

PELVIC EXAM PREREQUISITE TO HORMONAL CONTRACEPTIVES: UNJUSTIFIED INFRINGEMENT ON CONSTITUTIONAL RIGHTS, GOVERNMENTAL COERCION, AND BAD PUBLIC POLICY

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I. INTRODUCTION

Family planning programs receiving federal funds under Title X,¹ Medicaid,² and block grants³ mandate pelvic exams as a condition to access to oral contraceptives and sometimes other hormonal methods of birth control.⁴ Requiring a pelvic exam, an invasive procedure, infringes upon

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¹ Title X family planning program of the Public Health Services Act, 42 U.S.C. §§ 300 to 300a-6a (2003). The provisions were enacted in 1970 (with program guidelines specified by regulations of the Department of Health and Human Services (“HHS”) and 42 C.F.R. § 59 (2004) and administered by the Office of Population Affairs (“OPA”)) to make contraceptive services available to all who need them but are unable to afford them without governmental assistance. The program was designed to fulfill President Nixon’s promise that “no American woman . . . be denied access to family planning assistance because of her economic condition.” H.R. Doc. No. 91-139, at 8 (1969).

² Joint federal-state Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. § 1396 (2000). Under Medicaid, the federal government (through HHS) sets broad program parameters, including mandated provision of family planning services, and the individual states control the program’s administration. Medicaid is the largest source of public funding for family planning services in the United States. Rachel Benson Gold, *Key Policies Emerging to Govern Delivery of Family Planning in Medicaid Managed Care*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Feb. 1999, at 3, 3, available at http://www.guttmacher.org/journals/tgr_archive.html (last visited Feb. 1, 2004).

³ Maternal and Child Health (“MCH”) Block Grant program, Title V of the Social Security Act, 42 U.S.C. §§ 701–09 (2000), and Social Services block-grant program, Title XX of the Social Security Act, 42 U.S.C. § 1397 (2000).

⁴ Discussion of contraception in this Article refers to reversible contraception and focuses primarily on oral contraception, though the arguments are likely to apply to other hormonal methods of contraception for which pelvic exams are suggested. Depo-Provera, the only injectable contraceptive currently available, is administered once every twelve weeks. Norplant, the only contraceptive implant currently available, is a set of five match-stick-sized strips that are inserted under the skin and slowly release hormones for a period of up to five years or until removed. While NuvaRing (an intravaginal, hormonal contraceptive device) and Ortho Nova (a transdermal, hormonal contraceptive patch) are too new to be mentioned in the literature about publicly funded contraception, the source and rationale of the pelvic exam requirement for oral contraceptives, *see infra* notes 275–277 and accompanying text, suggest that the federal funding guidelines will also require pelvic exams for access to these new products. Indeed, their package labeling states that it is

women's bodily privacy rights. Patients seeking hormonal forms of birth control from private providers are not subject to this absolute requirement.⁵ Nor are men seeking contraception or sexual performance-enhancing drugs from publicly funded clinics required to undergo invasive prostate exams, despite presenting the same opportunity for preventive health care as women seeking oral contraceptives. The pelvic exam requirement increases the cost of providing oral contraceptives, results in decreased utilization of other publicly funded health care services, and imposes unnecessary discomfort and anxiety. These consequences deter impoverished women, particularly adolescents, from seeking such highly effective forms of contraception.

This Article argues that the risks posed to individuals and society by the pelvic exam requirement far outweigh the drug-related risks posed to any woman who makes a voluntary, informed decision to accept them. Following an overview of publicly funded contraception in Part II, the Article focuses on the unconstitutionality of the pelvic exam requirement. Part III examines its violation of substantive due process rights to contraceptive access, reproductive autonomy, and bodily integrity due to its lack of any rational basis. Part IV discusses the requirement's impact on the equal protection rights of women and minorities. Part V argues that the requirement is an unconstitutional condition on the exercise of fundamental reproductive privacy rights. Part VI focuses on mandated pelvic exams as an impermissible agency interpretation of statutory instructions.

In Part VII this Article argues that sound public policy compels the elimination of the unnecessary barrier to contraception that a mandatory pelvic exam creates. The requirement deters women from obtaining effective contraceptives, resulting in unwanted pregnancies and abortions as well as increased costs to individuals and society. The pelvic exam requirement perpetuates gender stereotypes by decreasing women's actual and perceived autonomy: unwanted pregnancies potentially derail education and career goals and force maternal roles and responsibilities upon women who do not desire them. Further, the requirement is inconsistent with other laws concerning medical decisions and Title X programs.

The Article concludes with a proposal to allow women to obtain oral contraceptive prescriptions by signing an informed consent and release after having been offered a pelvic exam and advised of the risks of foregoing it. Allowing women who use federally funded clinics the option to exercise their fundamental right to reproductive autonomy without requiring the forfeiture of bodily privacy rights will decrease individual and

"good medical practice" for women using these products to have physical evaluations that include "special reference to . . . pelvic organs and vagina (including cervical cytology)." NuvaRing package insert labeling, *infra* note 277.

⁵ Private providers who do not receive Title X funds (including all physicians operating for profit) may use discretion in administering pelvic exams.

social burdens imposed by unwanted pregnancies and abortions, increase women's autonomy, and help erode gender role stereotypes.

II. OVERVIEW OF PUBLICLY FUNDED CONTRACEPTION

A. *The Importance of Contraception Provided by Publicly Funded Family Planning Programs*

There are 3117 U.S. agencies that provide publicly funded contraceptive services⁶ to over 7000 family planning clinics nationwide.⁷ The average woman, who wants only two children, will use contraceptives for twenty to thirty years of her life.⁸ Thirty-three million U.S. women are in need of contraceptive services at any given time, and more than sixteen million of these women need these services subsidized.⁹ Of the 6.5 million women actually receiving subsidized family planning services, two-thirds do so at clinics supported by Title X funds.¹⁰ While most women prefer to see private physicians, low-income women are often forced to utilize publicly funded family planning clinics instead.¹¹

⁶ Lawrence B. Finer et al., *U.S. Agencies Providing Publicly Funded Contraceptive Services in 1999*, 34 PERSP. ON SEXUAL AND REPROD. HEALTH 15, 17 (2002).

⁷ Cynthia Dailard, *Challenges Facing Family Planning Clinics and Title X*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Apr. 2001, at 8, 8, available at http://www.guttmacher.org/journals/tgr_archive.html (last visited Feb. 1, 2004).

⁸ ALAN GUTTMACHER INST., FULFILLING THE PROMISE: PUBLIC POLICY AND U.S. FAMILY PLANNING CLINICS 10 (2000) [hereinafter ALAN GUTTMACHER INST., FULFILLING THE PROMISE], available at <http://www.guttmacher.org/pubs/fulfill.pdf> (last visited Feb. 1, 2004); Alan Guttmacher Inst., *Facts in Brief: Contraceptive Use* (2004) [hereinafter Alan Guttmacher Inst., *Facts in Brief*], http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Feb. 1, 2004).

⁹ Alan Guttmacher Inst., *Contraceptive Need and Services* tbl. 1 (1995), http://www.guttmacher.org/pubs/contra_tables.html (last visited Feb. 1, 2004).

¹⁰ Dailard, *supra* note 7, at 8; see also Jennifer J. Frost, *Public or Private Providers? U.S. Women's Use of Reproductive Health Services*, FAM. PLAN. PERSP., Jan.-Feb. 2001, at 4, 4. This Article will focus largely on Title X because its provision of funds to a majority of public family planning clinics, in conjunction with the mandate that clinics receiving its funds follow Title X standards in treating all of their patients (regardless of the clinics' receipt of other types of public funds), has resulted in Title X essentially setting the standards for all publicly funded family planning services in the United States. Rachel Benson Gold, *Title X: Three Decades of Accomplishment*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Feb. 2001, at 5, 6, available at http://www.guttmacher.org/journals/tgr_archive.html (last visited Feb. 1, 2004); ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 14, available at <http://www.guttmacher.org/pubs/fulfill.pdf>. Also, Title X is the only federal program with the sole purpose of providing family planning services. *Id.* at 12.

¹¹ Although Medicaid theoretically allows patients to choose either public or private family planning providers, Medicaid patients have difficulty finding private physicians who will serve them. In one survey, forty-six percent of obstetrician-gynecologists did not serve Medicaid patients, and those who did typically saw very few. See David J. Landry & Jacqueline Darroch Forrest, *Private Physicians' Provision of Contraceptive Services*, FAM. PLAN. PERSP., Sept.-Oct. 1996, at 203, 203. Seventy-one percent of women who made a medical family planning visit paid for by Medicaid received care at a public clinic, despite most low-income women's preference for a private provider. *Id.*

More than three million unplanned pregnancies occur in the United States each year, forty-seven percent of which result from the seven percent of women who do not use contraception.¹² Each year, publicly funded contraceptive services help prevent 1.3 million unplanned pregnancies, which otherwise would result in 632,300 abortions, 533,800 unintended births, and 165,000 miscarriages.¹³ Title X alone helps American women avoid one million unintended pregnancies each year.¹⁴ Every tax dollar spent for contraceptive services saves three dollars in Medicaid costs for health care for pregnant women and newborns.¹⁵

B. *The Importance of Oral Contraceptives and Other Hormonal Contraceptive Methods*

More than eighteen million American women use oral contraceptives, making "the pill" the most frequently used form of reversible contraception in the United States.¹⁶ It is also one of the safest drugs currently marketed.¹⁷ Hormonal contraceptives are by far the most effective method of reversible contraception,¹⁸ with a failure rate of less than one percent for Norplant, Depo-Provera, and oral contraceptives when used in perfect compliance (and only a five percent failure rate for oral contraceptives in actual observed use).¹⁹ Condoms, which are the second most popular and second most effective form of reversible contraception, have a twelve to sixteen

¹² Alan Guttmacher Inst., *Facts in Brief*, *supra* note 8, http://www.guttmacher.org/pubs/fb_contr_use.html.

¹³ Jacqueline Darroch Forrest & Renee Samara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, FAM. PLAN. PERSP., Sept.-Oct. 1996, at 188, 193 tbl. 4.

¹⁴ Dailard, *supra* note 7, at 8.

¹⁵ Forrest & Samara, *supra* note 13, at 193. Prevention of unplanned pregnancies with public services keeps 841,800 qualified women from needing pregnancy-related Medicaid assistance each year. *Id.*

¹⁶ Michael J. Rosenberg et al., *Compliance, Counseling and Satisfaction with Oral Contraceptives: A Prospective Evaluation*, FAM. PLAN. PERSP., Mar.-Apr. 1998, at 89, 89 (citing Michael J. Rosenberg et al., *Unintended Pregnancies and Use, Misuse and Discontinuation of Oral Contraceptives*, 40 J. REPROD. MED. 355 (1995)).

¹⁷ Rosenberg et al., *supra* note 16, at 89 (citing Philip C. Hannaford, *Combined Oral Contraceptives: Do We Know All of Their Effects?*, 51 CONTRACEPTION 325 (1995); CONTRACEPTIVE TECHNOLOGY 405, 409 (Robert A. Hatcher et al. eds., 16th rev. ed. 1994)).

¹⁸ Failure rates for nonhormonal contraceptive methods are: male condom, 12%; diaphragm, 18%; withdrawal, 19%; periodic abstinence, 20%; female condom, 21%; spermicides, 21%; sponge, 30%; cervical cap, 30%; no method, 85%. James Trussell et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 494, 495 (1995). While some forms of intrauterine devices (IUDs) have lower failure rates, not all forms are nonhormonal. BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES: A BOOK BY AND FOR WOMEN 264 (1992) (citing a 0.42% failure rate in the copper-T IUD, 3.0% failure rate for IUDs as a class). Insertion of the device requires placement by a clinician in a procedure as invasive as a pelvic exam, and contraindications preclude its use for most teenagers. Am. Acad. of Pediatrics, Comm. on Adolescence, *Contraception and Adolescents*, 86 PEDIATRICS 134 (1990).

¹⁹ SmarterSex.Org, *Contraceptives: How Effective Are They?*, at http://www.smartersex.org/contraception/efficacy_chart.asp (last visited Feb. 1, 2004).

percent failure rate, causing a significant risk of unintended pregnancy.²⁰ Hormonal contraceptives are also considered more convenient than other forms of birth control.²¹ Because hormonal methods of birth control are independent of intercourse, they are “largely outside the control and even the knowledge of a woman’s male partner”²² Therefore, such methods are essential in providing women reliable control over their fertility.

III. SUBSTANTIVE DUE PROCESS VIOLATIONS

Fifth Amendment substantive due process principles prohibit a federal regulation from infringing unjustifiably upon a constitutional right.²³ When the infringed right has been deemed fundamental by the U.S. Supreme Court, the regulation is subject to strict scrutiny review.²⁴ The first section of this Part discusses the pelvic exam requirement’s infringement upon implied fundamental rights. The second section explains the requirement’s violation of women’s substantive due process rights, which is unjustified under strict scrutiny review.²⁵ The final section illustrates how the requirement remains impermissible under both intermediate level and rational basis standards of review.

A. *The Requirement Infringes upon Implied Fundamental Rights of Privacy*

Many constitutional privacy rights that are not explicitly articulated in the Constitution are deemed to exist by implication.²⁶ The pelvic exam requirement infringes upon the implied fundamental privacy rights to use contraceptives and control reproduction as well as to maintain bodily integrity.²⁷

²⁰ Trussell et al., *supra* note 18, at 495 (citing a twelve percent failure rate for condoms); Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 171, 180 (1999) (citing a sixteen percent failure rate for condoms).

²¹ See, e.g., HOWARD W. ORY ET AL., MAKING CHOICES: EVALUATING THE HEALTH RISKS AND BENEFITS OF BIRTH CONTROL METHODS 5–9 (1983).

²² Jacqueline E. Darroch, *The Pill and Men’s Involvement in Contraception*, FAM. PLAN. PERSP., Mar.-Apr. 2000, at 90, 90.

²³ State regulations mandating pelvic exams are equally prohibited from infringing upon constitutional rights by the Fourteenth Amendment’s Due Process Clause.

²⁴ *United States v. Carolene Prods. Co.*, 304 U.S. 144, 153 n.4 (1938); see also *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977) (holding that strict scrutiny must be met for the government to justify a law restricting access to contraceptives).

²⁵ While the pelvic exam requirement is a condition on federal spending rather than on all women seeking hormonal contraception, discussion of a general rule’s compliance with due process requirements serves as a preface to an examination of the prerequisite’s constitutionality as a condition on spending. See *infra* Part V.

²⁶ See *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965); ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 762 (2d ed. 2002).

²⁷ The requirement also arguably infringes upon implied medical care decisionmaking rights. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), and *Wash-*

1. Right To Use Contraceptives and Control Reproduction via Access to Contraceptives

In 1965, the Supreme Court acknowledged the existence of a fundamental constitutional right for married people to purchase and use contraception.²⁸ In 1972, the Court extended this right to unmarried individuals, expanding it from one of marital privacy to one of reproductive privacy.²⁹ The result was a fundamental right of access to contraceptives, free from unjustified governmental interference, in order to control reproduction.³⁰ The Court famously held that “[i]f the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”³¹

Despite the fact that the pelvic exam prerequisite does not bar access to all forms of birth control, it is impermissible under *Griswold v. Connecticut* and *Eisenstadt v. Baird* because they hold that there is a right of access to *effective* contraception.³² By today's standards, nonhormonal methods' twelve percent or greater failure rates³³ constitute far less than the required efficacy.³⁴ The cases emphasize the right to determine family size—

ington v. Harper, 494 U.S. 210 (1990), established the existence of a medical care decisionmaking right, which includes the right to refuse life-saving treatment. Therefore, even if the pelvic exam had the effect of saving a woman's life, she has the right to refuse it.

²⁸ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

²⁹ *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

³⁰ *See id.* at 453; *see also* *Planned Parenthood v. Casey*, 505 U.S. 833, 851–53 (1992) (affirming the right's continued existence).

³¹ *Eisenstadt*, 405 U.S. at 453.

³² For single or married people to control the number and spacing of their children, the contraception to which they are entitled access must be effective. Thus, taken together, *Eisenstadt* and *Griswold* create a right of access to effective contraception for all. *See* *Planned Parenthood Fed'n v. Schweiker*, 559 F. Supp. 658, 660, 666 (D.D.C. 1983) (considering the lack of efficacy of nonprescription birth control as a factor in finding a parental notice restriction on adolescents' access to hormonal birth control unjustifiable because it would undermine Title X clinics' ability to reduce the number of unintended births and pregnancies).

