).

219. See *Wooley*, 430 U.S. at 715–16 (“Identifying the Maynards’ interests as implicating First Amendment protections does not end our inquiry however. We must also determine whether the State’s countervailing interest is sufficiently compelling to justify requiring appellees to display the state motto on their license plates.” (citing *United States v. O’Brien*, 391 U.S. 367, 376–77 (1968)); *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 650–51 (1985) (determining that compelled statements implicate the First Amendment before considering whether they survive rational basis review).

review—strict scrutiny, intermediate scrutiny, or rational basis²²⁰—and whether the regulation at issue satisfies that standard.²²¹

How one applies this two-step process to a particular regulation depends on the context of the speech,²²² and in this regard, the Supreme Court has addressed

220. In First Amendment free speech cases, the Court has employed these three different levels of review, depending on the circumstances. See *Snyder v. Phelps*, 131 S. Ct. 1207, 1215 (2011) (stating that “[n]ot all speech is of equal First Amendment importance, . . . and where matters of purely private significance are at issue, First Amendment protections are often less rigorous”) (internal citation omitted); *Riley v. Nat’l Fed’n of the Blind of N.C., Inc.*, 487 U.S. 781, 796 (1988) (“Our lodestars in deciding what level of scrutiny to apply to a compelled statement must be the nature of the speech taken as a whole and the effect of the compelled statement thereon.”). To survive strict scrutiny, a State measure regulating speech must be narrowly tailored to serve a compelling government interest. See *Wooley*, 430 U.S. at 715–16 (considering a State statute that required individuals to display a license plate with an ideological message and indicating that the Court “must . . . determine whether the State’s countervailing interest is sufficiently compelling to justify requiring appellees to display the state motto on their license plates”); *Riley*, 487 U.S. at 798 (considering the effect of a compelled factual statement on charitable solicitations and concluding that the State’s proffered interest “is not as weighty as the State asserts, and that the means chosen to accomplish it are unduly burdensome and not narrowly tailored”). Under intermediate scrutiny, the government must establish that it has a substantial interest supporting the regulation and that “the regulation directly advances the governmental interest asserted, . . . and . . . is no[] more extensive than is necessary to serve that interest.” *Cent. Hudson Gas & Electric Corp. v. Public Serv. Comm’n*, 447 U.S. 557, 566 (1980). See also *Florida Bar v. Went for It, Inc.*, 515 U.S. 618, 624 (1995) (noting that the test for commercial speech under *Central Hudson* “consist[s] of three related prongs: First, the government must assert a substantial interest in support of its regulation; second, the government must demonstrate that the restriction on commercial speech directly and materially advances that interest; and third, the regulation must be “narrowly drawn.”); *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 771 (1976) (“We have often approved [time, place, and manner restrictions on commercial speech] provided that they are justified without reference to the content of the regulated speech, that they serve a significant governmental interest, and that in so doing they leave open ample alternative channels for communication of the information.”). Finally, the Court’s permissive rational basis standard requires only that the regulation be rationally related to a legitimate government interest. See *Zauderer*, 471 U.S. at 651 (holding that “an advertiser’s rights are adequately protected as long as disclosure requirements are reasonably related to the State’s interest in preventing deception of consumers”); *Beauharnais v. Illinois*, 343 U.S. 250, 269 (1952) (Black, J., dissenting) (describing the rational basis test as one of “reasonableness”); *Lawrence v. Texas*, 539 U.S. 558, 579 (2003) (O’Connor, J., concurring) (“Under our rational basis standard of review, ‘legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest.’”) (quoting *Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440 (1985)); *R.A.V. v. City of St. Paul, Minn.*, 505 U.S. 377, 406 (1992) (White, J., concurring) (describing rational basis review as requiring a regulation to be “rationally related to a legitimate government interest.”).

221. See *Wooley*, 430 U.S. at 715–16.

222. See *Riley*, 487 U.S. at 798 (indicating that the standard of review in compelled speech cases depends on the context of the compelled statements). See also Scott W. Gaylord & Thomas J. Molony, *Casey and a Woman’s Right to Know: Ultrasounds, Informed Consent, and the First Amendment*, 45 CONN. L. REV. 595, 613 (2012) (stating that “Casey was similar to *Wooley* in which the context of the compelled speech, not the particular mode of expression, was constitutionally significant.”).

three distinct categories of compelled speech regulations, treating each category in a different way. The Court considered the first category in *West Virginia State Board of Education v. Barnette* and *Wooley*, which involved regulations that compelled ideological speech, speech about “politics, nationalism, religion, or other matters of opinion.”²²³ Not surprisingly, regulations of this type implicate the First Amendment and are subject to strict scrutiny.²²⁴ The second category consists of compelled speech requirements that either alter or chill speech that a person otherwise might wish to make. *Riley v. National Federation of the Blind of North Carolina, Inc.*²²⁵ and *Zauderer v. Office of Disciplinary Counsel*²²⁶ considered requirements of this type, and in both cases, the Court concluded that the First Amendment was implicated.²²⁷ In *Riley*, the Court determined that strict scrutiny applied to compelled statements affecting fully-protected speech,²²⁸ but in *Zauderer*, the Court held that rational basis review may apply to compelled statements that affect commercial speech, which receives less First Amendment protection.²²⁹ The final category of compelled speech includes government-required speech requirements that are incidental to the regulation of conduct and that neither require ideological speech nor chill protected speech a person otherwise might make.²³⁰ *Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*²³¹ teaches that these regulations do not implicate the First Amendment at all, and it is in this final category that the speech implicitly compelled under the primary care consultation requirement falls.²³²

Barnette and *Wooley* make clear that the First Amendment bars a State from requiring one to deliver publicly the State’s ideological message.²³³ As the Court put it in *Barnette*: “if there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.”²³⁴

223. See *Wooley*, 430 U.S. at 714–15; *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

224. See Donald L. Beschle, *Clearly Canadian? Hill v. Colorado and Free Speech Balancing in the United States and Canada*, 28 HASTINGS CONST. L.Q. 187, 191 (2001) (explaining that “strict scrutiny or some variant of it would be appropriate where government attempted to censor or punish speech, or regulate it on the basis of its content”); *Wooley*, 430 U.S. at 715–16.

225. 487 U.S. 781 (1988).

226. 471 U.S. 626 (1985).

227. *Riley*, 487 U.S. at 794; *Zauderer*, 471 U.S. at 651.

228. *Riley*, 487 U.S. at 788–89.

229. *Zauderer*, 471 U.S. at 650–51 & n.14.

230. *Rumsfeld v. Forum for Acad. & Inst. Rights, Inc.*, 547 U.S. 47, 61–62, 64 (2006).

231. 547 U.S. 47 (2006).

232. *Id.* at 61–62, 64.

233. *Wooley v. Maynard*, 430 U.S. 705, 714–15 (1977); *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943).

234. *Barnette*, 319 U.S. at 642.