³³ *See supra* note 18. While sterilization is a virtually one hundred percent effective nonhormonal method of contraception, it is equally or more invasive than a pelvic exam and would also preclude exercise of the right to determine number and spacing of children for women who desire to have more children in the future. Similarly, while some forms of IUDs are nonhormonal and provide levels of efficacy comparable to that of oral contraceptives, they require an insertion procedure as invasive as a pelvic exam, *see supra* note 18, work via a mechanism of action that is not fully understood and thus may implicate religious or moral concerns, *see infra* note 241 and accompanying text, and are associated with risks that many consider greater than those associated with oral contraceptives. *See* David Hubacher, *The Checkered History and Bright Future of Intrauterine Contraception in the United States*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 98, 98–99 (2002); Rod Seeley et al., *Control of Reproduction*, <http://www.mhhe.com/biosci/ap/seeleyap/repro/reading8.mhtml> (2001) (last visited Feb. 1, 2004).

³⁴ Compare the products liability principle of an “unavoidably unsafe” product, under which courts have held that an oral contraceptives manufacturer can only be held liable for harm resulting from its product's use if, at that time, there existed an alternative product that was at least as effective and provided less risk. A mere “alleged modicum of reduction

a right hardly fulfilled by a failure rate that would leave the average woman with four more pregnancies than desired if she used the most effective nonhormonal contraception for the thirty years the typical American woman spends trying to avoid pregnancy.³⁵ Therefore, denying a woman access to hormonal methods of contraception amounts to a ban on effective contraception and is impermissible under *Griswold* and *Eisenstadt*.

Even if the pelvic exam requirement does not *prevent* access to effective contraception, regulations *restricting* access to contraceptives are impermissible under the Supreme Court's holding in *Carey v. Population Services International*.³⁶ *Carey* made clear the sacrosanct status of the right to effective contraception by holding that strict scrutiny must be met for the government to justify a law restricting access to contraceptives.³⁷ In *Carey*, the Court declared unconstitutional a law that made it criminal to advertise or display contraceptives, to distribute or sell contraceptives to persons under sixteen, or for anyone besides a licensed pharmacist to distribute contraceptives to persons over fifteen.³⁸ The Court found that limiting distribution of contraceptives to pharmacists unduly restricted access to birth control (unjustifiably infringing the right to control procreation) and that the law violated the rights of those under sixteen to have access to contraceptives.³⁹

2. Right to Bodily Integrity

The Supreme Court has held that the individual has a dignity interest in bodily integrity.⁴⁰ This principle is "deeply embedded in our . . . constitutional traditions."⁴¹ The prominence of the fundamental right to bodily integrity within the context of substantive due process privacy rights is highlighted by *Roe v. Wade*⁴² and *Planned Parenthood v. Casey*,⁴³ both of which discuss the importance of a woman's right to bodily integrity in relation to the government's interests in protecting life and health. A pel-

of risk" does not justify a loss of effectiveness. Joanne Rhoton Galbreath, Annotation, *Products Liability: What Is an "Unavoidably Unsafe" Product?*, 70 A.L.R. 4th 16, §§ 4-5 (1989) (citing *Ackley v. Wyeth Laboratories, Inc.*, 919 F.2d 397 (6th Cir. 1990); *White v. Wyeth Labs., Inc.*, 533 N.E.2d 748 (Ohio 1988); *Patten v. Lederle Labs*, 676 F. Supp. 233 (D. Utah 1987)).

³⁵ ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 10, available at <http://www.guttmacher.org/pubs/fulfill.pdf>.

³⁶ 431 U.S. 678 (1977).

³⁷ *Id.* at 685-86.

³⁸ *Id.* at 682.

³⁹ *Id.* at 686.

⁴⁰ *See, e.g.*, *Winston v. Lee*, 470 U.S. 753, 761 (1985) (holding that compelling a criminal defendant to submit to surgery in order to retrieve a bullet necessary for the state's prosecution would violate the defendant's personal privacy and bodily integrity).

⁴¹ Dawn Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster*, 138 U. PA. L. REV. 179, 201 (1989).

⁴² 410 U.S. 113 (1973).

⁴³ 505 U.S. 833 (1992).

vic exam encroaches upon this fundamental right to bodily integrity. Such infringement is unconstitutional unless sufficiently justified by a governmental interest. Although the amount of justification necessary is determined by the level of scrutiny under which it is reviewed, the requirement fails under each level of review.

B. The Pelvic Exam Requirement Is Unconstitutional Under the Due Process Clause of the Fifth Amendment

The Supreme Court has held that strict scrutiny must be met for the government to justify a law restricting access to contraceptives.⁴⁴ To survive strict scrutiny review, the pelvic exam requirement must be narrowly tailored to serve a compelling governmental interest.⁴⁵ Although it has been established that the government has a compelling interest in protecting women's health,⁴⁶ the requirement fails strict scrutiny review because it is not narrowly tailored to the goal of protecting women's health from the preventable adverse effects of oral contraceptive use: the pelvic exam does not serve its stated purpose, it is not necessary, and it is overly broad. The requirement constitutes a burden that sufficiently outweighs any governmental interest under strict scrutiny review.

1. The Requirement Does Not Serve Its Stated Purpose

The purpose of the pelvic exam requirement is to protect women's health.⁴⁷ More specifically, its goal is to identify women who are at an unacceptably high risk of experiencing harmful side effects of hormonal contraceptives and preclude them from receiving prescriptions.⁴⁸ The pelvic exam requirement fails strict scrutiny review because it does not serve this purpose. Risk of cervical cancer is the only potential danger of oral contraceptive use that the pelvic exam can reveal.⁴⁹ Mandatory pelvic

⁴⁴ See *supra* note 24.

⁴⁵ See, e.g., *Adarand Constructors v. Peña*, 515 U.S. 200 (1995); *Sugarman v. Dougall*, 413 U.S. 634 (1973).

⁴⁶ *Roe*, 410 U.S. at 162 (finding that "the state does have an important and legitimate interest in preserving and protecting the health of the pregnant woman"); *Casey*, 505 U.S. 833, 875-76 (citing *Roe*, 410 U.S. at 162).

⁴⁷ See *infra* note 281; see also *infra* notes 275-277 and accompanying text.

⁴⁸ The purpose of Food and Drug Administration (FDA) labeling information that is used on hormonal contraceptive packaging, see *infra* notes 276-277 and accompanying text, is "to promote the safe and effective use of prescription drug products by patients and to ensure that patients have the opportunity to be informed of the benefits and risks involved in the use of prescription drug products." 45 Fed. Reg. 60,754, 60,754 (Sept. 12, 1980).

⁴⁹ See Felicia H. Stewart et al., *Clinical Breast and Pelvic Examination Requirement for Hormonal Contraception: Current Practice vs. Evidence*, 285 JAMA 2232, 2234 tbl. 2 (2001) (listing factors that render hormonal contraceptive methods "not recommended," as requiring "caution or special monitoring," or for which use has "disadvantages," of which the only ones detectable upon pelvic exam are existing cervical cancer or precursors to cervical cancer (cervical intraepithelial neoplasia), pregnancy (for which contraceptive use

exams do not serve their purpose of protecting women's health for at least three reasons: it has not been proven that oral contraceptive use is causally connected with cervical cancer, the exam is inadequate in accurately detecting the risks it is designed to identify, and the requirement actually *increases* risks to women's health.

a. There Is No Proven Causal Connection Between Hormonal Contraception and the Risks the Exam Requirement Is Designed To Detect

Under strict scrutiny review, a legislative rationale based on a mere associative correlation is insufficient justification for restricting a constitutional right. Rather, a causal connection between the relevant factors must be demonstrated in order to show that the requirement is necessary to achieve the government's compelling purpose.⁵⁰ Therefore, if oral contraceptives are merely *associated with*, but do not *cause*, cervical cancer or acceleration of cervical cancer, an exam to detect risk factors for cervical cancer cannot be *necessary* to protect women's health.

Public family planning clinics initially required annual pelvic exams for women receiving oral contraceptives in order to detect genital cancer, to which oral contraceptive use was suspected, though not shown, to have a causal connection.⁵¹ It has since been demonstrated that not only do oral contraceptives not cause endometrial or ovarian cancer, the drugs may actu-

is contraindicated not because of health risks to the mother or fetus but because it will not be efficacious), and unexplained vaginal bleeding (which is clearly detectable without a pelvic exam)); Mary-Ann B. Shafer, *Annual Pelvic Examination in the Sexually Active Adolescent Female: What Are We Doing and Why Are We Doing It?*, 23 J. ADOLESCENT HEALTH 68, 71 (1998) (listing risk factors for developing cervical cancer, of which the only two detectable upon pelvic exam are human papillomavirus ("HPV") and precancerous lesions). Women who have or are at risk for cervical cancer are often advised not to use oral contraceptives because there is some suggestion that the drugs' use may precipitate cervical cancer development or growth in those at risk. Victor Moreno et al., *Effect of Oral Contraceptives on Risk of Cervical Cancer in Women With Human Papillomavirus Infection: The IARC Multicentric Case-Control Study*, 359 LANCET 1085 (2002) (concluding that long-term use of oral contraceptives *could* be a co-factor that increases risk of cervical cancer by up to fourfold in women who test positive for cervical HPV DNA); Fabio Parazzini et al., *Time Since Last Use of Oral Contraceptives and Risk of Invasive Cervical Cancer*, 34 EUR. J. CANCER 884, 887-88 (1998) (positing that oral contraceptive use should be "critically reconsidered for women with a diagnosis of cervical intraepithelial neoplasia," concluding that there is an excess risk of cervical cancer for long-term users of oral contraceptives with neoplasia); JAMES OWEN DRIFE, THE BENEFITS AND RISKS OF ORAL CONTRACEPTIVES TODAY 22 (2d ed. 1996) (citing Giske Ursin et al., *Oral Contraceptive Use and Adenocarcinoma of the Cervix*, 344 LANCET 1390 (1994)).

⁵⁰ See CHEMERINSKY, *supra* note 26, at 762 (noting that a law will be upheld under strict scrutiny only if it is necessary to achieve a compelling governmental purpose).

⁵¹ ABRIDGED PROCEEDINGS OF THE SECOND CONFERENCE ON PUBLIC FAMILY PLANNING CLINICS: HOW TO ORGANIZE/HOW TO OPERATE 49 (G.D. Searle & Co. Reference and Resource Program ed. 1966) [hereinafter HOW TO ORGANIZE] (acknowledging the lack of evidence of a causal connection between oral contraceptive use and genital cancer, but arguing pelvic exams should be performed nonetheless).

ally *protect against* these cancers.⁵² While some researchers today still suspect that there is a causal link between oral contraceptive use and cervical cancer, no sound scientific data supports this hypothesis,⁵³ and data suggests otherwise.⁵⁴

b. The Exam Does Not Accurately Detect the Risks It Is Designed To Identify

Even if oral contraceptive use is linked to the development of cervical cancer, a pelvic exam (which includes a pap smear) does not serve its purpose because it does not accurately identify women with precancerous lesions or human papillomavirus ("HPV") that will lead to cancer. Results of a pap smear, the best screening tool available to detect precancerous lesions, may be falsely negative in fifteen to thirty percent of women with the lesions, even when obtained and interpreted correctly.⁵⁵ Of those lesions detected that are low-grade, fifty to seventy percent will spontaneously regress or remain stable for many years rather than develop into cancer.⁵⁶ While HPV can be detected by a pelvic exam, of the millions of women infected with it, only a few will ever develop cervical cancer.⁵⁷ Therefore, the exam does not accurately predict who is most likely to develop cervical cancer. Most importantly, even if the exam detects the existence of or precursors to cervical cancer, physicians maintain that "cervical intraepithelial neoplasia and cervical cancer awaiting treatment are not conditions that require avoiding hormonal methods [of contraception] or for which caution is recommended."⁵⁸

⁵² Family Health Int'l, *What Are the Benefits and Risks of Combined Oral Contraceptives?*, at <http://www.fhi.org/en/RH/Pubs/factsheets/OCriskben.htm> (2003) (last visited Feb. 1, 2004); David T. Baird & Anna F. Glasier, *Hormonal Contraception*, 328 NEW ENG. J. MED. 1543 (1993); DRIFE, *supra* note 49, at 34 (noting the continued "standard" advice that women using oral contraceptives have regular pelvic exams despite recent research concluding oral contraceptives are not linked to cervical cancer). Furthermore, pelvic examination has not been found effective as a screening measure to reduce ovarian cancer mortality and is not recommended for that purpose. Stewart et al., *supra* note 49, at 2238 (citing, inter alia, Sonia Regina Grover & Michael Quinn, *Is There Any Value In Bimanual Pelvic Examination As a Screening Test?*, 162 MED. J. AUSTRAL. 408 (1995)).

⁵³ LARA V. MARKS, *SEXUAL CHEMISTRY: A HISTORY OF THE CONTRACEPTIVE PILL* 181 (2001) (stating that "[n]o conclusive evidence has been collected anywhere to date on the connections between the pill and cervical cancer"); Stewart et al., *supra* note 49, at 2237-38 (referring to the risk of cervical cancer development or precursor progression as a "theoretical" concern); Hannaford, *supra* note 17, at 325 (stating that "[u]ncertainty also remains concerning the association between pill use and risk of carcinoma of the cervix").

⁵⁴ *E.g.*, DRIFE, *supra* note 49, at 34 (citing Baird & Glasier, *supra* note 52, for the proposition that there appears to be no increase in the risk of cervical cancer among women who take combined oral contraceptives).

⁵⁵ AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *GUIDELINES FOR WOMEN'S HEALTH CARE* 151 (1996) [hereinafter AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *GUIDELINES*].

⁵⁶ *Id.*

⁵⁷ *Id.* at 137.

⁵⁸ Stewart et al., *supra* note 49, at 2237.

c. Mandatory Pelvic Exams Will Result in an Increased Risk to Women's Health

The pelvic exam requirement will necessarily result in greater risks to women's health for three reasons. First, there will be an increase in pregnancies among women denied oral contraceptives (whether due to unsuitability for the drug or refusal to submit to the pelvic exam) because all other birth control methods except abstinence are less effective.⁵⁹ Carrying a pregnancy to term poses a greater risk to women's health than do oral contraceptives.⁶⁰ Having an abortion also carries much higher risks than do oral contraceptives.⁶¹ Therefore, women who are forced to use a less effective method of birth control face risks of pregnancy and abortion that could be avoided with hormonal contraception and that exceed the risks of oral contraceptive use, even without a pelvic exam.

Second, women's avoidance of pelvic exams will result in a decrease in use of the other general health⁶² and sexual health services, such as screening for sexually transmitted diseases, that are provided by publicly funded clinics.⁶³ Women who opt to use over-the-counter contraception, or none at all, in order to avoid mandatory pelvic exams will not receive the additional health services that are provided at a clinic visit for a hormonal contraceptive prescription.⁶⁴

⁵⁹ *Id.* at 2232 (stating that pelvic examinations "may reduce access to highly effective contraceptive methods, and may therefore increase women's overall health risks"); see *supra* notes 18–19 and accompanying text.

⁶⁰ Family Health Int'l, *A Comparison of Annual Deaths from Oral Contraceptive Related Diseases for Four Regions* (providing data that, for every 100,000 women in the western world, only six women using oral contraceptives die per year due to cervical cancer, while ten women *not* using oral contraceptives die from pregnancy), at http://www.fhi.org/en/RH/Pubs/factsheets/res_BenandRisks.htm (2003) (last visited Feb. 1, 2004). This is particularly true for teenagers. Jessica R. Arons, Note, *Misconceived Laws: The Irrationality of Parental Involvement Requirements for Contraception*, 41 WM. & MARY L. REV. 1093, 1125 n.211 (2000) (citing Am. Acad. of Pediatrics, Comm. on Adolescence, *supra* note 18, at 136). Furthermore, the health risks of pregnancy and childbirth increase greatly when the pregnancy is unwanted. Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1017 n.220 (1984) (citing William Cates, Jr., *Legal Abortion: The Public Health Record*, 215 SCI. 1586, 1587 (1982)).

⁶¹ THE MERCK MANUAL OF MEDICAL INFORMATION § 22, at ch. 255 (Mark H. Beers et al. eds., Second Home ed. 2003) [hereinafter MERCK MANUAL], available at http://www.merck.com/mrkshared/mmanual_home2/sec22/ch255/ch255c.jsp (last visited Feb. 1, 2004).

⁶² For many economically disadvantaged women, entry into the public health care system (which provides general health care services) often occurs only upon a pregnancy scare or a decision to seek reproductive or other sexual health care services. Stewart et al., *supra* note 49, at 2236; see also 136 CONG. REC. S13,680 (daily ed. Sept. 25, 1990) (statement of Sen. Packwood) (acknowledging that for many low-income women, a Title X funded clinic is their only point of contact with the health care system).

⁶³ 136 CONG. REC. S13,676 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy) (noting that publicly funded family planning programs serve as the entry point into the health care system for many patients in need of other important sexual health services, including HIV testing).

⁶⁴ See Stewart et al., *supra* note 49, at 2232, 2236, 2238 (commenting on the missed opportunity for counseling on prevention of sexually transmitted diseases and preventative

Third, it is well accepted by physicians and public health officials that, for the vast majority of women, the benefits of oral contraceptive use far outweigh the risks.⁶⁵ Women on the pill experience approximately half the incidence of ovarian and endometrial cancer as do nonusers.⁶⁶ Oral contraceptive use is also associated with decreased risks of ovarian cysts, uterine fibroids, benign breast disease, and pelvic inflammatory disease.⁶⁷ Pill use has the benefit of drastically reducing unwanted pregnancies, particularly ectopic pregnancies.⁶⁸ The only women for whom benefits of hormonal contraception do not generally outweigh the risks are those who are over thirty-five years of age and smoke⁶⁹ and those for whom there is an absolute contraindication for pill use.⁷⁰ None of these factors requires a pelvic exam to detect.⁷¹ Therefore, the research suggests that for most women oral contraceptives will *benefit* women's health, despite

services because of anxieties about the pelvic exam).

⁶⁵ See Family Health Int'l, *supra* note 52 (stating that although there are risks associated with oral contraceptive use, the risks tend to be small and are balanced by health benefits), at <http://www.fhi.org/en/RH/Pubs/factsheets/OCriskben.htm>; DRIFE, *supra* note 49, at 41 (asserting that the benefits of oral contraceptive use greatly outweigh the risks); Hannaford, *supra* note 17, at 325–26. This is also particularly true for young women. Stewart et al., *supra* note 49, at 2237; DRIFE, *supra* note 49, at 35; Arons, *supra* note 60, at 1125 n.211 (citing Am. Acad. of Pediatrics, Comm. on Adolescence, *supra* note 18, at 136).

⁶⁶ DRIFE, *supra* note 49, at 23–26; Family Health Int'l, *supra* note 52, at <http://www.fhi.org/en/RH/Pubs/factsheets/OCriskben.htm>.

⁶⁷ HOLLY MEAD, INST. FOR WOMEN'S POL'Y RES., EVALUATING AN RX-TO-OTC SWITCH OF ORAL CONTRACEPTIVES: A COST-BENEFIT ANALYSIS 8 (2000) (citing Trussell et al., *supra* note 18, at 494); Diane B. Petitti, *Safety of Birth Control Pills*, in HENRY J. KAISER FAMILY FOUND., THE PILL: FROM PRESCRIPTION TO OVER THE COUNTER 77, 77–115 (Sarah E. Samuels & Mark D. Smith eds., 1994); DRIFE, *supra* note 49, at 23.

⁶⁸ An ectopic pregnancy occurs when an embryo improperly implants in the fallopian tube (rather than the uterus), which poses great risks to the woman's life. Compared to women who use no form of birth control, women on the pill who become pregnant experience ninety percent fewer ectopic pregnancies. DRIFE, *supra* note 49, at 23 (citing David A. Grimes, *Reversible Contraception for the 1980s*, 255 JAMA 69 (1986)).

⁶⁹ DRIFE, *supra* note 49, at 39. Some, though not all, physicians consider smoking after age thirty-five an absolute contraindication to pill use. RICHARD P. DICKEY, MANAGING CONTRACEPTIVE PILL PATIENTS 200 (9th ed. 1998). The American College of Obstetricians and Gynecologists ("ACOG"), however, supports prescribing oral contraceptives to women over thirty-five who smoke if they are free of additional absolute contraindications to use and have been warned about the risks of use. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 93.

⁷⁰ Stewart et al., *supra* note 49, at 2236. Absolute contraindications to oral contraceptive use include: breast cancer, hypertension, certain heart and liver diseases, diabetes mellitus, history of thromboembolic disease, stroke, some types of migraine headaches, breastfeeding within six weeks of giving birth, and pregnancy.

⁷¹ *Id.* While a pelvic exam can detect pregnancy, it is not necessary because after fourteen days pregnancy would be suspected based on a medical history including missed period. *Id.* Pregnancy can also be detected by non- or less-invasive urine or blood screens. Moreover, there is no evidence that hormonal contraceptives are harmful for either the woman or the fetus if inadvertent exposure occurs during early pregnancy. Pregnancy is considered a contraindication because it renders the pill superfluous, not because it poses any known safety risks. *Id.*

any associated risks.⁷² Consequently, deterring use of these drugs because of a mandated prior pelvic exam results in higher risks to women's health.

2. *The Requirement Is Unnecessary*

The pelvic exam requirement fails strict scrutiny review because the exam is not necessary to determine whether a hormonal contraceptive should be prescribed for a woman.⁷³ International medical guidelines support the safety of providing hormonal contraception without a pelvic exam.⁷⁴ European physicians deem pelvic exams irrelevant and unnecessary barriers to contraception accessibility.⁷⁵ Even within the United States, many physicians do not favor the required pelvic exam.⁷⁶ The FDA,⁷⁷ Planned Parenthood,⁷⁸ other family planning clinics, and many states allow women to defer the pelvic exam for up to three months after beginning hormonal contraception.⁷⁹ The Title X regulations allow a de-

⁷² The World Health Organization has explicitly stated that "for young non-smoking women, the health benefits of oral contraceptive use (including an [sic] reduced risk of endometrial and ovarian cancers) far exceed the health risks." Emma Wilkinson, *HPV and Oral Contraceptives Linked to Cervical Cancer Risk*, 3 LANCET ONCOLOGY 265, 265 (2002).

⁷³ Stewart et al., *supra* note 49, at 2238 (concluding that "[h]ormonal contraception can safely be provided on the basis of careful medical history and blood pressure measurement. Breast and pelvic examinations and screening for cervical cancer and [sexually transmitted infections] . . . are not necessary for identifying women who should avoid these methods or need further evaluation before a decision about hormone use is reached."); see also Kim Best, *Medical Barriers Often Unnecessary*, NETWORK, FAMILY HEALTH INTERNATIONAL QUARTERLY BULLETIN, Vol. 21, No. 3 (2002) (stating that pelvic exams are only necessary before the insertion of IUDs and are not routinely needed for the safe use of hormonal methods of contraception), available at <http://www.reproline.jhu.edu/English/6read/6issues/6network/v21-3/nt2131.htm> (last visited Feb. 1, 2004).

⁷⁴ Cynthia Harper et al., *Provision of Hormonal Contraceptives Without a Mandatory Pelvic Examination: The First Stop Demonstration Project*, FAM. PLAN. PERSP., Jan.-Feb. 2001, at 13, 13; Stewart et al., *supra* note 49, at 2233 (citing the recommendation of both the World Health Organization and the U.S. Agency for International Development that "[a] pelvic examination is not necessary for safe use of combined oral contraceptives as a contraceptive method").

⁷⁵ Barbara A. Cromer & Maureen McCarthy, *Family Planning Services in Adolescent Pregnancy Prevention: The Views of Key Informants in Four Countries*, FAM. PLAN. PERSP., Nov.-Dec. 1999, at 287, 290.

⁷⁶ See, e.g., Stewart et al., *supra* note 49, at 2236 (asserting that the pelvic exam is a "medically unnecessary requirement" that "raises important ethical questions").

⁷⁷ Harper et al., *supra* note 74, at 13 (citing Food & Drug Admin., *Labeling Guidance for Combination Oral Contraceptives, Prescribing Information, Physician Labeling* (rev. Aug. 1994), at <http://www.fda.gov>; Food & Drug Admin., *Labeling Guidance for Progestin-Only Oral Contraceptives, Prescribing Information, Physician Labeling* (rev. May 1995), at <http://www.fda.gov>).

⁷⁸ Harper, et al., *supra* note 74 (citing PLANNED PARENTHOOD FED'N OF AM. NAT'L MED. COMM., *MANUAL OF MEDICAL STANDARDS AND GUIDELINES* (1996)).

⁷⁹ Finer et al., *supra* note 6, at 15; see also Jennifer J. Frost & Michele Bolzan, *The Provision of Public-Sector Services by Family Planning Agencies in 1995*, FAM. PLAN. PERSP., Jan.-Feb. 1997, at 6, 8 (stating that fifty-three percent of family planning agencies have instituted policies allowing the pelvic exam to be delayed for women seeking oral

layed pelvic exam if appropriate counseling is provided.⁸⁰ Planned Parenthood has recently considered removing the pelvic exam requirement entirely.⁸¹ Such widespread flexibility in and hesitancy about enforcing the requirement raises questions as to its necessity.

Furthermore, there are less invasive alternatives to pelvic exams that can detect the increased risk of developing cervical cancer that the exam is designed to identify. An oral medical and social history is noninvasive and is sufficient to gather most of the information relevant to identifying those women for whom hormonal contraception may not be safe⁸² or for whom a pelvic exam may be warranted.⁸³ For example, it is known that among young adult women, risk factors for eventual development of cervical cancer include early onset of sexual intercourse, an immuno-compromised state such as HIV infection, smoking,⁸⁴ infection with an oncogenic type of HPV, or multiple sexual partners.⁸⁵ Thus, those who are at risk can be identified by asking patients questions about their medical, sexual, smoking, and drug histories.

In addition to an oral medical and social history, a specimen sample⁸⁶ can be collected noninvasively to detect HPV. The vast majority of

contraceptives); Marjorie R. Sable et al., *Factors Affecting Contraceptive Use in Women Seeking Pregnancy Tests: Missouri, 1997*, FAM. PLAN. PERSP., May-June 2000, at 124, 130.

⁸⁰ Finer et al., *supra* note 6, at 15; Memorandum from Jerry Bennett, Acting Deputy Assistant Secretary for Population Affairs, to Regional Health Administrators of Title X programs (June 25, 1993), available at <http://opa.osophs.dhhs.gov/titlex/pis/opa93-1.pdf> (last visited Feb. 1, 2004). On January 11, 2001, OPA issued revised Program Guidelines for Project Grants for Family Planning Services, specifying that deferral of the pelvic exam until after initiation of oral contraceptives was permissible, if judged appropriate by the clinician, for a period of up to three months but no longer than six months. Nat'l Cervical Cancer Coalition, *OPA Issues Revised Title X Guidelines*, at http://www.nccc-online.org/fppaps_12.asp (2001) (last visited Feb. 1, 2004).

⁸¹ Harper et al., *supra* note 74, at 13.

⁸² For decades, European and developing countries have been safely distributing oral contraceptives without even requiring prescriptions. A pharmacist or other nonphysician screens out women who should not use the pill based on the patient's medical history. Francine M. Coeytaux & Amy Allina, *The Pill Without Prescription: The International Experience, in THE PILL: FROM PRESCRIPTION TO OVER THE COUNTER*, *supra* note 67, at 75; see also Stewart et al., *supra* note 49, at 2238 (concluding that "[h]ormonal contraception can safely be provided on the basis of careful medical history and blood pressure measurements").

⁸³ See *infra* Part III.B.3.

⁸⁴ After one recent study of the connection between oral contraceptive use and cervical cancer, researchers concluded that an interaction between tar exposure and HPV were the triggering events for development of cervical cancer in oral contraceptive users. Harry Haverkos, *The Cause of Invasive Cervical Cancer Could Be Multifactorial*, 54 BIOMED. & PHARMACOTHERAPY 54, 57 (2000).

⁸⁵ Shafer, *supra* note 49, at 68.

⁸⁶ A study of 330 young women aged thirteen to twenty who underwent pelvic examination and provided urine samples concluded that pelvic exams in asymptomatic women of this age group were unnecessary, as urine samples could detect most conditions requiring intervention (e.g., sexually transmitted diseases (STDs)), and it was unlikely that any adverse outcome would have resulted had the pelvic exam not been done at that time. Julius Schachter et al., *Routine Pelvic Examinations in Asymptomatic Young Women*, 335 NEW ENG. J. MED. 1847 (1996).

women who develop cervical cancer have HPV,⁸⁷ which is detectable by self-collected vaginal swabs.⁸⁸ Additionally, HPV DNA tests are available that can be done without a pelvic exam and are *better* than pelvic exams at detecting cervical abnormalities that could indicate a risk of developing cervical cancer.⁸⁹ Even among those medical researchers who favor pelvic exams prior to dispensing oral contraceptives, many acknowledge that pap screening largely safeguards against any increase of cervical cancer risk from hormonal contraceptives.⁹⁰ Pap screening is possible without a pelvic exam⁹¹ in light of the recent findings of feasibility and accuracy in diagnosis by self-collected vaginal swabs. Screening for HPV is already offered by publicly funded clinics. Thus, implementation of a pap smear alternative would not require additional funding.⁹²

Moreover, after pill use has begun, these risk factors can be monitored with follow-up oral medical and social questions and self-collected HPV tests so that the need for annual follow-up pelvic exams for oral contraceptive users is eliminated.⁹³ Thus, pelvic exams are not *necessary* to determine whether oral contraceptives can be safely prescribed or continued.

3. *The Requirement Is Overinclusive*

The pelvic exam requirement fails strict scrutiny review because it is overinclusive. Even if pelvic exams do serve their purpose and are warranted for some women, they are not necessary for all women.⁹⁴ For instance, women who recently had a pelvic exam from a different provider

⁸⁷ Of women who develop cervical cancer, ninety-three to one hundred percent have HPV. Judith Reichman, *New Pap Smear Guidelines (Today)*, NBC television broadcast, Feb. 3, 2003 (on file with author); see also Jan M. Walboomers et al., *Human Papillomavirus Is a Necessary Cause of Invasive Cervical Cancer Worldwide*, 189 J. PATHOLOGY 12 (1999); Eduardo L. Franco et al., *Epidemiological Evidence and Human Papillomavirus Infection as a Necessary Cause of Cervical Cancer*, 91 J. NAT'L CANCER INST. 506 (1999).

⁸⁸ Patti E. Gravitt et al., *Evaluation of Self-Collected Cervicovaginal Cell Samples for Human Papillomavirus Testing by Polymerase Chain Reaction*, 10 CANCER EPIDEMIOLOGY, BIOMARKERS & PREVENTION 95 (2001); Celeste Robb-Nicholson, *By the Way, Doctor*, 7 HARV. WOMEN'S HEALTH WATCH 8 (2000) (citing the probable value of self-collected vaginal swab testing for HPV in women who decline pelvic exams); Schachter, *supra* note 86, at 1847.

⁸⁹ Robb-Nicholson, *supra* note 88, at 8.

⁹⁰ Parazzini et al., *supra* note 49, at 888.

⁹¹ Gravitt et al., *supra* note 88, at 95; Robb-Nicholson, *supra* note 88, at 8.

⁹² Dailard, *supra* note 7, at 8.

⁹³ See Reichman, *supra* note 87 (stating that pap smears to detect cervical cancer need not be done yearly for women over thirty who have had three normal pap smears in a row).

⁹⁴ The International Planned Parenthood Federation took the position in 1995 that "[p]hysical examination, including breast and pelvic examinations, may be beneficial for certain groups of women as part of their reproductive health care but they are not essential to all women for safe use of oral contraceptives." Stewart et al., *supra* note 49, at 2233 (citing Int'l Planned Parenthood Fed'n, *IMAP Statement on Steroidal Oral Contraception*, 29 IPPF MED. BULL. 1, 1-6 (1995)).

may not need another.⁹⁵ Likewise, women without any or with merely insignificant risk factors for developing cervical cancer do not need a pelvic exam to protect their safety.⁹⁶ In January 2003, the American Cancer Society modified its suggested pap smear schedule to recommend that women under twenty-one not receive pap smears for cervical cancer screening *at all* until three years after the onset of sexual intercourse.⁹⁷

Furthermore, physicians consider HPV to be essentially a necessary precondition to cervical cancer.⁹⁸ The number of women who do not have HPV but will develop cervical cancer is so small that it is economically unjustifiable to perform an expensive cervical cancer detection exam on this group.⁹⁹ By this same logic, it is constitutionally unjustifiable to impose such an invasive procedure when so many would not benefit from the exam after a less invasive screen for HPV.¹⁰⁰

Moreover, though HPV is essentially a necessary precursor to development of cervical cancer, the vast majority of HPV infections do not evolve into cervical cancer.¹⁰¹ Thus, the requirement of "passing" a pelvic exam is even more overinclusive, as most women who fail the HPV screen will not suffer potential detriments to health as a result of the pill. In fact, research shows that while oral contraceptive use is a risk factor for cervical cancer in women with HPV, there is no connection between oral contraceptives and cervical cancer in women who do not have HPV.¹⁰² Even for women who have HPV, the risk of developing cervical cancer

⁹⁵ In one survey, eighty-three percent of women who went to a new provider for oral contraceptives had received a pelvic exam within the last three years. Harper et al., *supra* note 74, at 15.