The *Barnette* Court considered a First Amendment challenge to a state board of education requirement that school children salute the U.S. flag while reciting the pledge of allegiance.²³⁵ In assessing the challenge, the Court framed the issue as whether the government has the “power to force an American citizen publicly to profess a[] statement of belief or to engage in a[] ceremony of assent to one.”²³⁶ The Court concluded that the government does not have this power because exercising it would “invade[] the sphere of intellect and spirit which it is the purpose of the First Amendment . . . to reserve from all official control.”²³⁷

The Court in *Wooley* addressed a similar challenge to a New Hampshire statute that required motorists to display the State’s motto “Live Free or Die” on their license plates, a requirement the plaintiffs—Jehovah’s Witnesses—claimed was contrary to “their moral, religious, and political beliefs.”²³⁸ In determining that the compulsion implicated the First Amendment, the Court admitted that the State’s infringement was not as extreme as that considered in *Barnette*, but the Court determined nevertheless that it “forc[ed] an individual, as part of his daily life - indeed constantly while his automobile is in public view - to be an instrument for fostering public adherence to an ideological point of view he finds unacceptable.”²³⁹ Accordingly, the Court applied strict scrutiny to strike down the statute, concluding that “where the State’s interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual’s First Amendment right to avoid becoming the courier for such message.”²⁴⁰

In contrast to *Barnette* and *Wooley*, *Riley* did not involve matters of ideology or opinion, but rather a requirement under North Carolina law that professional fundraisers make a purely factual disclosure—“the gross percentage of revenues retained in prior charitable solicitations”²⁴¹—in the course of soliciting donors. According to the *Riley* Court, that the compelled disclosure was one of fact and not one of opinion was inapposite: “[Previous compelled speech cases] cannot be distinguished simply because they involved compelled statements of opinion while here we deal with compelled statements of ‘fact’: either form of compulsion burdens protected speech.”²⁴² The Court’s concern with compelled statements of fact, though, was the effect of the compelled statements on otherwise fully-protected speech. In determining that the compelled statements implicated the First Amendment, the Court in *Riley* pointed out that “[m]andating speech that a speaker would not otherwise make necessarily *alters*

235. *Id.* at 628–30.

236. *Id.* at 634.

237. *Id.* at 642.

238. *Wooley*, 430 U.S. at 707.

239. *Id.* at 715.

240. *Id.* at 717.

241. *Riley v. Nat’l Fed’n of the Blind*, 487 U.S. 781, 784 (1988).

242. *Id.* at 797–98.

the content of the speech.”²⁴³ Likewise, the Court determined that strict scrutiny applied because the compelled factual statements were “inextricably intertwined with otherwise fully protected speech”²⁴⁴—charitable solicitations—and notably, the examples the Court gave of other impermissible compelled statements of fact both related to fully-protected political speech:

[W]e would not immunize a law requiring a speaker favoring a particular government project to state at the outset of every address the average cost overruns in similar projects, or a law requiring a speaker favoring an incumbent candidate to state during every solicitation that candidate’s recent travel budget. Although the foregoing factual information might be relevant to the listener, and, in the latter case, could encourage or discourage the listener from making a political donation, a law compelling its disclosure would clearly and substantially burden the protected speech.²⁴⁵

The Court in *Riley* emphasized that context matters: “Our lodestars in deciding what level of scrutiny to apply to a compelled statement must be the nature of the speech taken as a whole and the effect of the compelled statement thereon.”²⁴⁶ The First Amendment was implicated in *Riley* because the compelled statements were required in a context in which other protected speech was to be made, with the result that the compelled statements would affect the content of the other speech.²⁴⁷ And because the other protected speech was entitled to the most robust First Amendment protection, strict scrutiny applied to the compelled statements.²⁴⁸

While the Court in *Riley* recognized that there are differences between regulations restricting a person’s speech and those requiring a person to speak, the Court determined that, in the context of statements that alter fully-protected speech, the distinction did not affect the standard of review.²⁴⁹ *Riley* conceded,

243. *Id.* at 795 (emphasis added).

244. *Id.* at 796.

245. *Id.* at 798.

246. *Id.* at 796.

247. *See id.*

248. *See id.* at 798 (applying “exacting First Amendment scrutiny” to a law that required factual disclosures that would burden fully-protected speech).

249. *Id.* at 796 (“There is certainly some difference between compelled speech and compelled silence, but in the context of protected speech, the difference is without constitutional significance . . .”). The Court rejected the State’s argument that, because the fundraiser’s speech had financial implications, the Court should not apply strict scrutiny to the compelled statements, but instead should apply the lower level of scrutiny applicable to commercial speech. *See id.* at 795–96 (“The State argues that . . . this portion of the Act regulates only commercial speech. . . . [but] where . . . the component parts of a single speech are inextricably intertwined, we cannot parcel out the speech, applying one test to one phrase and another test to another phrase.”).

however, that a different standard of review might apply in another context.²⁵⁰ In doing so, the Court referred to *Zauderer*, a case in which the distinction between restrictions on speech and compelled speech did matter.²⁵¹

At issue in *Zauderer* was whether a state could require attorneys to disclose in advertisements for their services how contingent fees would be calculated and what costs clients would be responsible for if their claims were not successful.²⁵² As in *Riley*, the *Zauderer* Court determined that the First Amendment was implicated²⁵³ because the disclosure requirements affected other speech.²⁵⁴ Unlike *Riley*, though, the Court in *Zauderer* determined that rational basis review applied to the compelled statements,²⁵⁵ notwithstanding the fact that restrictions on commercial speech typically are subject to intermediate scrutiny.²⁵⁶ In arriving at this decision, the Court in *Zauderer* emphasized that “the interests at stake . . . [were] not of the same order as those discussed in *Wooley* . . . and *Barnette*” because the State “ha[d] not attempted to ‘prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.’”²⁵⁷

In *Rumsfeld*, however, the Court departed dramatically from *Riley* and *Zauderer* and did not apply any standard of review to the compelled statements of fact that were at issue. *Rumsfeld* involved a challenge to the Solomon Amendment, a federal statute that bars federal funding of educational institutions that do not provide military recruiters access to the institutions’ facilities and students at a level that is at least as favorable as that provided to

250. *Id.* at 796 n.9 (citing *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985)) (“Purely commercial speech is more susceptible to compelled disclosure requirements.”).

251. *See Zauderer*, 471 U.S. at 651.

252. *See id.* at 633 (describing the required disclosures).

253. *See id.* at 651 (“We do not suggest that disclosure requirements do not implicate the advertiser’s First Amendment rights at all.”).

254. *See id.* (“We recognize that unjustified or unduly burdensome disclosure requirements might offend the First Amendment by chilling protected commercial speech.”).

255. *See id.* (holding that “an advertiser’s rights are adequately protected as long as disclosure requirements are reasonably related to the State’s interest in preventing deception of consumers.”).

256. *See id.* at 638 (“Commercial speech that is not false or deceptive and does not concern unlawful activities . . . may be restricted only in the service of a substantial governmental interest, and only through means that directly advance that interest.”).

257. *Id.* at 651 (quoting *W. Va. State Bd. of Ed. v. Barnette*, 319 U.S. 624, 642 (1943)). Indeed, the interests at stake in *Zauderer* were not of the same order as those in *Riley* because the Court has considered charitable solicitations to constitute ideological speech. *See Sec’y of State of MD v. Joseph H. Munson Co., Inc.*, 467 U.S. 947, 960 (1984) (“[S]olicitation is characteristically intertwined with informative and perhaps persuasive speech seeking support for particular causes or for particular views on economic, political, or social issues” (quoting *Schaumburg v. Citizens for a Better Env’t*, 444 U.S. 620, 632 (1980)); *Riley v. Nat’l Fed’n of the Blind*, 487 U.S. 781, 803 (1988) (Scalia, J., concurring) (“We have held the solicitation of money by charities to be . . . the dissemination of ideas.”).

other potential employers.²⁵⁸ Forum for Academic and Institutional Rights (“FAIR”), a group representing law schools and law faculties whose members opposed the Congressional policy regarding homosexuals in the military, argued that the statute interfered with their members’ ability to “express[] their opposition to discrimination based on . . . sexual orientation.”²⁵⁹ Among other things, FAIR contended that the Solomon Amendment’s equal access rule impermissibly compelled law schools to speak by forcing them to “send e-mails and post notices” for military recruiters, assistance they customarily provided to all employers.²⁶⁰ The Court, while acknowledging that the compelled statements required consideration of the law schools’ First Amendment rights, rejected FAIR’s claim, finding that the speech was merely incidental to the government’s regulation of conduct and was a “far cry” from the speech at issue in *Barnette* and *Wooley*:

The compelled speech to which the law schools point is plainly incidental to the Solomon Amendment’s regulation of conduct, and “it has never been deemed an abridgment of freedom of speech or press to make a course of conduct illegal merely because the conduct was in part initiated, evidenced, or carried out by means of language, either spoken, written, or printed.” . . . Compelling a law school that sends scheduling e-mails for other recruiters to send one for a military recruiter is simply not the same as forcing a student to pledge allegiance, or forcing a Jehovah’s Witness to display the motto “Live Free or Die,” and it trivializes the freedom protected in *Barnette* and *Wooley* to suggest that it is.²⁶¹

In reaching this conclusion, it was important to the *Rumsfeld* Court that the Solomon Amendment did not “dictate the content of the speech at all” and only required law schools to speak for military recruiters if they were doing so for other employers.²⁶²

Therefore, while *Riley* indicates that compelled statements of fact are not excluded from First Amendment scrutiny,²⁶³ *Rumsfeld* explains that *Riley* only goes so far and does not mean that all compelled factual statements implicate the First Amendment and therefore are subject to review.²⁶⁴ As the Ninth Circuit

258. *Rumsfeld v. Forum for Acad. & Inst’l Rights, Inc.*, 547 U.S. 47, 51 (2006).

259. *Id.* at 52.

260. *Id.* at 61–62.

261. *Id.* at 62.

262. *Id.*

263. See *Riley v. Nat’l Fed’n of the Blind*, 487 U.S. 781, 797–98 (1988) (“These cases cannot be distinguished simply because they involved compelled statements of opinion while here we deal with compelled statements of ‘fact’: either form of compulsion burdens protected speech.”).

264. See *Rumsfeld*, 547 U.S. at 61–65 (applying neither strict scrutiny, intermediate scrutiny, nor rational basis review in analyzing compelled speech claims).

stated in *Jerry Beeman and Pharmacy Services, Inc. v. Anthem Prescription Management, LLC*:²⁶⁵

[*Rumsfeld*] makes clear that not all fact-based disclosure requirements are subject to First Amendment scrutiny. Instead, such requirements implicate the First Amendment only if they affect the content of the message or speech by forcing the speaker to endorse a particular viewpoint or by chilling or burdening a message that the speaker would otherwise choose to make.²⁶⁶

When one examines *Barnette*, *Wooley*, *Riley*, *Zauderer*, and *Rumsfeld* together, some common threads emerge. First, whether government-compelled speech implicates the First Amendment depends on whether the compelled speech is itself protected or would alter or chill other speech that is protected. In *Barnette* and *Wooley*, for example, the compelled speech itself was ideological.²⁶⁷ In *Riley* and *Zauderer*, the compelled speech itself was purely

265. 652 F.3d 1085 (9th Cir. 2011).

266. *Id.* at 1099–1100. The Ninth Circuit’s opinion was vacated and the case remanded back to the Ninth Circuit panel following the response of the California Supreme Court to a certified question regarding the interpretation of the free speech clause under the California constitution. *See Beeman v. Anthem Prescription Mgmt., LLC*, 689 F.3d 1002, 1005 (9th Cir. 2012) (certifying question to California Supreme Court); *Beeman*, 741 F.3d 29, 29 (2014) (vacating earlier opinion remanding case to Ninth Circuit panel following opinion of California Supreme Court). Nevertheless, the vacated opinion remains instructive as to the interpretation of the First Amendment. The California Supreme Court, however, in responding to the Ninth Circuit’s certified question, disagreed with the federal court’s conclusion that the Court in *Rumsfeld* had determined that the factual statements in that case did not implicate the First Amendment. In so doing, the California Supreme Court focused on the Court’s statement that “[the] compelled statements of fact . . . like compelled statements of opinion, are subject to First Amendment scrutiny.” *Beeman v. Anthem Prescription Mgmt., LLC*, 315 P.3d 71, 81 (2013) (quoting *Rumsfeld*, 547 U.S. at 62)). The California Supreme Court, however, read *Rumsfeld* too literally. To be sure, any government-compelled statement—factual or otherwise—must be examined initially to determine if the First Amendment is implicated. Only if a court determines that the First Amendment is implicated, though, will it employ a standard of review to determine whether the alleged encroachment is permissible. The Court in *Rumsfeld* did not employ any standard of review to evaluate FAIR’s free speech claims, as evidenced by the fact that it did not consider the magnitude of the government’s interest or whether the Solomon Amendment was narrowly tailored, directly related, or rationally related to the interest. *See Rumsfeld*, 547 U.S. at 61–68. *Contra Wooley*, 430 U.S. at 715–16 (“Identifying the Maynards’ interests as implicating First Amendment protections does not end our inquiry however. We must also determine whether the State’s countervailing interest is sufficiently compelling to justify requiring appellees to display the state motto on their license plates.”); *Casey*, 505 U.S. at 884 (determining first that the First Amendment was implicated, noting that a State may reasonably regulate the practice of medicine, and then concluding that required disclosures did not violate the Constitution).