⁹⁶ For example, ACOG, which initially established the pelvic exam as a prerequisite to oral contraceptives in publicly funded clinics, now states that "[a] pelvic examination is not necessary prior to initiating oral contraceptives in teenagers." Stewart et al., *supra* note 49, at 2233 (citing AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, ORAL CONTRACEPTIVES FOR ADOLESCENTS: BENEFITS AND SAFETY (1999)).

⁹⁷ Reichman, *supra* note 87. The rationale for eliminating pap smears in this group of women is that it prevents overly invasive, unnecessary, expensive, and potentially reproduction-detrimental therapies in women in whom ninety percent of low-grade lesions will regress, rather than develop into cancer. *Id.*

⁹⁸ There is an extremely high correlation between HPV and cervical cancer development. See, e.g., Walboomers et al., *supra* note 87, at 12; Franco et al., *supra* note 87, at 506.

⁹⁹ See Shafer, *supra* note 49, at 71–72 (finding that it is not cost-effective to use pelvic exams to screen for cervical cancer in young women who do not possess risk factors).

¹⁰⁰ Cf. Craig v. Boren, 429 U.S. 190, 212–14 (Stevens, J., concurring) (noting the overinclusiveness of a statute forbidding the sale of beer to all males under age twenty-one and females under age eighteen on the rationale of increasing traffic safety, where only two percent of males were known to have driven while intoxicated and consumption of alcohol by these males was not prohibited).

¹⁰¹ Robb-Nicholson, *supra* note 88, at 8; see also AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 137 (reporting that "[a]lthough millions of women are infected with HPV, only a few will ever develop significant cervical neoplasia").

¹⁰² Wilkinson, *supra* note 72, at 265 (referring to a 2002 study by Sylvia Franceschi and colleagues that found no connection between oral contraceptives and cervical cancer in women who tested negative for HPV).

does not increase until after four years of using oral contraceptives.¹⁰³ Because a large number of women who begin taking oral contraceptives will discontinue use shortly thereafter,¹⁰⁴ the pelvic exam requirement is overinclusive even for women with a possible risk of cervical cancer.

Even if oral contraceptive use is causally connected to cervical cancer, the pelvic exam requirement is still overinclusive because any increased risk of developing the disease is extremely small.¹⁰⁵ Furthermore, the mortality rate from cervical cancer in the United States is only one per 100,000 women.¹⁰⁶ Among teenagers aged fifteen to nineteen, the rate of cervical cancer is only one in 500,000, and, when limited to women in this age group who are sexually active (those most likely to be seeking oral contraceptives), one million pelvic exams must be performed to detect one case of cervical cancer.¹⁰⁷ Such low incidence and mortality rates render the required privacy-invading exam overinclusive, particularly since the exam could still be available and encouraged for those who do not object to it.

Under Title X, certain types of tests, such as tests for HIV and other sexually transmitted diseases, are only performed “as indicated.”¹⁰⁸ Pelvic exams could also be required “as indicated,” according to physician discretion¹⁰⁹ based on risk factors that can be elicited through an oral medical history, medical records, or other less invasive tests.¹¹⁰ Indeed, in most cases after an abnormal finding, the doctor informs the patient of the increased risks associated with beginning oral contraception and helps the patient make a decision.¹¹¹ This process would effectively protect women’s safety without the overinclusiveness of the current regulations.

¹⁰³ Moreno et al., *supra* note 49, at 1085; Amy Berrington de Gonzalez et al., *Risk of Cervical Cancer According to Duration of Oral Contraceptive Use*, 360 LANCET 410 (2002); Wilkinson, *supra* note 72, at 265; *see also* Parazzini et al., *supra* note 49, at 887 (1998) (stating excess risk of cervical cancer among oral contraceptive users declines with time since ceasing use and is largely restricted to long-term use).

¹⁰⁴ AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 99.

¹⁰⁵ *See, e.g.*, D. A. Edelman & W. A. A. van Os, *Combined Oral Contraceptives and the Risk of Cervical Cancer*, 56 INT’L J. GYNECOLOGY & OBSTETRICS 57, 57 (1997).

¹⁰⁶ *See* Family Health Int’l, *supra* note 52, at <http://www.fhi.org/en/RH/Pubs/factsheets/OCriskben.htm>.

¹⁰⁷ Shafer, *supra* note 49, at 71.

¹⁰⁸ OFF. OF POPULATION AFFAIRS, U.S. DEP’T OF HEALTH & HUMAN SERVS., PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES § 8.3 (2001).

¹⁰⁹ Private providers already use this discretionary approach of deciding decide whether a pelvic exam should be performed on a case-by-case basis.

¹¹⁰ This suggestion has already been made in the context of adolescent females. Shafer, *supra* note 49, at 70.

¹¹¹ *See* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 93 (stating that, in the absence of absolute contraindications, “the health care provider should fully explain side effects and risks for all methods [of contraception]” and “the patient’s choice of a method of contraception or family planning should be the principal factor for prescribing one [contraceptive method] over another”).

The overinclusiveness of the requirement alone is substantial enough to constitute an unjustified infringement on women's fundamental rights.¹¹² In conjunction with the requirement's lack of necessity and failure to serve its purpose, the overinclusiveness of the pelvic exam requirement is an unconstitutional violation of women's substantive due process rights.

4. The Burden of the Pelvic Exam Requirement Renders It Impermissible Under Strict Scrutiny Review

In *Eisenstadt v. Baird*, the Supreme Court characterized requiring prescriptions for birth control as a "substantial burden" to place on the exercise of the constitutional right of access to contraceptives.¹¹³ Although some argue that oral contraceptives should be available without a prescription,¹¹⁴ this requirement has not been rendered unconstitutional. The government's interest in protecting women's health is thought to outweigh a woman's right of access to contraception such that the hurdle of visiting a physician to obtain a prescription is a justifiable infringement on her right. However, a prescription merely entails a woman consulting a physician who has deemed access to the drug an acceptable risk.

In contrast, the pelvic exam requirement forces bodily invasion regardless of a physician's opinion. Because bodily integrity, as opposed to convenient access to contraception, is the right countervailing the government's interest, the balance tips in favor of the woman's right. While the government has a sound interest in women's receiving information about the risks of a prescription through consultation with a physician, it has only a weak interest in women undergoing a pelvic exam due to the exam's lack of necessity for protecting women's health. Under *Eisenstadt*, a very strong evidentiary showing is necessary to warrant the additional burden of a pelvic exam beyond the "substantial burden" of obtaining a prescription.¹¹⁵ When weighed against the government's weak interest in protecting health, given the absence of a link between oral contraceptive use and pelvic exam findings, the requirement's imposition on women's fundamental rights to contraceptive accessibility and bodily integrity is unconstitutional under strict scrutiny.

¹¹² The requirement also arguably fails strict scrutiny review because it applies only to the women who obtain oral contraceptives at public clinics. Cf. Brenda D. Hofman, Note, *The Squeal Rule: Statutory Resolution and Constitutional Implications—Burdening the Minor's Right of Privacy*, 1984 DUKE L.J. 1325, 1351 (arguing safeguards to protect adolescents from the hazards of oral contraceptives would be underinclusive where they did not apply to adult women using equally hazardous contraceptives).

¹¹³ 405 U.S. 438, 463 (1972) (White, J., concurring).

¹¹⁴ See, e.g., MEAD, *supra* note 67; Petitti, *supra* note 67, at 77–115.

¹¹⁵ 405 U.S. at 463 (White, J., concurring); cf. Elizabeth A. Silverberg, Note, *Looking Beyond Judicial Deference to Agency Discretion: A Fundamental Right of Access to RU 486?*, 59 BROOK. L. REV. 1551, 1603 n.215 (1994) (arguing that restrictions beyond obtaining a prescription for the chemical contraceptive RU 486 would make access to the drug even more burdensome).

C. Under More Deferential Review, the Pelvic Exam Requirement Remains Unconstitutional

Due to the pelvic exam requirement's confinement within the government's conditional spending programs, it is possible that a court would examine the pelvic exam requirement with an intermediate level of review.¹¹⁶ Under such a standard, the regulation must be substantially related to serving an important governmental objective.¹¹⁷ Based on its ineffectiveness at detecting increased risks of adverse effects of oral contraceptives,¹¹⁸ the pelvic exam requirement is not substantially related to serving its purpose and, therefore, fails intermediate level review.

Although there are fundamental rights at issue, a court may utilize mere rational basis review because the rights affected involve the receipt of public funding.¹¹⁹ Under rational basis review, the pelvic exam requirement must only be a reasonable way to achieve a legitimate governmental goal.¹²⁰ However, because of the lack of connection between oral contraceptives and the risk factors the pelvic exam requirement is designed to detect, the requirement is not even a reasonable way to protect women's health against potential adverse effects of oral contraceptive use. In fact, the exam requirement is irrational: while intended to protect women's health by helping prevent genital cancers, it increases women's health risks generally,¹²¹ resulting in increased incidences of ovarian and endometrial cancer.¹²²

IV. EQUAL PROTECTION VIOLATION

The pelvic exam requirement for access to publicly funded hormonal contraception constitutes an equal protection violation under both disparate treatment and disparate impact analyses. The requirement treats women differently from men and disproportionately affects minority women. It

¹¹⁶ See Susan Frelich Appleton, *Standards for Constitutional Review of Privacy-Invasive Welfare Reforms: Distinguishing the Abortion-Funding Cases and Redeeming the Undue-Burden Test*, 49 VAND. L. REV. 1, 18, 60 (1996) (discussing the abortion-funding cases' application of rational basis review on grounds that welfare reforms are part of a governmental conditional spending program but arguing that "it is not unrealistic to expect the Court to apply something more than rational-basis review to state manipulations of reproductive choice through the combination of action and inaction embodied in welfare reform").

¹¹⁷ *Craig v. Boren*, 429 U.S. 190, 197 (1976).

¹¹⁸ See *supra* Part III.B.1.

¹¹⁹ See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).

¹²⁰ *Williamson v. Lee Optical*, 348 U.S. 483 (1955).

¹²¹ See *supra* Part III.B.1.c.

¹²² Because oral contraceptives actually protect against endometrial and ovarian cancer (with pill users experiencing only half the incidence of these diseases as non-pill users), see *supra* text accompanying notes 52 and 66, the deterrent effect of the pelvic exam requirement will result in increased incidences of these cancers. See *infra* Part VII.A.1.

violates women's and minorities' rights to equal protection because the government's determination of who can and cannot exercise the fundamental rights of bodily privacy and access to contraceptives is not justified by a compelling governmental interest. In fact, the requirement is unconstitutional under any level of review: it fails even rational basis review because it increases risks to women's health and because the government can have no legitimate interest in a health care program that creates a caste system.

A. *Disparate Treatment Analysis*

Government-funded family planning service regulations cause impermissibly disparate treatment of women. Because pelvic exams cannot identify any conditions that are causally connected to or that absolutely contraindicate oral contraceptive use, their only legitimate purpose is the general health care of Title X beneficiaries—detecting sexually transmitted diseases,¹²³ pelvic inflammatory disease, or cancer.¹²⁴ Yet even assuming that the exam effectively serves this purpose, the requirement still violates equal protection.

Equal protection doctrine mandates that a state must treat similarly situated persons alike.¹²⁵ However, while women are subjected to invasive preventive care at family planning clinics, men are not.¹²⁶ Men are not

¹²³ Even if a pelvic exam serves an important governmental objective of protecting public health by detecting STDs, it is still unconstitutional to mandate it prior to receipt of oral contraceptives. STDs are unrelated to the risks of oral contraceptive use and can be detected by less invasive visual exams, urine screens, and serological tests. See Shafer, *supra* note 49, at 70–71; Diane R. Blake et al., *Sexually Transmitted Disease Evaluation in Young Women: Can It Be Done Without a Speculum?*, 20 J. ADOLESCENT HEALTH 126 (1997).

¹²⁴ The legislative history of the Family Planning Amendments of 1989 acknowledges the importance of Title X clinics in providing for essential preventive care via disease screening. See 136 CONG. REC. S13,676 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy); *id.* at S13,680 (statement of Sen. Packwood).

[A] central Title X principle is that clients visiting family planning clinics for contraceptive care must be offered related preventive health services. As a result, the program regulations and official guidelines specify a wide range of screening services to be delivered to clients at Title X-supported clinics, including pelvic examinations . . . [and] Pap smears

ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 23, available at <http://www.guttmacher.org/pubs/fulfill.pdf>.

¹²⁵ *Plyler v. Doe*, 457 U.S. 202, 216 (1982).

¹²⁶ The language of the regulations classifies on the basis of gender, specifying the exam requirement only for women. Even if this is not considered a facial gender classification, the invasive requirement for women constitutes disparate treatment of women under the rationale of *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001). *Erickson* held that an employee prescription benefit plan, which excluded coverage for prescription contraceptives, constituted disparate treatment of women. *Id.* The “mere facial parity” of the benefit plan’s coverage did not preclude a finding of violation of Title VII’s prohibition against gender discrimination in employment where benefits carved out from

required to have STD screening or prostate exams (which include rectal exams) to obtain condoms or a prescription for virility drugs such as Viagra, despite the opportunity for preventative health care equivalent to that imposed on women by the pelvic exam.¹²⁷ Rather, the regulations impose prostate exams on men only “as appropriate.”¹²⁸ This discrepancy in treatment under Title X provisions violates women’s right to engage in nonprocreative sex, which the Supreme Court has recognized as fundamental.¹²⁹ Just as Viagra and condoms¹³⁰ enable men to engage in sex at will, with less anxiety about impotence or fear of pregnancy, oral contraceptives allow women, otherwise constrained by the realistic fear of pregnancy,¹³¹ to engage in nonprocreative sex.¹³²

coverage were “uniquely designed for women.” *Id.* at 1271.

Additionally, a strong argument exists that because restrictions on access to oral contraceptives uniquely burden women, they should be treated like restrictions that explicitly classify based on gender, even if the regulation’s classification is facially neutral. *See* Cass R. Sunstein, *Why the Unconstitutional Conditions Doctrine Is an Anachronism (with Particular Reference to Religion, Speech, and Abortion)*, 70 B.U. L. REV. 593, 618 (1990) [hereinafter Sunstein, *Unconstitutional Conditions Doctrine*] (making this argument in reference to abortion, citing Brief for Nat’l Coalition Against Domestic Violence, *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989)). Although the Supreme Court in *Geduldig v. Aiello*, 417 U.S. 484 (1974), found an insurance plan’s denial of benefits for disability resulting from a normal pregnancy classified not by gender, but by pregnant and nonpregnant persons, it found that “[t]here is no risk from which men are protected and women are not.” *Id.* at 496. However, the lack of a requirement for a similar examination for men seeking contraception from a clinic protects men, but not women, from the risks associated with denial of effective contraception. Accordingly, the pelvic exam requirement classifies by gender, rather than by oral contraceptive seekers and non-oral contraceptive seekers, even under the rationale of *Geduldig*. Additionally, because the proportion of women who are pregnant (and therefore affected by the policy in *Geduldig*) is drastically smaller than the proportion of women at Title X clinics who are affected by the pelvic exam requirement, the *Geduldig* policy can be more readily construed as a non-gender-based classification than the pelvic exam requirement.

¹²⁷ Anita L. Nelson, *Whose Pill Is It Anyway?*, FAM. PLAN. PERSP., Mar.-Apr. 2000, at 89, 89. Viagra is a drug that temporarily relieves impotence in men. Medicaid, one source of family planning services under Title XIX of the Social Security Act, *see supra* note 2, pays for Viagra for men. ALAN GUTTMACHER INST., THE INSTITUTE’S FUTURE IX: A STRATEGIC PLAN FOR THE ALAN GUTTMACHER INSTITUTE, 1999–2003 9 (2001), available at http://www.agi-usa.org/about/strat_plan.pdf (last visited Feb. 1, 2004); Idaho Women’s Network, *Reproductive Health and Rights*, at http://www.idahowomensnetwork.org/issues/status_of_women.htm (last visited Feb. 1, 2004).

¹²⁸ OFF. OF POPULATION AFFAIRS, *supra* note 108, § 8.3.