267. In *Barnette*, the Court repeatedly emphasized its concern about compelled affirmation of a belief or opinion about political ideas. *See W. Va. State Bd. of Ed. v. Barnette*, 319 U.S. 624, 631 (1943) (“[W]e are dealing with a compulsion of students to declare a belief.”). *See also id.* at 633 (noting that the requirement that students salute the flag “requires the individual to communicate by word and sign his acceptance of the political ideas it thus bespeaks” and “requires affirmation

factual, but affected otherwise protected speech—in *Riley*, fully-protected speech soliciting donations, and in *Zauderer*, commercial speech.²⁶⁸ In *Rumsfeld*, on the other hand, the compelled speech itself was factual and had no apparent effect on any protected message a law school might wish to convey.²⁶⁹ As a result, the speech did not implicate the First Amendment. Second, whether the compelled statements directly regulate speech by dictating content or merely are incidental to the regulation of conduct is important. In *Barnette*, *Wooley*, *Riley*, and *Zauderer*, the government specified what the speaker had to say.²⁷⁰

of a belief and an attitude of mind.”), 634 (noting that the case presented the issue of the “validity of the asserted power to force an American citizen publicly to profess any statement of belief or to engage in any ceremony of assent”), 635–36 (“The question which underlies the flag salute controversy is whether such a ceremony so touching matters of opinion and political attitude may be imposed upon the individual by official authority”); 642 (“We think the action of the local authorities in compelling the flag salute and pledge transcends constitutional limitations on their power and invades the sphere of intellect and spirit which it is the purpose of the First Amendment to our Constitution to reserve from all official control.”). The Court in *Wooley* noted the same concerns. See *Wooley*, 430 U.S. at 715 (“The First Amendment protects the right of individuals to hold a point of view different from the majority and to refuse to foster, in the way New Hampshire commands, an idea they find morally objectionable.”).

268. See *Riley*, 487 U.S. at 798 (“Although the foregoing factual information might be relevant to the listener, . . . a law compelling its disclosure would clearly and substantially burden the protected speech.”); *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626, 651 (1985) (“We recognize that unjustified or unduly burdensome disclosure requirements might offend the First Amendment by chilling protected commercial speech.”).

269. Admittedly, the Court in *Rumsfeld* does not state this expressly when assessing the constitutionality of the Solomon Amendment’s implicit requirement that law schools send e-mail messages and post notices for military recruiters when the law schools do the same for other employers. The Court does, however, make this point in considering the Solomon Amendment’s implicit requirement to host recruiting events for military employers, and it does so after drawing on cases (e.g., *Tornillo* and *Pacific Gas*) in which a government regulation forced a person to accommodate a third party’s speech in connection with the person’s own speech. See *Rumsfeld*, 547 U.S. at 64 (“A law school’s . . . accommodation of a military recruiter’s message is not compelled speech because the accommodation does not sufficiently interfere with any message of the school.”). See also *Hurley v. Irish Am. Gay, Lesbian, and Bisexual Grp. of Boston*, 515 U.S. 557, 572–73 (1995) (“Since every participating unit affects the message conveyed by the private organizers, the state courts’ application of the statute produced an order essentially requiring petitioners to alter the expressive content of their parade.” (emphasis added)); *Pac. Gas & Elec. Co. v. Pub. Util. Comm’n*, 475 U.S. 1, 9 (1986) (“Compelled access like that ordered in this case both penalizes the expression of particular points of view and forces speakers to alter their speech to conform with an agenda they do not set.”); *Miami Herald Publ’g Co. v. Tornillo*, 418 U.S. 241, 258 (1974) (“The choice of material to go into a newspaper . . . and treatment of public issues and public officials . . . constitute the exercise of editorial control and judgment.”); *Rumsfeld*, 547 U.S. at 64 (indicating that the Court in *Tornillo* “concluded that this right-of-reply statute infringed the newspaper editors’ freedom of speech by altering the message the paper wished to express” (citing *Tornillo*, 418 U.S. at 258)).

270. See *Barnette*, 319 U.S. at 626 (considering a school board requirement that students recite the pledge of allegiance); *Wooley*, 430 U.S. at 707 (evaluating a requirement that motorists display license plates with New Hampshire State motto); *Riley*, 487 U.S. at 786 (addressing constitutionality of statute that required professional fundraisers to disclose to potential donors

In contrast, the Court in *Rumsfeld* emphasized the fact that the Solomon Amendment did not influence the content of any statement a law school might be required to make.²⁷¹ Third, the First Amendment is more likely to be implicated when the government compels a person to speak publicly. *Barnette* and *Wooley* both suggest that publicly disseminated ideological messages reflect the heart of First Amendment protection.²⁷² As the Court in *Wooley* stressed:

[W]e are faced with a state measure which forces an individual, as part of his daily life indeed constantly while his automobile is in *public* view to be an instrument for fostering *public* adherence to an ideological point of view he finds unacceptable. . . . New Hampshire's statute in effect requires that appellees use their private property as a 'mobile billboard'

. . . .²⁷³

Considered in light of these common threads, the primary care consultation requirement does not implicate the First Amendment. First, the implicitly compelled disclosures are purely factual and do not affect or risk chilling any protected speech a woman might otherwise make or wish to make. The statements a woman must make to fulfill the purposes of the requirement (*i.e.*, telling her primary care physician that she is pregnant and is considering abortion and requesting a referral) do not force a woman to express any viewpoint about "politics, nationalism, religion, or other matters of opinion"²⁷⁴ and "[are] simply not the same as forcing a student to pledge allegiance, or forcing a Jehovah's Witness to display the motto 'Live Free or Die'"²⁷⁵ Moreover, it is hard to see how a woman speaking to her primary care physician

gross receipts actually given to charities during prior 12-month period); *Zauderer*, 471 U.S. at 629 (considering statute that required specific disclosures with respect to contingent fee arrangements).

271. See *Rumsfeld*, 547 U.S. at 62 ("The Solomon Amendment, unlike the laws at issue in [*Barnette* and *Wooley*], does not dictate the content of the speech at all").

272. See *Pickup v. Brown* 740 F.3d 1208, 1227 (9th Cir. 2014), *cert denied* 134 S. Ct. 2881 (2014) ("[W]here a professional is engaged in a public dialogue, First Amendment protection is at its greatest That principle makes sense because communicating to the *public* on matters of *public concern* lies at the core of First Amendment values."). See also *Snyder v. Phelps*, 131 S. Ct. 1207, 1215 (2011) ("Speech on 'matters of public concern' . . . is at the heart of the First Amendment's protection.") (citations omitted).

273. *Wooley*, 430 U.S. at 715 (emphasis added). See also *Barnette*, 319 U.S. at 634 ("Hence validity of the asserted power to force an American citizen *publicly* to profess any statement of belief or to engage in any ceremony of assent to one presents questions of power that must be considered independently of any idea we may have as to the utility of the ceremony in question.") (emphasis added); *Zauderer*, 471 U.S. at 650 ("Ohio has not attempted to prevent attorneys from conveying information to the *public*") (emphasis added).

274. *Barnette*, 319 U.S. at 642.

275. *Rumsfeld*, 547 U.S. at 62.

would be engaging in any protected speech that the compelled statements of fact would alter.²⁷⁶

Second, the primary care consultation requirement is not a regulation directed at speech and does not dictate the specific content of what a woman says. In enacting the model statute, the State's interest would not be in "disseminat[ing] an ideology,"²⁷⁷ but instead in protecting both unborn life and women's health by making sure that women receive the robust consultation that *Roe* contemplated.²⁷⁸ That the State's interest is not speech-related is confirmed by the fact that the primary care consultation requirement does not obligate a woman to consult with a physician who holds any particular point of view with respect to abortion, but one whom she has chosen to provide her with comprehensive care. Some of these physicians may prefer childbirth over abortion; others may not.²⁷⁹

Finally, the primary care consultation requirement does not require a woman to make any statement publicly.²⁸⁰ As the Court stated in *Pacific Gas and Electric Company v. Public Utilities Commission of California*: "The essential thrust of the First Amendment is to prohibit improper restraints on the *voluntary public* expression of ideas There is necessarily . . . a concomitant freedom *not* to speak *publicly*, one which serves the same ultimate end as freedom of speech in its affirmative aspect."²⁸¹ Under the model statute, a woman must share a few facts with and make a simple request of her chosen physician in a medical office, where confidentiality is a way of life as required both by professional ethics standards and federal law.²⁸²

276. If a woman were intending to deliver an anti-abortion message, then a requirement that she disclose her plans would raise concerns of the type considered in *Riley*, but that seems an extremely unlikely situation.

277. *Wooley*, 430 U.S. at 717.

278. *See supra* note 99 and accompanying text.

279. *See Norton, supra* note 152 (noting that some ob/gyns have "personal objections" to abortions); *Questions, supra* note 70 (indicating that "most OB/GYN[s] are supportive of all reproduction choices, including abortion"); Sofia Resnick, *The rise of anti-abortion-rights OB-GYNs*, COLORADO INDEPENDENT (June 2, 2011), <http://www.coloradoindependent.com/89735/the-rise-of-anti-abortion-rights-ob-gyns> (noting an emerging trend of ob/gyns who oppose abortion and discussing efforts of medical student groups who favor choice and those who oppose it).

280. That the statements would not be made publicly is not dispositive to the First Amendment question. Even though public statements were not required under the Pennsylvania statute at issue in *Casey*, the Court concluded that the law implicated the First Amendment rights of physicians to be free from compelled speech. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (considering physicians' compelled speech claims). Intuitively, however, requiring a private statement would be less burdensome on one's First Amendment rights than requiring a public one.

281. *Pac. Gas & Elec. Co. v. Pub. Util. Comm'n*, 475 U.S. 1, 11 (emphasis added) (quoting *Harper & Row Publishers, Inc. v. Nation Enter.*, 471 U.S. 539, 559 (1985)).

282. *See supra* notes 160–63 and accompanying text.

The primary care consultation requirement, therefore, does not implicate the First Amendment and consequently is not subject even to rational basis review.²⁸³ The district court in *Daugaard*, though, reached the opposite conclusion with respect to South Dakota's pregnancy help center consultation requirement.²⁸⁴ When it did so, however, it veered off course, focusing on *Riley*, *McIntyre v. Ohio Elections Comm'n*,²⁸⁵ and *Hurley v. Irish-American Gay, Lesbian and Bisexual Group of Boston*²⁸⁶ and dismissing *Rumsfeld*.²⁸⁷

Riley, *McIntyre*, and *Hurley* all dealt with compelled speech that threatened to alter protected speech parties otherwise wished to make. As discussed above, the Court in *Riley* determined that a State law impermissibly required statements in the context of charitable solicitations.²⁸⁸ In *Hurley*, likewise, the Court invalidated a Massachusetts public accommodation law to the extent that it required parade organizers to include a group whose participation would deliver a message the parade organizers did not wish to make.²⁸⁹ Finding that a parade represents expressive conduct protected by the First Amendment, the Court

283. The requirement, though, certainly would satisfy rational basis review in light of the many justifications described in Part II of this Article.

284. *Planned Parenthood Minn., N.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1071–72 (D.S.D. 2011).

285. 514 U.S. 334 (1995).

286. 515 U.S. 557 (1995).

287. Even if *Daugaard* were correct that the South Dakota law implicated the First Amendment, the model statute is distinguishable. In striking down the pregnancy help center consultation requirement, the court in *Daugaard* suggested that the requirement compelled a woman to disclose private information to “someone who is opposed to her decision to undergo an abortion.” *Daugaard*, 799 F. Supp. 2d at 1056. This is not the case with respect to the model statute, which does not dictate that a primary care physician who consults with a woman be opposed to abortion. Physicians fall on both sides of the abortion debate. As one abortion provider states, “most OB/GYN[s] are supportive of all reproduction choices, including abortion. . . .” *Questions*, *supra* note 70. Notably, the American College of Obstetricians favors choice, being “committed to improving access to abortion.” *Committee Opinion, Increasing Access to Abortion*, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN (Nov. 2014), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion>. Moreover, a woman's primary care physician is not a stranger, but instead is a person with whom the woman has an existing professional relationship and in whom the woman has placed some level of trust.

In addition, the model statute is distinct from the South Dakota law in that the model statute does not require a woman to participate in an interview. *See Daugaard*, 799 F. Supp. 2d at 1056 (finding that the South Dakota statute compelled a woman to speak by requiring her to participate in an interview). Finally, unlike the South Dakota law, the model statute requires consultation with a physician who is bound by professional ethics requirements and by Federal law to maintain the confidentiality of the information provided. *See supra* notes 160–61 and accompanying text.

288. *Riley v. Nat'l Fed'n of the Blind*, 487 U.S. 781, 798 (1988).

289. *See Hurley*, 515 U.S. at 559 (finding unconstitutional a Massachusetts law that would require a parade organizer to “include . . . a group imparting a message the organizers do not wish to convey.”).

emphasized that Massachusetts could not “compel a speaker to *alter* [his or her] message by including one more acceptable to others.”²⁹⁰ Similarly, in *McIntyre*, the Court struck down an Ohio election law that permitted the distribution of campaign information only if it identified the author.²⁹¹ As the Court in that case explained, “an author’s decision to remain anonymous, like other decisions concerning omissions or additions to the content of a publication, is an aspect of the freedom of speech protected by the First Amendment.”²⁹² Thus, the holdings in *Riley*, *Hurley*, and *McIntyre* are inapposite to the constitutionality of South Dakota’s pregnancy help center consultation requirement, which would not compel a woman to deliver a message that would modify other protected speech a woman might make or wish to make.²⁹³ As a result, the *Daugaard* court was wrong to rely on these precedents to support its conclusion that the South Dakota statute implicated a woman’s First Amendment right to be free from compelled speech.