¹²⁹ *See supra* notes 28–31 and accompanying text.

¹³⁰ While condoms also prevent transmission of STDs, they serve the purpose of enabling men to engage in nonprocreative sex with fewer concerns about pregnancy.

¹³¹ Although nonhormonal forms of birth control are available, these methods are significantly less effective and require either cooperation of a male partner or an invasive insertion procedure by a clinician.

¹³² *See* Kathryn Kindell, *Prescription for Fairness: Health Insurance Reimbursement for Viagra and Contraceptives*, 35 TULSA L.J. 399, 399, 419 (2000) (arguing that equal protection doctrine requires health insurance plans to cover prescription contraceptives for women if they cover Viagra for men because both drugs serve the same goal of enabling “sex at will”).

B. Disparate Impact Analysis

Even if the pelvic exam requirement is not considered an impermissible gender-based classification, it still violates the equal protection rights of women and minorities. To be constitutional as a facially neutral classification, the pelvic exam requirement cannot both have a very disproportionate impact and be motivated by a discriminatory purpose.¹³³

1. Disparate Impact

The burden of the pelvic exam requirement falls exclusively on women and disproportionately on minority women.¹³⁴ Requiring an embarrassing, uncomfortable exam¹³⁵ of only one distinctly identifiable group stigmatizes¹³⁶ that group as acceptably subject to humiliation by degrading, systematic processes. This results in a caste system in which women, particularly minority women, are denied dignity for no legitimate purpose.¹³⁷ The Fourteenth Amendment prohibits such laws because “no group may be made into second-class citizens.”¹³⁸ Further, Title X provisions them-

¹³³ See CHEMERINSKY, *supra* note 26, at 685–86 (combining the holdings of *Palmer v. Thompson*, 403 U.S. 217 (1971), and *Washington v. Davis*, 426 U.S. 229 (1976)).

¹³⁴ The proportion of minority Title X recipients (60%) is more than double the proportion of minorities in the general population (29%), and the Caucasian proportion of Title X recipients (40%) is roughly half the proportion of Caucasians in the general population (71%), resulting in an approximately four-fold impact on minorities compared to nonminorities. Cynthia Dailard, *Community Health Centers and Family Planning: What We Know*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Oct. 2001, at 6–7, available at http://www.guttmacher.org/journals/tgr_archive.html (last visited Feb. 1, 2004).

¹³⁵ HOW TO ORGANIZE, *supra* note 51, at 44 (asserting that most women find the pelvic exam to be embarrassing and uncomfortable).

¹³⁶ Cf. Kenneth L. Karst, *The Supreme Court 1976 Term—Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 6 (1977) (discussing stigmatization in the context of equal protection of women). Although rules resulting in stigma upon a group have only been held explicitly impermissible in cases dealing with race, *see, e.g.*, *Washington v. Davis*, 426 U.S. 229 (1976); *Palmer v. Thompson*, 403 U.S. 217 (1971); *Strauder v. West Virginia*, 100 U.S. 303 (1879), the logic applies equally to women. *See infra* Part IV.C (arguing that classifications based on gender carry a risk of stigmatic harm equally dangerous to those based on race, such that gender classifications are adequately suspect to warrant strict scrutiny).

¹³⁷ A caste system involves social stratification in which social practices produce obstacles to the development of self-respect in members of the system's lower classes. This phenomenon largely stems from the presence of highly visible but morally irrelevant characteristics (e.g., race or gender) and results in systematic disadvantages and “second-class citizenship” for those in the lower classes. Cass R. Sunstein, *The Anticaste Principle*, 92 MICH. L. REV. 2410, 2428–35 (1994).

¹³⁸ *Id.* at 2428–29, 2435; *see* *Strauder v. West Virginia*, 100 U.S. 303 (1880) (holding as impermissible processes that result in the “branding” of inferiority or stigmatization of a racial group such that a caste system develops); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (holding that the right to procreate is too fundamental to be distributed according to a system of constitutional caste); *see also* Kathleen Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1415, 1497 (1989) (arguing the unconstitutional conditions doctrine is concerned with preventing a constitutional caste system by protecting against “hierarchy among classes that, without the government intervention, would make the same choice”).

selves prohibit this result because they specifically mandate that services be provided in a manner which protects the dignity of the individual.¹³⁹

a. Gender Impact

Restrictions on access to oral contraceptives uniquely burden women.¹⁴⁰ “Control of reproduction is the sine qua non of women’s capacity to live as equal people.”¹⁴¹ The pelvic exam requirement leaves women who decline the exam without effective control over their reproduction, forcing them to rely on their partners. As a result of this deprivation of control, which is not experienced by men, women must cope with the psychological burdens of vulnerability and the physical, emotional, and financial burdens of pregnancy and motherhood or abortion. As acknowledged in *Erickson v. Bartell Drug Co.*, “the adverse economic and social consequences of unintended pregnancies fall most harshly on women and interfere with their choice to participate fully and equally in ‘the marketplace and the world of ideas.’”¹⁴²

As a result, women are burdened with economic difficulties in a vicious cycle that creates and maintains a caste system. The stigma of caste is manifest in the derogatory term “welfare queen,”¹⁴³ which refers to poor women with children who have become dependent upon public support. Another manifestation of this stigma is characterization as a “housewife,” which carries strong connotations of inferiority among many circles of society.¹⁴⁴ For those who are forced into the role of “housewife” by an unintended pregnancy, derailed goals, and economic reliance on male partners, this has as much sting of inferiority¹⁴⁵ as does the differential treatment of racial minorities found by the Supreme Court to create an

¹³⁹ 42 C.F.R. § 59.5(3) (2002).

¹⁴⁰ See Sunstein, *Unconstitutional Conditions Doctrine*, *supra* note 126, at 618 (citing Brief for National Coalition Against Domestic Violence as Amicus Curiae Supporting the Appellees, *Webster v. Reproductive Health Servs.*, 492 U.S. 490 (1989) (No. 88-605)).

¹⁴¹ Law, *supra* note 60, at 1028.

¹⁴² 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (quoting *Stanton v. Stanton*, 421 U.S. 7, 14–15 (1975)); see also KRISTINE M. BABER & KATHERINE R. ALLEN, *WOMEN AND FAMILIES: FEMINIST RECONSTRUCTIONS* 102 (1992) (observing that “the responsibility of bearing and caring for children has limited women’s autonomy and ability to participate in activities that enhance their personal development and their social and economic status”).

¹⁴³ See Appleton, *supra* note 116, at 18 (referring to society’s perception of the “welfare queen” as the “least deserving of the poor”); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 17, 111 (1997); Catherine Albiston, *The Social Meaning of the Norplant Condition: Constitutional Considerations of Race, Class, and Gender*, 9 *BERKELEY WOMEN’S L.J.* 9, 17 (1994).

¹⁴⁴ See, e.g., Ralph Gardner, Jr., *Mom vs. Mom*, *N.Y. MAG.*, Oct. 21, 2002, at 21 (citing examples of children embarrassed by their mother’s stay-at-home status).

¹⁴⁵ See *id.* (discussing one nonworking mother’s feelings of “insuperiority” and the desire of the nonworking woman to “have something that’s a reflection of her as an individual—a label that says she’s a capable, creative person who knows about more than just baby formula or after-school programs”).

impermissible brand of inferiority and implied caste system.¹⁴⁶ As more and more women choose to have careers, those who are unemployed are no longer the norm and are increasingly viewed as inferior because of their economic dependence. Consequently, deprivation of access to effective contraception results in a type of caste system in which women who are financially dependent, nonworking mothers are relegated to the lower castes. Women should not be stigmatized as inferior by being forced into roles which they do not desire.

*Strauder v. West Virginia*¹⁴⁷ supports the proposition that the processes which cause the stigmatization of one group to such an extent that a caste system develops are impermissible under equal protection doctrine.¹⁴⁸ In *Skinner v. Oklahoma*,¹⁴⁹ the Supreme Court held that the right to procreate is too fundamental to be distributed according to a caste system¹⁵⁰ and later, in *Carey v. Population Services International*, that the right to contraceptives should be viewed as part of the "constitutionally protected right of decision in matters of childbearing that is the underlying foundation of the holdings in *Griswold*, *Eisenstadt v. Baird*, and *Roe v. Wade*."¹⁵¹ Taken together, these cases indicate that it is constitutionally impermissible for the fundamental right of access to contraceptives to be distributed in a manner which results in inferiority of one group. The reduced access to oral contraceptives caused by the pelvic exam requirement results in the stigmatization of women as inferior and therefore violates equal protection doctrine.

b. Racial Impact

The pelvic exam requirement also has a disparate impact on racial minorities. Because economic status is closely linked with race and ethnicity in the United States, patients of publicly funded clinics are disproportionately from racial and ethnic minority groups.¹⁵² Minority women are also more likely to depend specifically on publicly funded family planning clinics for their contraceptive services.¹⁵³

Additionally, minority women are more likely to experience contraceptive failure, rendering the availability of highly effective contraception

¹⁴⁶ See *supra* note 136.

¹⁴⁷ 100 U.S. 303, 308 (1879).

¹⁴⁸ See *supra* text accompanying note 136 (explaining why the rationale of *Strauder* applies to women as well as racial minorities).

¹⁴⁹ 316 U.S. 535 (1942).

¹⁵⁰ Sullivan, *supra* note 138 at 1498.

¹⁵¹ 431 U.S. 678, 688–89 (1977).

¹⁵² See *supra* note 134.

¹⁵³ One study found that 75% of women seeing private doctors and HMOs were non-Hispanic white, compared to only 42% at non-Title X public clinics and 57% at Title X clinics. Of women seeing private doctors, 13% were non-Hispanic black, compared to 24% at public clinics. And 9% of women seeing private doctors were Hispanic, compared to 26% at non-Title X public clinics and 15% at Title X clinics. Frost, *supra* note 10 at 10.

particularly important.¹⁵⁴ Denying hormonal contraception for refusal to submit to pelvic exams is perhaps most detrimental to African American women, who may be particularly vulnerable to their male sexual partners' contraception decisions.¹⁵⁵ Relegating women who refuse pelvic exams and cannot afford private physicians to contraceptive methods with significantly lower efficacy rates will result in many more unintended pregnancies for minority women than for nonminority women. This effect exacerbates the disparate impact on minority women because there are already disproportionately more minority women who utilize publicly funded clinics.

In addition to disproportionately burdening minorities, the pelvic exam requirement implies their inferiority within a caste system. The mandatory exam is a surcharge that women utilizing Title X clinics must pay in order to exercise their right to contraceptive access.¹⁵⁶ The four-fold impact of the requirement upon minorities over Caucasians¹⁵⁷ renders it largely a requirement for minority women. "To attach a surcharge to the price that a discrete group of [women] . . . must pay to exercise a constitutional right" is "to create a system of constitutional caste and relegate that group to the lower levels."¹⁵⁸ Thus, requiring a pelvic exam as a prerequisite to oral contraceptives for Title X recipients violates the Equal Protection Clause.

2. Discriminatory Purpose Behind the Pelvic Exam Requirement

In addition to its disparate impact, the pelvic exam requirement constitutes an equal protection violation because evidence points to discriminatory purposes¹⁵⁹ behind the regulation. Because our society has a long history of discrimination against women and minorities, it is likely that many laws with a discriminatory impact were motivated by a discriminatory purpose.¹⁶⁰ Compelling arguments have been made that govern-

¹⁵⁴ ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 48, available at <http://www.guttmacher.org/pubs/fulfill.pdf>.

¹⁵⁵ See Sable et al., *supra* note 79, at 124 (citing K. Libbus & C.A. Arps, *Beliefs Related to the Use of Oral Contraceptives by African-American Women*, 9 J. NAT'L BLACK NURSES ASS'N 29 (1997)).

¹⁵⁶ See *infra* Part V.D.

¹⁵⁷ See *supra* note 134.

¹⁵⁸ Lynn A. Baker, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 CORNELL L. REV. 1185, 1251 (1990).

¹⁵⁹ The discriminatory purpose test articulated in *Personnel Administrator of Massachusetts v. Feeney* requires that to be impermissible a regulation must be "selected or reaffirmed . . . at least in part 'because of,' not merely 'in spite of,' its adverse effects upon an identifiable group." 442 U.S. 256, 279 (1979).

¹⁶⁰ CHEMERINSKY, *supra* note 26, at 685 (citing David Strauss, *Discriminatory Intent and the Taming of Brown*, 56 U. CHI. L. REV. 935 (1989)); see also *Frontiero v. Richardson*, 411 U.S. 677, 682, 684 (1973) (plurality opinion) (noting that gender classifications "are inherently suspect and must therefore be subjected to close judicial scrutiny" in part because "[t]here can be no doubt that our Nation has had a long and unfortunate history of sex discrimination").

ment programs which exert control over women's reproduction, either by facilitating use of or restricting access to birth control, are intended to oppress women, especially minorities.¹⁶¹ The requirement of a pelvic exam despite a lack of evidence of any connection between oral contraceptive use and health-related factors detectable by the exam also suggests that there may be an illegitimate purpose behind the requirement.

a. Discriminatory Purpose with Respect to Women

A strong argument can be made that the pelvic exam requirement was created with a purpose discriminatory to women. The requirement may stem from a paternal effort to make decisions for women, presuming them incapable of weighing the risks and benefits of oral contraception without an exam.¹⁶² Alternatively, the pelvic exam requirement may have been intended to degrade women. Some scholars argue that history demands skepticism of rules based on women's biological differences from men because "less than a century ago 'doctors and scientists were generally of the view that a women's [sic] intellect, her capacity for education, for reasoning . . . was biologically limited.'"¹⁶³ Additionally, the "protection" of women through use of the "pedestal/cage" has historically been key in the oppression of women,¹⁶⁴ and biological differences have served as a prime justification for the subjugation of women.¹⁶⁵

The constructs of law have historically supported the dominance of men and subservience of women¹⁶⁶ by creating separate spheres for the sexes and enacting limits on women's power to control reproductive capacity.¹⁶⁷ When legislatures' interest in enacting laws is control over women's decisions and actions, these "male-dominated governmental bodies echo the

¹⁶¹ See generally ROBERTS, *supra* note 143 (documenting such government programs' effects on black women and black communities). See also *infra* Parts IV.B.2.a, IV.B.2.b.

¹⁶² See Stewart et al., *supra* note 49, at 2236 (stating that in areas of medical services other than women's reproductive care, it would not be considered appropriate to withhold a prescription from someone who has been informed of the risks involved and chooses to forego screening for an unrelated condition). Cf. Appleton, *supra* note 116, at 36-37 & nn.214-215 (discussing the impermissibility of welfare programs, such as Norplant bonuses, that constitute "paternalistic effort[s] to help vulnerable women make sound family choices").

¹⁶³ Law, *supra* note 60, at 1033 (quoting Wendy Webster Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and Feminism*, 7 WOMEN'S RTS. L. REP. 175, 199 (1982)).

¹⁶⁴ *Id.* at 957 (citing BARBARA ALLEN BABCOCK ET AL., *SEX DISCRIMINATION AND THE LAW: CAUSES AND REMEDIES* 26-53 (1973)).

¹⁶⁵ Nadine Taub, Book Review, 80 COLUM. L. REV. 1686, 1687 (1980) (reviewing CATHARINE MACKINNON, *SEXUAL HARASSMENT OF WORKING WOMEN: A CASE OF SEX DISCRIMINATION* (1979)).

¹⁶⁶ See Barbara Kirk Cavanagh, Note, "A Little Dearer Than His Horse": *Legal Stereotypes and the Feminine Personality*, 6 HARV. C.R.-C.L. L. REV. 260 (1971) (summarizing the history of the use of the law to assure the dependency of women); Law, *supra* note 60, at 964.