In rejecting *Rumsfeld* as the controlling precedent, the court in *Daugaard* stated that “there is a clear difference between ‘The U.S. Army recruiter will meet interested students in Room 123 at 11 a.m.’ and ‘I am pregnant and have chosen to have an abortion. The name of my abortion physician is Dr. X.’”²⁹⁴ The court failed to explain, however, why the difference was significant with respect to a woman’s First Amendment freedom.

Contrary to the court’s conclusion in *Daugaard*, the distinction between the compelled speech at issue in *Rumsfeld* and that under the pregnancy help center consultation requirement is not meaningful from a First Amendment perspective. Just as with the Solomon Amendment, South Dakota’s consultation requirement did not require a woman to express a particular ideological message or risk altering or chilling protected speech a woman otherwise might wish to make.²⁹⁵ Moreover, unlike the speech at issue in *Barnette*, *Wooley*, *Riley*, and *Zauderer*, both the Solomon Amendment and the South Dakota statute only implicitly required speech incidental to the regulation of conduct, with neither regulation expressly mandating what a person must say.²⁹⁶ Furthermore, while the Court in *Rumsfeld* pointed out that the speech related to the Solomon Amendment is compelled only to the extent that law schools offer the same type of speech for other recruiters, this hardly raises a meaningful distinction from

290. *Id.* at 581 (emphasis added).

291. *McIntyre v. Ohio Elections Comm’n*, 514 U.S. 334, 336, 357 (1995).

292. *Id.* at 342.

293. *See Riley*, 487 U.S. at 797–98; *Hurley*, 515 U.S. at 580–81; *McIntyre*, 514 U.S. at 357.

294. *Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1056 (D.S.D. 2011).

295. *See supra* text accompanying note 266 (discussing *Rumsfeld*).

296. *Id.*

South Dakota's consultation requirement given the practical reality that all law schools want to facilitate placement of their students.²⁹⁷

Nevertheless, the *Daugaard* court's intuition was correct—there is a difference between requiring a woman to disclose that she is pregnant and planning to have an abortion and requiring a law school to disclose logistical information about meeting with a military recruiter.²⁹⁸ The district court's mistake, though, was concluding that this distinction made a difference from a First Amendment perspective.²⁹⁹ Rather than implicating a woman's First Amendment right to be free from compelled speech, the pregnancy help center consultation requirement under the South Dakota statute and the primary care consultation requirement under the model statute implicate a woman's Fourteenth Amendment right to privacy with respect to personal medical information, a right that finds its genesis in *Whalen v. Roe*,³⁰⁰ a 1977 decision that the Court in *Casey* cited when it considered the First Amendment claims brought by physicians with respect to Pennsylvania's informed consent statute.³⁰¹

Whalen involved a challenge to a New York statute that required physicians to provide the State with duplicate copies of prescription forms (for certain controlled substances) that included detailed personal information, such as the "the drug and dosage[] and the name, address, and age of the patient."³⁰² In considering the plaintiffs' claims, the Court in *Whalen* noted two privacy interests at stake—the interest in avoiding disclosure of personal information and the interest in being permitted to make certain important decisions.³⁰³ The Court in *Whalen* concluded that the New York statute did not unconstitutionally infringe on either of those two interests.³⁰⁴

In rejecting the claim that the New York statute unconstitutionally infringed upon patients' interest in avoiding disclosure of personal matters, the Court

297. Compare *Rumsfeld v. Forum for Aca. & Inst'l Rights, Inc.*, 547 U.S. 47, 64–65 (2006) with *Daugaard*, 799 F. Supp. 2d at 1052.

298. *Daugaard*, 799 F. Supp. 2d at 1056.

299. *Id.* at 1056–57.

300. See *Whalen v. Roe*, 429 U.S. 589, 599 (1976) (suggesting that the Constitution protects a person against disclosure of personal information); *U.S. Citizens Ass'n v. Sebelius*, 705 F.3d 588, 602 (6th Cir. 2013) (citing *Whalen* in support of the proposition that "[s]ubstantive due process protects an individual's interest in avoiding the disclosure of personal matters, such as private health information"); *Greenville Women's Clinic v. Commissioner*, 317 F.3d 357, 369 (4th Cir. 2002) (observing that *Whalen* recognizes a constitutional right to privacy with respect to personal information). But see *Seaton v. Mayberg*, 610 F.3d 530, 536–37 (9th Cir. 2010) (indicating that *Whalen* did not specifically recognize a constitutional right to privacy of personal medical information and that the Supreme Court never has held that such a right exists).

301. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992).

302. *Whalen*, 429 U.S. at 593.

303. *Id.* at 599–600.

304. *Id.* at 600.

indicated that nothing in the record suggested that the statute increased the risk of public disclosure of the information and that disclosure to State officials was not:

meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care[, including] . . . disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies[,which] are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient.³⁰⁵

Whatever one might conclude regarding the consultation requirement at issue in *Daugaard*, the Court's analysis in *Whalen* applies equally to the limited disclosures implicitly required under the model statute. While the disclosures associated with the primary care consultation requirement could be considered to be an "unpleasant invasion of privacy" and some women may fear that the disclosures will reflect on them "unfavorably,"³⁰⁶ such disclosures are not at all uncommon when a person seeks medical care and they further the State's important interests in protecting unborn life and women's health.³⁰⁷

As to the second privacy interest addressed in *Whalen*, the court emphasized:

[It cannot] be said that any individual has been deprived of the right to decide independently, with the advice of his physician, to acquire and to use needed medication. Nor does the State require access to these drugs to be conditioned on the consent of any state official or other third party. Within dosage limits . . . the decision to prescribe, or to use, is left entirely to the physician and the patient.³⁰⁸

To paraphrase *Casey*, "[w]hat [was] at stake [was] the [patient's] right to make the ultimate decision,"³⁰⁹ and the New York law did not take that away. And as discussed in Part III, the primary care consultation requirement likewise preserves a woman's right to choose abortion. Therefore, the model statute not

305. *Id.* at 602.

306. *Id.* *Whalen's* facts—involving a physician's disclosure of patient information—and the substantial ability of states to regulate the practice of medicine, *see Casey*, 505 U.S. at 884, suggest that a state could require a physician to disclose to a woman's primary care physician that the woman was pregnant and planning to have an abortion. The fact that the primary care consultation requirement would require the woman herself to make the disclosure could raise some additional discomfort, but should not be of constitutional significance. *See Walls v. City of Petersburg*, 895 F.2d 188, 194–95 (4th Cir. 1990) (upholding under strict scrutiny the requirement that employees personally respond to a background questionnaire requesting personal financial information); *Taylor v. Best*, 746 F.2d 220, 225 (4th Cir. 1984) (upholding under strict scrutiny that prisoners disclose information about family background to psychologists).