¹⁶⁷ Law, *supra* note 60, at 958.

rationale behind laws that once barred women from equal protection in the paid labor force and political and civic affairs.”¹⁶⁸ The Supreme Court has specifically acknowledged this country’s “long and unfortunate history of sex discrimination.”¹⁶⁹ In *United States v. Virginia*¹⁷⁰ the Court found that a gender classification clearly resulting in greater benefits for men would be easily defended if women were established as fully equal to men, but the historical treatment of women as inferior to men made it likely that the classification was “a witting or unwitting device for preserving tacit assumptions of male superiority.”¹⁷¹ A lack of gender equality has also impacted issues of women’s health, which historically have been largely ignored within the Department of Health and Human Services (“HHS”).¹⁷²

In addition to our country’s history of discrimination against women, the legislative history of a particular regulation can also serve as evidence of discriminatory purpose.¹⁷³ At the time the pelvic exam requirement was created,¹⁷⁴ family planning program administrators knew that oral contraceptives were not causally connected with genital cancer.¹⁷⁵ A legitimate, nondiscriminatory reason behind the requirement thus cannot be inferred from the requirement’s creation.¹⁷⁶ It is also significant that pelvic exams are not required of women seeking care from private providers and that the requirement is a questionable interpretation of the FDA’s recommendation that pelvic exams “should” be performed.¹⁷⁷ The

¹⁶⁸ Johnsen, *supra* note 41, at 203–04 (citing as evidence *Hoyt v. Florida*, 368 U.S. 57 (1961) (women exempted absolutely from participation in jury service); *Breedlove v. Suttles*, 302 U.S. 277 (1937) (women who did not register to vote exempted from poll tax); *Muller v. Oregon*, 208 U.S. 412 (1908) (restrictions placed on women’s working hours outside the home); *Bradwell v. Oregon*, 83 U.S. 130 (1872) (women excluded from receiving licenses to practice law)).

¹⁶⁹ *Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) (plurality opinion).

¹⁷⁰ 518 U.S. 515 (1996).

¹⁷¹ *Id.* at 535 n.8.

¹⁷² Silverberg, *supra* note 115, at 1596–99 (citing examples such as failing to include women in research studies, permitting drugs not adequately tested for safety in women to be prescribed to women, underfunding research of women’s diseases, providing greater accessibility to diagnostic procedures and greater availability of therapeutic intervention to men, giving disparate diagnoses of and attention to health complaints of women and men, and failing to include women in decisionmaking processes surrounding drugs for women).

¹⁷³ Dorothy E. Roberts, *The Future of Reproductive Choice for Poor Women and Women of Color*, 14 WOMEN’S RTS. L. REP. 305, 307 (1992) (citing CATHARINE A. MACKINNON, FEMINISM UNMODIFIED 7, 97 (1987); Law, *supra* note 60, at 957–62); see also Meredith Blake, *Welfare and Coerced Contraception: Morality Implications of State Sponsored Reproductive Control*, 34 U. LOUISVILLE J. FAM. L. 311, 311–17 (1995–1996).

¹⁷⁴ See *infra* note 275 and accompanying text.

¹⁷⁵ See HOW TO ORGANIZE, *supra* note 51, at 49.

¹⁷⁶ Furthermore, such a purpose is impossible to establish for the 2001 decision to maintain the pelvic exam requirement because there is no legislative history surrounding that decision. “OPA’s interpretive guidance did not require clearance by other agencies within the government or publication in the Federal Register because it does not establish new policy.” Nat’l Cervical Cancer Coalition, *supra* note 80, at http://www.nccc-online.org/fppaps_12.asp.

¹⁷⁷ See *infra* notes 275–277 and accompanying text.

absence of any legitimate justification makes it probable that the true purpose behind the requirement was impermissible discrimination. This likelihood of a discriminatory purpose, in conjunction with the vastly disparate impact of the requirement on women, provides grounds for invalidation of the requirement as a violation of equal protection doctrine.

In *Planned Parenthood v. Casey*, the Supreme Court upheld patronizing informed consent rules for women seeking abortions.¹⁷⁸ However, the decision of whether or not to obtain an abortion affects not only a woman's life but also arguably a fetal life. In such a situation, women's authority to make decisions is less clear than in the contraception-seeking situation, in which the decision by a woman affects only her *own* life. In the absence of a viable fetal life, the government's interest does not outweigh a woman's right to control reproduction such that it justifies burdening her reproductive decisions.¹⁷⁹ Paternalism is especially inappropriate with respect to a woman seeking contraception for whom, unlike the pregnant women considered by *Casey*, there is not the emotional influence of an unwanted pregnancy which could arguably influence her judgment.

b. Discriminatory Purpose with Respect to Minorities

Many laws have been created with the discriminatory purpose of exercising control over the reproductive decisions of minority groups.¹⁸⁰ One possible motivation is the perpetuation of minorities' poverty by enlarging already financially disadvantaged families.¹⁸¹ At the other end of the spectrum, legislators and providers may paternalistically presume that minorities are incapable of making the "right" decisions.¹⁸² In particular, some health care providers consider minority women unable to follow an oral contraceptive regimen with enough compliance for its use to be effective.¹⁸³ A plausible theory of discriminatory governmental purpose is that the lack of abortion services under Title X,¹⁸⁴ in addition to the lack

¹⁷⁸ 505 U.S. 833 (1992).

¹⁷⁹ *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁸⁰ See ROBERTS, *supra* note 143 at 4 (describing "a long experience of dehumanizing attempts to control Black women's reproductive lives" through the "systematic, institutionalized denial of reproductive freedom [that] has uniquely marked Black women's history in America").

¹⁸¹ See *id.* at 210, 235 (discussing legislators' enacting caps on the number of children for which a woman may receive governmental assistance while acknowledging that such caps are not known to deter poor women from having additional children). By simultaneously enacting policies that increase unwanted pregnancies, do not fund abortions, and limit governmental assistance, the government appears to be perpetuating the poverty of families subject to Title X and other welfare regulations.

¹⁸² For example, they may want to encourage sterilization (rather than temporary forms of oral contraception) for poor minority women because they believe such women are unfit mothers who should not have children at all. See Albiston, *supra* note 143, at 19.

¹⁸³ See ROBERTS, *supra* note 173, at 310 n.32.

¹⁸⁴ 42 U.S.C. § 300a-6 (2000) (prohibiting Title X funds from being used for abortions or abortion-related services).

of effective contraception (for those who decline a pelvic exam), is intended to cause poor women to resort to sterilization,¹⁸⁵ which, unlike abortion, *is* covered by Title X funds.¹⁸⁶

The myriad of historical examples of discrimination against minorities and legislation implicating reproductive issues for minorities¹⁸⁷ make a racially discriminatory purpose to the pelvic exam requirement highly probable. During the slave trade in the United States, the law allowed female slaves to be sexually exploited for their capacity to produce more slaves, while simultaneously separating them from their children.¹⁸⁸ In its early years, contraception distribution was associated with eugenics and racial genocide,¹⁸⁹ and, as acknowledged in current Title X provisions themselves,¹⁹⁰ government-sponsored programs of the 1960s and 1970s coerced thousands of women, who were vastly disproportionately minorities, into sterilization.¹⁹¹ Legislative proposals and mainstream media have reflected discriminatory reproductive policy goals by suggesting Norplant should be required as a condition of probation or receipt of welfare benefits,¹⁹² which affect minority women more frequently than nonminority women.¹⁹³

Law enforcement has exhibited a similarly discriminatory intent with respect to minorities' reproductive rights. For example, officers in Charleston, South Carolina, arrested forty-two African American women and only one non-African American woman under a policy of prosecut-

¹⁸⁵ See Blake, *supra* note 173, at 338–39 (citing Laurie Nsiah-Jefferson, *Reproductive Laws, Women of Color, and Low-Income Women*, in *REPRODUCTIVE LAWS FOR THE 1990s* 23, 47 (1989), for the proposition that “subtle coercion by care providers may often confirm the view of the welfare patient that sterilization is the only alternative to impersonal, degrading reproductive health care that often denies access to safe, effective contraception or to abortion”); ROBERTS, *supra* note 143, at 235.

¹⁸⁶ That sterilization is covered by Title X funds and is provided upon demand, despite the fact that it entails risks greater than those of oral contraceptives alone suggests a discriminatory desire to stop the reproduction of Title X recipients, who are disproportionately racial minorities. Blake, *supra* note 173, at 326–28.

¹⁸⁷ See Suzanne Sangree, *Control of Childbearing by HIV-Positive Women: Some Responses to Emerging Legal Policies*, 41 *BUFF. L. REV.* 309, 319–23 (1993) (discussing ways in which “[t]he government has . . . sought to exert control over childbearing through welfare and [M]edicaid funding schemes that shape the reproductive choices of poor women, a class which is disproportionately comprised of women of color and disabled women”).

¹⁸⁸ ROBERTS, *supra* note 143, at 23–28, 33; see also Sangree, *supra* note 187, at 319–23.

¹⁸⁹ ROBERTS, *supra* note 143, at 7, 70–81, 98–103; Vanessa Northington Gamble, *Race, Class, and the Pill: A History*, in *THE PILL: FROM PRESCRIPTION TO OVER THE COUNTER*, *supra* note 67, at 30–35.

¹⁹⁰ 42 U.S.C. § 300a-8 (2000) (specifically prohibiting coercion of sterilization procedures in Title X clinics).

¹⁹¹ ROBERTS, *supra* note 143, at 89–98; Blake, *supra* note 173, at 313–17; see also Sangree, *supra* note 187, at 324–25 (discussing disproportionate sterilization of Native Americans, Puerto Ricans, and African Americans).

¹⁹² Albiston, *supra* note 143, at 11; Blake, *supra* note 173, at 318–19.

¹⁹³ ROBERTS, *supra* note 143, at 3–4, 104–12.

ing pregnant women whose prenatal tests indicated use of crack cocaine.¹⁹⁴ Similarly, health care professionals in Florida reported African American, substance-abusing, pregnant women to law enforcement officials ten times more often than their white counterparts, despite the fact that white women's rate of substance abuse was actually higher.¹⁹⁵ The mere existence of a policy to prosecute pregnant women who use crack, but not, for example, alcohol, is itself evidence of discrimination with respect to reproduction by minorities: alcohol use during pregnancy is far more injurious to the fetus but also more prevalent among white women.¹⁹⁶ Finally, courts' actions concerning reproduction indicate a possible discriminatory intent against minority women.¹⁹⁷

The lack of a record to indicate a permissible purpose behind creating or maintaining the pelvic exam requirement, the long history of discrimination against minorities with respect to reproductive policies, and the requirement's failure to serve a purpose relevant to oral contraceptive use make a discriminatory purpose behind the requirement highly probable. In conjunction with its disparate impact upon minorities, this likely discriminatory purpose provides grounds for invalidation of the requirement as an equal protection violation.

C. The Pelvic Exam Requirement Is Unconstitutional on Equal Protection Grounds Under All Standards of Review

Strict scrutiny is the appropriate level of review for an equal protection analysis concerning the race and gender discrimination inherent in the pelvic exam requirement. There is a fundamental right involved,¹⁹⁸ and there are violations arguably based on race.¹⁹⁹ Additionally, while gender-based classifications are generally subject to an intermediate level

¹⁹⁴ *Id.* at 164–72.

¹⁹⁵ *Id.* at 175.

¹⁹⁶ *Id.* at 177; Albiston, *supra* note 143, at 15; see also Deborah A. Frank et al., *Growth, Development, and Behavior in Early Childhood Following Prenatal Cocaine Exposure: A Systematic Review*, 285 JAMA 1613, 1613, 1617, 1620–21, 1624 (2001) (discussing the situation in South Carolina and concluding that cocaine exposure has not been associated with harm to the fetus that would “justify policies that violate the usual canons of medical ethics and civil liberties”).

¹⁹⁷ See Johnsen, *supra* note 41, at 203 n.81 (citing, as an example of a reason to be concerned about fair treatment of minorities regarding reproductive decisions, a national survey indicating that eighty-one percent of documented court orders compelling pregnant women to undergo medical treatment (such as cesarean sections, intrauterine transfusions, and hospital detention) involved women who were African American, Asian, or Hispanic); Albiston, *supra* note 143, at 11 (citing judges' imposition of Norplant as a condition of probation, which is more likely to affect minority women).

¹⁹⁸ *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938) (holding that laws infringing upon fundamental rights may be subject to “more searching judicial inquiry”).

¹⁹⁹ Even though the requirement is facially neutral as to race, it is subject to strict scrutiny because of the likely discriminatory purpose discussed *supra* in Part IV.B.2.b. CHEMERINSKY, *supra* note 26, at 682.

of scrutiny,²⁰⁰ if, in addition to a disparate impact on one gender, the purpose of the law is to stigmatize that gender (as opposed to merely perpetuating gender roles), the law should be subject to strict scrutiny.²⁰¹

The purpose of strict scrutiny review is to ensure equal protection of the laws through “‘smok[ing] out’ illegitimate uses” of suspect classifications “by assuring that the legislative body is pursuing a goal important enough to warrant use of a highly suspect tool.”²⁰² Without thoroughly examining the justification for race- or gender-conscious measures, there is no way to determine which classifications are motivated by malicious intent.²⁰³ The gender classification utilized in the regulations requiring the pelvic examination is suspect: historical discrimination against minorities and women, particularly within the context of reproductive decisionmaking rights, creates valid skepticism about this classification’s purpose.²⁰⁴

In *J.E.B. v. Alabama ex rel. T.B.*, the Supreme Court left open the possibility that gender classifications should be subject to strict scrutiny when it declined to decide whether gender classifications were inherently suspect.²⁰⁵ The Court did acknowledge that our country’s history of sex discrimination warrants heightened scrutiny for gender-based classifications.²⁰⁶ Then, in *United States v. Virginia*, the Court applied an especially rigorous version of intermediate scrutiny, requiring a showing of an “exceedingly persuasive justification” in order for a gender-based classification to be upheld.²⁰⁷ The Court further asserted that the “demanding” burden of justification rested on the state and could not be satisfied with a “hypothesized” justification.²⁰⁸

²⁰⁰ *Craig v. Boren*, 429 U.S. 190 (1976). *But see* *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 137 n.6 (1994) (suggesting that intermediate level scrutiny is the *minimum* standard for assessing a gender-based classification).

²⁰¹ In *City of Richmond v. J.A. Croson Co.*, the Supreme Court employed strict scrutiny to review a race-based affirmative action policy in part because of the stigma inflicted by race-based classifications. 488 U.S. 469, 493 (1989). Because of their similar stigma, gender-based classifications should also be reviewed under strict scrutiny. John Calotto, Note, *Strict Scrutiny for Gender, via Croson*, 93 COLUM. L. REV. 508, 539 (1993). There are powerful analogies between race- and gender-based discrimination, as both women and minorities have been subject to oppression, are defined by highly visible, immutable characteristics, are economically disadvantaged in comparison to men and whites, respectively, and have a history of exercising limited political power. *Law, supra* note 60, at 963–64.

²⁰² *Croson*, 488 U.S. at 493.

²⁰³ *Id.*

²⁰⁴ *See McCleskey v. Kemp*, 481 U.S. 279, 322 (1987) (Brennan, J., dissenting) (arguing that statistical evidence of race discrimination in the administration of the death penalty, when coupled with a history of race discrimination in the jurisdiction, is enough to cause a petitioner’s death sentence to violate the Eighth Amendment because, since *Furman v. Georgia*, 408 U.S. 238 (1972), “the Court has been concerned with the *risk* of the imposition of an arbitrary sentence, rather than the proven fact of one”).

²⁰⁵ 511 U.S. 127, 137, n.6 (1994).

²⁰⁶ *Id.* at 136.

²⁰⁷ 518 U.S. 515, 534 (1996) (holding that the state violated the Equal Protection Clause because it failed to show an “exceedingly persuasive justification” for excluding women).

²⁰⁸ *Id.* at 533.

Furthermore, just as classifications based on race have been subjected to strict scrutiny review because of their "danger of stigmatic harm,"²⁰⁹ classifications based on gender carry an equivalent risk. Based on the high visibility and immutability of sex characteristics, the Supreme Court has found gender comparable to race in warranting strict scrutiny.²¹⁰ Gender should qualify as a suspect classification,²¹¹ particularly in regards to the pelvic examination requirement: HHS and the FDA have historically ignored issues of women's health, women have historically been oppressed by our society, and women are a discrete group defined by immutable physical traits.

Strict scrutiny is especially appropriate in the case of the pelvic exam requirement because the fundamental rights of bodily privacy and access to contraceptives are involved.²¹² In *Eisenstadt v. Baird*, Justice White stated:

Due regard for protecting constitutional rights requires that the record contain evidence that a restriction on distribution of [contraceptives] is essential to achieve the statutory purpose Given *Griswold v. Connecticut* . . . and absent proof of the probable hazards of using [contraception,] . . . to sanction a medical restriction upon distribution of a contraceptive not proved hazardous to health would impair the exercise of the constitutional right.²¹³

Therefore, the pelvic exam requirement should be reviewed under strict scrutiny for evidence that this restriction on distribution of oral contraceptives is essential to achieve the goal of protecting women's health. However, if a reviewing court applies the principles of stare decisis, it will likely employ intermediate level review.²¹⁴ It is even possible that the

²⁰⁹ *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989).

²¹⁰ *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973) (plurality opinion).