307. *See Cohen*, *supra* note 73 (noting the importance of sharing with an ob/gyn if a woman has had a previous abortion).

308. *Whalen*, 429 U.S. at 603.

309. *Casey*, 505 U.S. at 877.

only satisfies *Casey*'s undue burden standard,³¹⁰ but also is constitutional under *Whalen*.³¹¹

IV. CONCLUSION

The primary care consultation requirement thus offers numerous benefits to women, while respecting their constitutional rights. Nonetheless, the model statute is unlikely to please either side of the abortion debate completely. One would expect abortion rights advocates to view the primary care consultation requirement as yet another roadblock standing in the way of a woman's right to choose. Abortion opponents, on the other hand, may feel uneasy about a woman's consultation with a primary care physician who might have a favorable view of abortion.

Yet, the model statute offers a valuable refuge for women faced with a "decision . . . fraught with emotional consequences."³¹² And it just might save a life—perhaps a woman's, perhaps an unborn child's, perhaps the lives of both. Therefore, those on both sides of the abortion debate should support the model statute, and state legislatures across the country should adopt the legislation and take an important step toward fulfilling the promise of *Roe*.

V. APPENDIX

MODEL STATUTE³¹³

Section 1. SHORT TITLE. This Act may be cited as the "Pre-Abortion Consultation Enhancement Act."

Section 2. DEFINITIONS.³¹⁴ The following definitions apply in this Act:

- (a) Abortion – The use or prescription of any instrument, medicine, drug, or other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to do any of the following:
 - (i) increase the probability of a live birth;
 - (ii) preserve the life or health of the child; or

310. *Id.* at 876–77.

311. *Whalen*, 429 U.S. at 603–04.

312. *Gonzales*, 550 U.S. at 159.

313. Although drafted as a stand-alone statute, the provisions of the model easily could be incorporated into a State's existing informed consent law.

314. The definitions of "Abortion," "Medical emergency," and "Woman" are taken from N.C. GEN. STAT. § 90-21.81, which is part of North Carolina's informed consent statute. Legislators in a State other than North Carolina may wish to modify the definitions to conform to the existing laws of their State.

- (iii) remove a dead, unborn child who died as the result of (A) natural causes in utero, (B) accidental trauma, or (C) a criminal assault on the pregnant woman or her unborn child which causes the premature termination of the pregnancy.
- (b) Existing relationship – A professional relationship that began before the pregnancy with respect to which a woman seeks an abortion, but excluding a relationship that has been terminated for one or more substantial reasons unrelated to the requirements of Section 3(a).
- (c) Internist – An individual licensed to practice medicine in accordance with the laws of any State or territory of the United States who is engaged in the practice of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, or obstetrics/gynecology.³¹⁵
- (d) Medical emergency – A condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including any psychological or emotional conditions. For purposes of this definition, no condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function.
- (e) Ob/gyn – An individual licensed to practice medicine in accordance with the laws of any State or territory of the United States who is engaged in the practice of obstetrics/gynecology.
- (f) Physician – An individual licensed to practice medicine in accordance with the laws of this State.
- (g) Primary ob/gyn – An ob/gyn with whom a woman has an existing relationship for the purposes of receiving non-emergency gynecological or obstetrical care and, if a woman has an existing relationship with more than one such ob/gyn, the ob/gyn who has provided her with the most comprehensive care over time.

315. Based on the disciplines of primary care identified in N.C. GEN. STAT. § 143-613(b).

- (h) Primary internist – An internist with whom a woman has an existing relationship for the purposes of receiving first contact and continuing care with respect to any undiagnosed sign, symptom, or health concern not limited by problem, origin, organ system, or diagnosis³¹⁶ and, if a woman has an existing relationship with more than one such internist, the internist who has provided her with the most comprehensive care over time.
- (i) Primary care physician – A woman’s primary ob/gyn or, if Section 3(a)(i) does not apply, her primary internist.
- (j) Woman – A female human, whether or not she is an adult.

Section 3. CONSULTATION WITH AND REFERRAL BY PRIMARY CARE PHYSICIAN.

- (a) Except in the case of a medical emergency, no abortion shall be performed upon a woman in this State unless, before the performance of the abortion, the physician who will perform the abortion has received,
 - (i) if the woman has a primary ob/gyn, [clear and convincing] [reasonably reliable] evidence of the following:
 - (A) that the woman consulted with her primary ob/gyn regarding her decision to have the abortion and has requested a referral for the purposes of performing the abortion;
 - (B) the recommendation of the woman’s primary ob/gyn as to the advisability of her having an abortion or, if the primary ob/gyn declined to make any recommendation, the fact that the primary physician so declined,
 - (C) the reasons, if any, that the primary ob/gyn gave for making a particular recommendation or declining to make a recommendation;
 - (D) that the primary ob/gyn referred the woman to another physician for the purposes of performing the abortion or declined to make such a referral; and
 - (E) if the primary ob/gyn declined to make a referral to a physician for the purposes of performing the abortion, any reasons the primary ob/gyn gave for declining to do so.
 - (ii) if the woman has a primary internist and clause (i) above does not apply, [clear and convincing] [reasonably reliable] evidence of the following:

316. Based on the American Academy of Family Physicians’ definition of “primary care.” See *Primary Care*, AMERICAN ACADEMY OF FAMILY PHYSICIANS, <http://www.aafp.org/about/policies/all/primary-care.html> (last visited Mar. 5, 2016).

- (A) that the woman consulted with her primary internist regarding her decision to have the abortion and has requested a referral for the purposes of performing the abortion;
 - (B) the recommendation of the woman's primary internist as to the advisability of her having an abortion or, if the primary internist declined to make any recommendation, the fact that the primary physician so declined,
 - (C) the reasons, if any, that the primary internist gave for making a particular recommendation or declining to make a recommendation;
 - (D) that the primary internist referred the woman to another physician for the purposes of performing the abortion or declined to make such a referral; and
 - (E) if the primary internist declined to make a referral to a physician for the purposes of performing the abortion, any reasons the primary internist gave for declining to do so.
- (b) The requirements under Section 3(a) shall not apply if the physician who performs the abortion is the woman's primary ob/gyn. The requirements under Section 3(a)(i) shall not apply if, prior to the abortion, the physician who will perform the abortion receives from the woman a written certification that the woman (i) has no primary ob/gyn or (ii) having in good faith exercised reasonable diligence to do so, has been unable to schedule an appointment for urgent care with her primary ob/gyn for a time within 72 hours of her first attempt to schedule such an appointment. The requirements under Section 3(a)(ii) shall not apply if, prior to the abortion, the physician who will perform the abortion receives from the woman a written certification that the woman (i) has no primary internist or (ii) having in good faith exercised reasonable diligence to do so, has been unable to schedule an appointment for urgent care with her primary internist for a time within 72 hours of her first attempt to schedule such an appointment.
- (c) A completed certification substantially in the form of EXHIBIT A, signed by the individual whom the woman has certified in writing to be her primary care physician, shall constitute evidence sufficient to satisfy the requirements of Section 3(a).
- (d) The evidence required under Section 3(a) and any certification obtained under Sections 3(b) or 3(c) shall be maintained in the permanent files of the facility in which the abortion was performed for a period of no less

than seven years.³¹⁷ Such evidence and certifications shall be kept confidential, but may be inspected by local, state, or national public health officers.