²¹¹ For an argument that all reproductive health legislation should be subject to strict scrutiny, see Ruth Colker, *An Equal Protection Analysis of United States Reproductive Health Policy: Gender, Race, Age, and Class*, 1991 DUKE L.J. 324, 325 (1991). See Law, *supra* note 60, for an argument that laws governing reproductive biology should be subject to heightened scrutiny "to ensure that (1) the law has no significant impact in perpetuating either the oppression of women or culturally imposed sex-role constraints on individual freedom or (2) if the law has this impact, it is justified as the best means of serving a compelling state purpose." *Id.* at 1008-09.

²¹² It has also been argued that strict scrutiny should be utilized for "any government benefit condition whose primary purpose or effect is to pressure recipients to alter a choice about exercise of a preferred constitutional liberty in a direction favored by government." Sullivan, *supra* note 138, at 1499-1500.

²¹³ 405 U.S. 438, 464 (1972) (White, J., concurring).

²¹⁴ See, e.g., *United States v. Virginia*, 518 U.S. 515 (1996); *Craig v. Boren*, 429 U.S. 190, 197 (1976).

court will utilize only rational basis review because the limitation of rights only occurs where women have benefited from federal funds.²¹⁵

The result is the same regardless of the level of review: the requirement is unconstitutional. For the reasons discussed under the substantive due process violation analysis above, the pelvic exam requirement fails strict scrutiny: it is unnecessary because less invasive methods can protect women's health equally well, it is overly broad, and it does not serve its purpose of protecting the health of women.²¹⁶ The requirement fails intermediate level review because it is not substantially related to serving its important governmental objective of protecting women's health from preventable adverse effects of oral contraceptive use, nor, alternatively, is it substantially related to serving the important objective of providing preventive health services to Title X beneficiaries. It is vastly underinclusive in its failure to provide preventive health services to male beneficiaries, unduly burdens female beneficiaries, and creates a caste system in which the government has no substantial (or even legitimate) interest. The pelvic exam requirement fails rational basis review because not only is it not rationally related to the objective of protecting women's health from preventable adverse effects of oral contraceptive use because it increases risks to women's health but the government also has no legitimate interest in a system of preventive health care which creates a caste system.

V. UNCONSTITUTIONAL CONDITION ON EXERCISE OF THE RIGHT TO USE CONTRACEPTION

The basic premise of the unconstitutional conditions doctrine²¹⁷ is that "the government may not deny a benefit to a person because [s]he exercises a constitutional right."²¹⁸ The pelvic exam requirement places a condition that is unconstitutional (waiving the right to bodily integrity) on the exercise of women's privacy right to use contraception.²¹⁹

²¹⁵ See *Maier v. Roe*, 432 U.S. 464 (1977); *Harris v. McRae*, 448 U.S. 297 (1980).

²¹⁶ See *supra* Part III.B.

²¹⁷ It is sometimes argued that the unconstitutional conditions doctrine is an anachronism performing a function fully served by the standard process of reviewing the right infringed upon by a challenged regulation in light of the governmental interest it serves under the appropriate standard of review. See generally Sunstein, *Unconstitutional Conditions Doctrine*, *supra* note 126. However, analysis of the pelvic exam requirement under this doctrine is useful to illuminate the theory underlying the doctrine and the arguments of waivable rights and governmental power to limit benefits. More importantly, the doctrine is still applied by courts and would likely prove important to invalidate the pelvic exam requirement because it is not a "blanket restriction," as it applies only to individuals benefiting from federal spending.

²¹⁸ *CHEMERINSKY*, *supra* note 26, at 946 (quoting *Regan v. Taxation with Representation of Wash.*, 461 U.S. 540, 545 (1983)).

²¹⁹ While only the *recipient*, not the beneficiary, of federal funds has standing to challenge conditional spending, there are situations in which a recipient might assert a claim on behalf of the beneficiaries it serves. For example, a university receiving Title X funds has an interest in promoting the general health of and contraceptive use by its students.

A. *Governmental Denial of Benefits to Women Who Exercise Their Constitutional Bodily Privacy Right*

Bodily privacy is a constitutional right²²⁰ that is clearly infringed upon by intrusive pelvic exams. Thus, when women decline pelvic exams they are exercising their constitutional rights. Government-subsidized birth control is a benefit²²¹ received by those who qualify under financial status requirements.²²² Thus, refusing to dispense government-subsidized birth control to a woman because she declines a pelvic exam is governmental denial of a benefit to someone who exercises a constitutional right. This is prohibited by the doctrine of unconstitutional conditions.

B. *Coercion To Waive Bodily Privacy Rights in Exchange for Exercising Constitutional Rights to Reproductive Autonomy and Access to Contraception: Distinguished from the Abortion Funding Cases*

The pelvic exam requirement has been analogized to medical practitioners holding effective contraception hostage until a woman submits to the invasive exam.²²³ Although within the context of abortion the right to reproductive autonomy does not “carr[y] with it a constitutional entitlement to the financial resources to avail [oneself] of [it],”²²⁴ the pelvic exam requirement is distinguishable. The exercise of contraceptive rights for those lacking financial resources is possible with federal funds but requires allowing the government to invade bodily privacy. In the abortion context, the exercise of rights for the “indigent” is not possible with federal funds because the government does not provide abortion services. Thus, abortions do not involve coerced decisions because there is no receipt of a benefit that is conditioned on relinquishment of a constitutional right: either a woman can afford to obtain an abortion from a non-federally funded source or she cannot get one at all. In contrast, the choice surrounding the pelvic exam requirement involves more than the availability of funds: it involves deciding between foregoing hormonal contraceptives

Thus, it may assert their constitutional rights in seeking invalidation of the exam requirement due to its deterrent effect on use of the university's health services.

²²⁰ See, e.g., *Winston v. Lee*, 470 U.S. 753, 761 (1985); *Rochin v. California*, 342 U.S. 165, 172 (1952).

²²¹ Whether government-subsidized birth control is a benefit or an entitlement is arguable and will be discussed further, see *infra* Part V.C., but benefit status is used here under a conservative approach to make the strength of the argument even more apparent.

²²² Although Title X family planning services are available to women of all economic strata, subsidies vary depending on patients' finances. 42 U.S.C. §§ 300 to 300a-6a (2003). Medicaid requires women to meet financial requirements to qualify for its benefits. 42 U.S.C. § 1396 (2000).

²²³ Nelson, *supra* note 127, at 89.

²²⁴ *Harris v. McRae*, 448 U.S. 297, 316 (1980) (upholding the Hyde Amendment, which prohibits using federal Medicaid funds to perform abortions, except in cases of rape, incest, or endangerment of the mother's life).

or relinquishing bodily privacy. The cost of an abortion for both the poor and the wealthy in the abortion funding cases (*Harris v. McRae*,²²⁵ *Maher v. Roe*,²²⁶ and *Rust v. Sullivan*²²⁷) is purely financial; with the pelvic exam requirement, the cost of oral contraceptives for the wealthy is financial, while the cost of oral contraceptives for the poor is bodily invasion.

The rationale of *Harris* is that the government's regulation (limiting the range of medical services it would fund) was not a "deprivation" or "denial" because privacy and other fundamental rights are exclusively "negative" rights—i.e., the individual has a right to be left alone and not be "disturbed" by the government—and failure to fund abortions did not violate the negative right to privacy.²²⁸ In contrast, the regulation requiring a pelvic exam violates the individual's negative right to bodily integrity.²²⁹ The performance of an invasive pelvic exam literally involves disturbance of the individual and can hardly be described as the individual's being left alone. To receive federally funded family planning services, an abortion seeker has to *forego* an *exercise* of the right to an abortion. To receive the desired federally funded family planning service (i.e., hormonal contraception), the contraception seeker has to *undergo* a *violation* of the right to bodily privacy.

Harris and *Rust* indicate that it is permissible for Medicaid not to fund abortion because lack of funding leaves poor women with the same choices and no worse off than they would have been had Medicaid never existed.²³⁰ The pelvic exam requirement, however, creates a new set of choices, potentially leaving women worse off than if Title X had never existed.²³¹ The existence of the Title X program subjects women to potential pressure from partners or family members to undergo the exams in order to save the costs of private physicians; forces women who cannot afford to visit private providers to make decisions affirmatively to forego

²²⁵ *Id.*

²²⁶ 432 U.S. 464 (1977) (upholding a state regulation granting Medicaid benefits for childbirth but denying such benefits for nontherapeutic abortions).

²²⁷ 500 U.S. 173 (1991) (upholding an abortion gag rule imposed on recipients of federal health funds).

²²⁸ See Appleton, *supra* note 116, at 18.

²²⁹ This invasion of a negative right renders inapplicable Kathleen Sullivan's criticism of the coercion approach's articulation of a theoretical foundation for the unconstitutional conditions doctrine. Sullivan argues that it is unhelpful to identify coercion of beneficiaries as the harm of rights-pressuring conditions on government benefits in developing a theoretical foundation for solving unconstitutional conditions problems because to argue that conditions make recipients of the benefit worse off with respect to a benefit than they ought to be runs counter to the ground rules of a negative Constitution. Sullivan, *supra* note 138, at 1419–50.

²³⁰ *Harris*, 448 U.S. at 316 (1980); *Rust*, 500 U.S. at 201–02.

²³¹ See Linda Maher, *Government Funding in Title X Projects: Circumscribing the Constitutional Rights of the Indigent*: *Rust v. Sullivan*, 29 CAL. W. L. REV. 143, 166 (1992) (characterizing the Title X program as a "government buy-back program" that attempts to purchase constitutional freedoms, under "the guise of a desperately needed health care program for poor Americans").

their constitutional rights, choosing between either long-term control over their futures or exercise of their rights to bodily integrity; and likely results in most women submitting to potentially emotionally traumatic bodily invasion,²³² as most women probably deem temporary violation of their constitutional rights to be “the lesser of two evils” when compared to long-term deprivation of their constitutional rights. In short, poverty—not conditions on federal spending—precludes abortion seekers *from receiving* desired services from private providers. Here, while poverty will have the same result of precluding oral contraceptive seekers from receiving desired services from private providers, the condition on spending itself also creates the accompanying result of countless women *being subjected to* undesired, invasive exams.

While the abortion funding cases emphasize the significant leeway the government has in structuring its medical programs, the Supreme Court has indicated that a certain degree of coercion is unacceptable.²³³ The Court has found it impermissible for the government to present a choice of only “the lesser of the two evils.”²³⁴ Choosing between bodily invasion and lack of effective control over one’s reproductive life certainly qualifies as such a choice. Therefore, the pelvic exam requirement is unacceptably coercive²³⁵ in a way in which abortion restrictions are not.

Analysis of the pelvic exam requirement further differs from the analysis in the abortion funding cases because constitutional caselaw does not protect abortion in the same way it does birth control.²³⁶ In the case of abortion, the government has a powerful interest that weighs against women’s rights to bodily integrity and reproductive control: potential fetal life.²³⁷ In the case of contraception, the balance necessarily shifts in favor of women’s rights with the elimination of the government’s interest in fetal life. Because birth control access receives more constitutional protection than does abortion, the pelvic exam requirement is most certainly impermissible as it is unnecessary to protect women’s

²³² It is argued that the unconstitutional conditions doctrine “attempts to prevent hierarchy among classes that, without the government intervention, would make the *same* choice.” Sullivan, *supra* note 138, at 1497. By this argument, the pelvic exam requirement is an impermissible condition because it results in poor women making different choices than they would make if wealthier.

²³³ David S. Coale, Note, *Norplant Bonuses and the Unconstitutional Conditions Doctrine*, 71 TEX. L. REV. 189, 201 (1992) (citing *Sherbert v. Verner*, 374 U.S. 398, 404 (1963) (criticizing an effort to induce Sherbert to modify her religious beliefs); *Speiser v. Randall*, 357 U.S. 513, 519 (1958) (observing that denying a tax exemption for engaging in certain forms of speech will have an impermissible chilling effect on speech)).

²³⁴ *Union Pac. R.R. v. Pub. Serv. Comm’n*, 248 U.S. 67, 70 (1918).

²³⁵ Based on its coercive nature and its perpetuation of a medically unnecessary requirement, the pelvic exam requirement has also been argued to be unethical. Stewart et al., *supra* note 49, at 2236.

²³⁶ See *Planned Parenthood v. Casey*, 505 U.S. 833, 851–59 (1992); see also Silverberg, *supra* note 115, at 1606.

²³⁷ E.g., *Rust v. Sullivan*, 500 U.S. 173 (1991); *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).

health and is a substantial obstacle that deters many women from obtaining effective contraception.²³⁸ The question then becomes: does the government's interest in preventing a few (if any) adverse effects of oral contraceptive use, where less intrusive means of preventing those effects are available, outweigh women's right to maintain bodily integrity and control their reproduction? The answer is clearly no.

Casey implicitly held that an abortion regulation would also be impermissible if it were so rigid that it would not allow for a physician to exercise medical judgment in waiving compliance with the regulation due to adverse effects on the mental or physical health of the woman.²³⁹ In the hormonal contraceptive context, which receives more protection, the mandatory pelvic exam requirement precludes physician waiver even if medical judgment suggests the procedure may result in unwarranted harm to the woman's mental or physical health.

While other types of contraceptives are available without a pelvic exam, they are not comparable because they are less effective, less convenient, and not entirely within the woman's control.²⁴⁰ Contraceptive method preference also implicates religious beliefs and prohibitions.²⁴¹ Supporting these arguments is the logic of *Planned Parenthood Federation of America v. Schweiker*,²⁴² which implicitly rejected a requirement for women either to pay the costs of the pill from private providers or to accept a less effective method of birth control. In *Schweiker*, the court determined that a parental notice restriction on adolescents' access to birth control was unjustifiably intrusive because it would deter adolescents from using Title X clinics, thus undermining the clinics' purpose of reducing the number of unintended births and pregnancies.²⁴³ An even stronger argument exists for invalidating the pelvic exam requirement because the privacy rights of adult women weigh more heavily against

²³⁸ See *infra* Part VII.A.1.

²³⁹ *Casey*, 505 U.S. at 883–84.

²⁴⁰ “The availability of safe, effective and convenient methods of contraception is central to a woman's control over her life and her fertility.” Anna Birenbaum, *Shielding the Masses: How Litigation Changed the Face of Birth Control*, 10 S. CAL REV. L. & WOMEN'S STUD. 411, 424 (2001); see also *infra* Part VII.B.

²⁴¹ State and federal cases interpreting the First Amendment Free Exercise Clause have recognized the importance of religious objections to some medicines and treatments. Coale, *supra* note 233, at 201 (citing JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW 1237 (4th ed. 1991) (“When the objection to medical treatment is based on religious principles . . . a serious free exercise clause problem is presented.”)). While, in this case, oral contraceptives might be undesirable for those with religious concerns (most forms of the pill prevent implantation of the fertilized egg, which may constitute abortion from the perspective of those who believe life begins at fertilization), the extensive entanglement of religious beliefs with preferences about contraception makes governmental involvement in choice of contraceptive method a complicated, and oftentimes controversial, issue.

²⁴² 559 F. Supp. 658 (D.D.C. 1983).

²⁴³ *Id.* at 663–65.

the government's interests than do those of adolescents.²⁴⁴ A pelvic exam is more intrusive than parental notification, and the Title X goal of prohibiting unintended pregnancies and abortions is just as important for adult women as it is for adolescents.²⁴⁵ Under the rationale of *Schweiker*, poor women who are often economically dependent upon male partners or parents should not have to seek permission from others (in the form of financial support to see a private provider) to obtain effective oral contraception.²⁴⁶

C. *The Greater Power Does Not Include the Lesser Power*

According to the unconstitutional conditions doctrine, "although [the] government may choose not to provide certain benefits altogether, it may not condition the conferral of a benefit, once provided, on a beneficiary's waiver of a constitutional right."²⁴⁷ The conventional opposing argument is that because the government does not have to provide subsidized contraceptive services at all, it has the power to restrict those provisions in any manner it wants. However, that argument fails where the benefit being provided is itself a constitutional entitlement. In the abortion context, a woman has a right to choose abortion but no entitlement to the means to achieve it, "even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual."²⁴⁸ In contrast, women have not merely a right to choose to use effective contraceptives²⁴⁹ but a constitutional entitlement of access to them, free from unjustified governmental interference.²⁵⁰ "[W]hat the government cannot restrict for all, it may not restrict for those over whom it has special leverage because of their dependency."²⁵¹

²⁴⁴ The Constitution weighs adolescents' rights against those of both their parents and the power of the state, whereas an adult's rights are weighed only against the state's. Arons, *supra* note 60, at 1096 n.23 (citing *Carey v. Population Servs. Int'l*, 431 U.S. 678, 692 (1977) (holding that the power of the state to regulate minors is greater than its power to regulate adults)).