- (e) Neither the recommendation of a woman's primary care physician nor any referral by such person shall limit (i) the ability of the woman to decide to have an abortion or to have an abortion performed by a physician of her choosing and (ii) the ability of a physician to perform an abortion for the woman.

Section 4. OBLIGATIONS OF OB/GYNS AND INTERNISTS.³¹⁸ An ob/gyn or internist located in this State:

- (a) shall consider a woman's request for consultation as contemplated by Section 3(a) of this Act [(or by a similar provision under the law of another jurisdiction)]³¹⁹ to be a request for urgent or similar care and in good faith shall attempt to schedule an appointment with the woman as soon as reasonably practicable in accordance with such physician's normal procedure for scheduling and prioritizing appointments for urgent or similar care.
- (b) with whom the woman consults as contemplated by Section 3(a) [(or by a similar provision under the law of another jurisdiction)]³²⁰ shall inform the woman of her right to withhold consent to disclosure to third parties of the substance of any information discussed during the course of the consultation and shall provide the woman with such forms as may be necessary to revoke any consent previously given that otherwise would authorize the physician to make such disclosure.
- (c) shall, in the course of an appointment scheduled for consultation as contemplated by Section 3(a) of this Act [(or by a similar provision under

317. Based on the recordkeeping provision that the U.S. Supreme Court determined constitutional in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 81, 86 (1976).

318. States have substantial latitude in regulating physician conduct. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (concluding that compelling a physician to provide information to a woman seeking an abortion is permissible because a state has the power to adopt reasonable regulations with respect to the practice of medicine). *See also* Scott W. Gaylord, *A Matter of Context: Casey and the Constitutionality of Compelled Physician Speech*, 43 J. L. MED. & ETHICS 35, 45 (2012) ("The Court [has] recognized that the State has broad latitude to regulate the practice of medicine.").

319. Included to assist in cross-jurisdictional application.

320. Included to assist in cross-jurisdictional application.

the law of another jurisdiction)],³²¹ provide such consultation as the ob/gyn or internist, as applicable, considers appropriate based on his or her own professional judgment; provided that no ob/gyn or internist shall be required (i) to make a recommendation as to the advisability of a woman's having an abortion or (ii) to make a referral to a physician to perform an abortion for any woman.

Section 5. UNLAWFUL REMUNERATION FOR REFERRALS. It shall be unlawful for any physician to, knowingly and willfully, solicit or receive any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a woman to another physician for the purposes of performing an abortion;³²² provided that a personal referral by a physician to another physician in the same group practice as the referring physician shall not violate the prohibition in this Section (a). For purposes of this Section, the term "group practice" has the meaning set forth in 42 U.S.C. § 1395nn(h)(4).

Section 7. PENALTIES.

- (a) The following persons shall be guilty of a _____, and upon conviction thereof, shall be fined not more than \$_____:
- (i) Any physician who (A) performs an abortion in violation of Section 3(a) of this Act, (B) fails to comply with his or her obligations under Section 4 of this Act, or (C) who violates the prohibition in Section 5 of this Act;
 - (ii) Any physician or other person who fails to comply with the confidentiality requirements under Section 3(d) of this Act; and
 - (iii) Any person who knowingly and willfully engages in a plan, scheme, practice, or activity designed to evade the requirements of this Act.
- (b) Notwithstanding anything to the contrary contained in this Act, a woman upon whom an abortion is performed in violation of this Act may not be prosecuted or held civilly liable for such violation of this Act or for a conspiracy to violate this Act.³²³

Section 8. SEVERABILITY. If any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of this Act or the application thereof to any person or circumstance is found to be unconstitutional, the same

321. Included to assist in cross-jurisdictional application.

322. Based on Health Insurance Portability and Accountability Act of 1996 § 1177, 42 U.S.C. § 1320a-7b(b) (2012).

323. See Prenatal Nondiscrimination Act (PRENDA) of 2015, S. 48, 114th Cong. § 3(a) for a similar provision.

is hereby declared to be severable, and the balance of this Act shall remain effective, notwithstanding such unconstitutionality. The [General Assembly/Legislature] hereby declares that it would have passed this Act, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases, or words be declared unconstitutional.³²⁴

Exhibit A

CERTIFICATION BY PRIMARY CARE PHYSICIAN

PATIENT: _____

1. I, the undersigned physician, hereby certify as follows:

I am a physician licensed under the laws of _____ and engaged in the practice of:

- ____ family medicine.
- ____ general pediatric medicine.
- ____ general internal medicine.
- ____ internal medicine/pediatrics.
- ____ obstetrics/gynecology.

2. I have a professional relationship with the above-named patient (the "Patient") for the purposes of providing:

- ____ non-emergency gynecological and/or obstetrical care.
- ____ first contact and continuing care with respect to undiagnosed signs, symptoms, or health concerns not limited by problem, origin, organ system, or diagnosis.

3. I have been informed by the Patient that she is considering having an abortion with respect to a presently existing pregnancy (the "Abortion"), and she has requested that I refer her to a physician to perform the Abortion.

4. The Patient has been my patient for purposes of the care described in paragraph 2 since _____, which I reasonably believe is before the date on which the Patient's presently existing pregnancy began.

324. Based on N.C. GEN. STAT. § 90-21.92.

5. I have consulted with the Patient regarding her decision to have the Abortion.

___ In my medical judgment based upon the information I have, the Abortion is advisable in the Patient's particular circumstances.

___ In my medical judgment based upon the information I have, the Abortion is not advisable in the Patient's particular circumstances.

___ I have declined to make any recommendation as to the advisability of the Abortion.

My reason(s) for the determination indicated above or for declining to make a recommendation are as follows (attach additional pages as necessary):

6. I have:

___ referred the patient to a physician for the purposes of performing the Abortion.

___ declined to make a referral to a physician for the purposes of performing the Abortion.

If I have declined to make a referral, my reason(s) for doing so are as follows (attach additional pages as necessary):

- 7. If I have made a referral to a physician for the purposes of performing the Abortion, (i) I have not received, directly or indirectly, any remuneration for making such referral, (ii) I do not expect to receive, directly or indirectly, any remuneration for making such referral, and (iii) if offered to me, I will not accept, directly or indirectly, any remuneration for making such referral.

Date: _____

Signature: _____

Name: _____

Address: _____

Telephone: _____