²⁴⁵ Title X is intended to serve all age groups in need of family planning services. 42 U.S.C. § 300 (2003); Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, § 6(c), 84 Stat. 1506 (1970).

²⁴⁶ See *Planned Parenthood v. Casey*, 505 U.S. 833, 887-88 (1992) (holding that women have the right to make reproductive decisions even without their partners' approval); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (invalidating portions of a Missouri statute that required a woman seeking an abortion to obtain spousal consent if married or parental consent if unmarried and under the age of eighteen).

²⁴⁷ Sunstein, *Unconstitutional Conditions Doctrine*, *supra* note 126, at 593 n.2 (citing LAURENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 10-8, at 681 & n.29 (2d ed. 1988)).

²⁴⁸ *DeShaney v. Winnebago*, 489 U.S. 189, 196 (1989) (referring to *Harris v. McRae*, 448 U.S. 297 (1980)).

²⁴⁹ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

²⁵⁰ *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); see also *Planned Parenthood v. Casey*, 505 U.S. 833, 851-53 (1992) (affirming the right's continued existence).

²⁵¹ Sullivan, *supra* note 138, at 1499.

The existence of Title X family planning clinics is itself testimony to the government's recognition that many women would not have access to effective contraception without such clinics.²⁵² Because this right of access exists and the government has acknowledged a duty to provide access to effective contraception for the poor,²⁵³ it does not have the power to refuse to fulfill this duty.²⁵⁴ Moreover, although the government need not provide any access to contraception, the pelvic exam requirement still violates the fundamental right to be free from unjustified governmental interference in existing access to contraception²⁵⁵ because the pelvic exam requirement's irrational and discriminatory nature makes it unjustifiable under any level of review.²⁵⁶

Even if a greater power includes any lesser power where both serve the *same* purpose,²⁵⁷ the greater power to provide Title X family planning services does not include the lesser power to restrict access to oral contraceptives with irrelevant exams in order to protect women's health. The purpose of the greater power of establishing Title X family planning clinics is to reduce the number and adverse consequences of unintended pregnancies²⁵⁸ and allow women to lead independent lives.²⁵⁹ Rather than fully serving the purposes of Title X, the pelvic exam requirement actually defeats the Title X purposes of reducing the consequences of unintended

²⁵² See 136 CONG. REC. S13,680 (daily ed. Sept. 25, 1990) (statement of Sen. Packwood) (acknowledging that Title X is the only source of contraceptives for many women); *id.* at S13,685 (statement of Sen. Adams) (acknowledging that 4.1 million women rely on Title X for contraceptive services); ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 6 (stating that Title X's "enactment sprang from a fundamental recognition that absent government support, only women who could afford a visit to a private physician and the method the physician prescribed would benefit from the new era of modern contraception"), available at <http://www.guttmacher.org/pubs/fulfill.pdf>.

²⁵³ See *supra* note 1; HHS Proposed Rules for National Guidelines for Health Planning, 45 Fed. Reg. 78,552 (Nov. 25, 1980) [hereinafter HHS Proposed Rules] (acknowledging that in order for poor individuals to be independent, and to protect them from social, economic, and psychological health costs, public family planning services are necessary).

²⁵⁴ See HHS, Unified Agenda, Statement of Regulatory and Deregulatory Priorities, 62 Fed. Reg. 57,043, 57,043 (1997) [hereinafter Unified Agenda] (stating that "[t]he Department of Health and Human Services (HHS) is statutorily obligated to protect and promote the health and the social and economic well-being of all Americans, and, in particular, of those least able to help themselves— . . . the disadvantaged—by helping them and their families develop and maintain healthy, productive, and independent lives").

²⁵⁵ As in *Goldberg v. Kelly*, 397 U.S. 254 (1970), federal law (rather than the Constitution) has established the affirmative entitlement to provision of contraceptives here, so Title X recipients have a property right in this welfare benefit which permits them to expect continued receipt of the benefits unless the government provides notice of and a hearing about an intent to discontinue the benefits.

²⁵⁶ See *supra* Parts III.B–C and IV.C.

²⁵⁷ See Sullivan, *supra* note 138, at 1460.

²⁵⁸ This is true particularly among those at high risk for an unintended pregnancy (*e.g.*, poor and minority women). HHS Proposed Rules, *supra* note 253, at 78,564.

²⁵⁹ Unified Agenda, *supra* note 254, at 57,043. HHS also acknowledges that in order for individuals to be independent, public family planning services are necessary. HHS Proposed Rules, *supra* note 253, at 78,564.

pregnancies and fostering women's independence.²⁶⁰ Thus even were the government to have the power of not subsidizing contraceptives, this greater power would not include the lesser power to restrict access to subsidized contraceptives for only some recipients.

D. The Pelvic Exam Constitutes a Penalty Instead of a Mere Lack of Subsidy

The pelvic exam requirement amounts to an impermissible penalty on the exercise of the constitutional right of access to effective contraception. The traditional counterargument to this proposition is that the government is not penalizing the exercise of a right; rather, it is merely not providing a subsidy. However, this argument carries less weight when both the right being exercised and the subject of the subsidy itself are constitutional entitlements. Unlike the abortion context, the government has acknowledged a duty to provide poor women with the effective contraception to which they are constitutionally entitled.²⁶¹ The argument that it may refuse to subsidize oral contraceptives for those who decline a pelvic exam therefore fails. Wealthy women can exercise their constitutional right to contraceptive access without a pelvic exam. Poor women are "charged" a pelvic exam to exercise their right of access. The pelvic exam is therefore a penalty on women who cannot afford to visit a private practitioner.

Additionally, a condition on the exercise of a constitutional right constitutes a penalty if the condition is unrelated to the benefit.²⁶² In the abortion funding cases, the Supreme Court held that the lack of funding for abortions with public medical insurance was merely a nonsubsidy.²⁶³ However, it conceded that the government's withdrawal of general welfare benefits²⁶⁴ or all Medicaid benefits²⁶⁵ from an otherwise needy woman for having an abortion would be a penalty due to the lack of germaneness of the condition to these benefits. Similarly, the pelvic exam's lack of germaneness to oral contraceptive prescription²⁶⁶ renders the exam condition a penalty on the exercise of a constitutional right. In sum, the pelvic exam requirement is unconstitutional because it is impermissibly coercive to require the forfeiture of bodily privacy rights in exchange for

²⁶⁰ See *infra* Parts VII.A.2 (increase in unwanted pregnancies and abortions) and VII.C (decreased autonomy of women).

²⁶¹ See *supra* note 32.

²⁶² See Sullivan, *supra* note 138, at 1464.

²⁶³ *Maier v. Roe*, 432 U.S. 464, 474 n.8 (1977); see also Sullivan, *supra* note 138, at 1464.

²⁶⁴ *Maier*, 432 U.S. at 474 n.8; see also Sullivan, *supra* note 138, at 1464.

²⁶⁵ *Harris v. McRae*, 448 U.S. 297, 317 n.19 (1980); see also Sullivan, *supra* note 138, at 1464.

²⁶⁶ See *supra* Parts III.B.1–2.

the exercise of the right to reproductive autonomy and access to effective contraception.²⁶⁷

VI. IMPERMISSIBLE STATUTORY CONSTRUCTION

Even if the pelvic exam requirement is constitutional, it is nonetheless impermissible under administrative law. Because Congress explicitly delegated authority to HHS to create regulations under Title X,²⁶⁸ the pelvic exam requirement is entitled to great deference by a reviewing court.²⁶⁹ In deciding the legality of an agency's interpretation of statutory instructions, a court must first decide whether the legislature has directly addressed "the precise question at issue."²⁷⁰ If, as here, it has not, the court must determine whether the agency's interpretation of the statute is acceptable.²⁷¹ Unless the regulation is arbitrary, capricious, or manifestly contrary to the statute, it will be upheld.²⁷² However, because the pelvic exam requirement is arbitrary and capricious and its effect is manifestly contrary to HHS's statutory instructions, administrative law requires that it be invalidated.

A. Legislative Intent of Title X Provisions

The statute delegating authority to HHS reads:

The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services²⁷³

²⁶⁷ See also Maher, *supra* note 231, at 167 (arguing that if an American can ever bargain away his or her constitutional rights, this should never transpire between the government and the poor because the uneven bargaining power alone would invalidate any such contract).

²⁶⁸ 42 U.S.C. § 300a-4 (2000) ("Grants and contracts made under this subchapter shall be made in accordance with such regulations as the Secretary may promulgate.").

²⁶⁹ *Chevron, Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 845 (1984); *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001).

²⁷⁰ *Chevron*, 467 U.S. at 842.

²⁷¹ *Id.* at 842–43. The pelvic exam requirement is maintained by "interpretive guidance" from OPA, rather than a legislative rule by HHS, and it "did not require clearance by other agencies within the government or publication in the Federal Register because it does not establish new policy." Nat'l Cervical Cancer Coalition, *supra* note 80, available at http://www.nccc-online.org/fppaps_12.asp. Therefore, a court would probably review the requirement with lesser deference, as in *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944).

²⁷² *Chevron*, 467 U.S. at 844.

²⁷³ 42 U.S.C. § 300 (2003).

Grants and contracts made under this title . . . shall be made in accordance with such regulations as the Secretary may promulgate.²⁷⁴

The statute itself does not address the specific issue of the necessity of a pelvic exam prior to dispensing oral contraceptives but grants explicit authority to HHS to create regulations. Therefore, a reviewing court will defer to the HHS decision to require pelvic exams of women seeking oral contraceptives unless the regulation can be shown to be arbitrary, capricious, or manifestly contrary to the statute.

B. Impermissible Construction of Title X Provisions

The requirement for a pelvic exam prior to dispensing oral contraceptives in Title X programs was initially articulated in 1976 in the program guidelines developed by ACOG for project grants for family planning services.²⁷⁵ Today, the requirement is maintained under a policy of OPA to follow FDA-required drug label prescribing information for contraceptives dispensed through its programs, and an interpretation by OPA that language in FDA package insert labeling *requires* women to receive pelvic exams prior to beginning oral contraceptives and annually thereafter.²⁷⁶ As an example of such language, one FDA insert specifies that “[a] complete medical history and physical examination *should* be taken prior to the initiation or reinstatement of oral contraceptives and at least annually during use of oral contraceptives. These physical examinations should include special reference to . . . pelvic organs, including cervical cytology.”²⁷⁷

²⁷⁴ 42 U.S.C. § 300a-4 (2000).

²⁷⁵ PUB. HEALTH SERV., U.S. DEP'T OF PUB. HEALTH, EDUC., AND WELFARE, PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES UNDER SECTION 1001, PUBLIC HEALTH SERVICES ACT 11-13 (1976). The requirement for a pelvic exam prior to and annually after dispensing oral contraceptives under the Title XIX Medicaid, Title V MCH Block Grant, and Title XX Block Grant programs was articulated by the U.S. Public Health Service in 1967. PROGRAM AREA COMM. ON POPULATION & PUB. HEALTH, FAMILY PLANNING: A GUIDE FOR STATE AND LOCAL AGENCIES 66 (1968) (citing Pub. Health Servs., Dep't of Health, Educ., and Welfare, Division of Direct Health Services Circular Memo No. 67-14 (1967)).

²⁷⁶ OFF. OF POPULATION AFFAIRS, *supra* note 108, § 8.3; see Memorandum from Jerry Bennett to Regional Health Administrators of Title X programs, *supra* note 80 (discussing the continued existence of the pelvic exam requirement and stating that “Title X has traditionally taken the position that grantees should conform to current FDA policy as expressed in its labeling standards for contraception. OPA continues to be of the view that this policy is appropriate . . .”), available at <http://opa.osophs.dhhs.gov/titlex/pis/opa93-1.pdf>; Nat'l Cervical Cancer Coalition, *supra* note 80, available at http://www.nccc-online.org/fppaps_12.asp.

²⁷⁷ FDA package insert labeling for oral contraceptives, cited in DICKEY, *supra* note 69 at 184 (emphasis added). Another FDA label asserts that “[i]t is good medical practice for women using [hormonal contraception], as for all women, to have an annual medical evaluation including physical examination . . . [which] *should* include special reference to . . .

The text of the statute, the legislative history surrounding it, and the overall purpose of Title X render the pelvic exam requirement impermissible because the decisions to implement and maintain the requirement are arbitrary and capricious, and its effect is directly contrary to its purpose. By eliminating oral contraceptives from the family planning options available to women who do not want to undergo a pelvic exam, the requirement reduces the “broad range of *acceptable* . . . family planning methods offer[ed]” to women and diminishes the “broad range of . . . *effective* family planning methods offer[ed]” to women²⁷⁸—results directly contrary to the language of the statute.

In contrast to other public health laws, which are intended to provide a broad range of general health care services,²⁷⁹ the exclusive purpose of Title X is to provide family planning services.²⁸⁰ Within this narrowly defined objective, the primary goals are prevention of unintended pregnancy and improvement of maternal health.²⁸¹ HHS’s construction of the statute to require pelvic exams is arbitrary and capricious because women do not need a pelvic exams to serve Congress’s goal of preventing unintended pregnancy or improving maternal health.²⁸² In fact, the requirement is manifestly contrary to congressional intent in enacting Title X because its deterrent effect results in increases in unwanted pregnancies²⁸³ and greater risks to maternal health.²⁸⁴ Furthermore, in the absence of any statutory instruction to consider factors which might support the requirement of a pelvic exam on other grounds, the fact that the requirement serves no purpose that is relevant to oral contraceptive use²⁸⁵ renders it arbitrary and capricious.²⁸⁶

The arbitrariness of the requirement is further apparent in its inconsistency with OPA’s own policy of following FDA labeling guidance. OPA’s interpretation of “should” to mean “must” is arbitrary and capri-

pelvic organs and vagina (including cervical cytology).” FDA package insert labeling for NuvaRing (emphasis added), available at <http://www.epigee.org/guide/inserts/nuvaring.pdf> (last visited Feb. 1, 2004).

²⁷⁸ 42 U.S.C. § 300 (2003) (emphasis added).

²⁷⁹ *E.g.*, Medicaid, Title XIX of the Social Security Act, 42 U.S.C. § 1396 (2000); MCH Block Grant program, Title V of the Social Security Act, 42 U.S.C. §§ 701–709 (2000).

²⁸⁰ 136 CONG. REC. S13,685 (daily ed. Sept. 25, 1990) (statement of Sen. Adams); ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 6, 22 (citing Pub. L. No. 91-572), available at <http://www.guttmacher.org/pubs/fulfill.pdf>; Dailard, *supra* note 7, at 6.

²⁸¹ 136 CONG. REC. S13,676 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy that “[t]he purpose of [T]itle X is to provide services and information to reduce the incidence of unintended pregnancy, to improve maternal health, and to reduce the need for abortion”).

²⁸² See *supra* Parts III.B.1 and III.B.2.

²⁸³ See *infra* Part VII.A.2.

²⁸⁴ See *supra* Part III.B.1.c.

²⁸⁵ See *supra* Part III.B.1.

²⁸⁶ SEC v. Chenery Corp., 318 U.S. 80, 94–95 (1943) (indicating that an agency must be able to explain why it has chosen to implement a regulation).

cious because there is no basis for equating the two. "Should" is understood in everyday parlance to indicate that something is beneficial or preferable, whereas "must" is understood to indicate that something is mandatory and nonnegotiable. If OPA had accurately followed FDA labeling guidance, publicly funded clinics would have a policy urging women seeking oral contraceptives to get pelvic exams instead of a policy requiring them as an absolute prerequisite. Because HHS's construction of its statutory instructions for administering Title X programs is arbitrary, capricious, and manifestly contrary to Congress's intent, the requirement should be invalidated.

VII. PUBLIC POLICY ARGUMENTS FOR ELIMINATING MANDATORY PELVIC EXAMS

Even if a court upheld the pelvic exam requirement on legal grounds, it should be eliminated because it constitutes bad public policy. A 1993 task force that reviewed Title X guidelines recommended removing the pelvic exam requirement and leaving it to clinician discretion to determine whether or not such an exam is necessary prior to dispensing hormonal contraception.²⁸⁷ This recommendation is good public policy because it encourages use of contraception, helps to weaken gender stereotypes, is consistent with related bodies of law, and is supported by a cost-benefit analysis.

A. *Encouragement of Contraceptive Use*

Public policy and the legislation and regulations that implement it should encourage the use of contraceptives. Control of fertility provided by highly effective hormonal contraception allows women and couples to have children when they are best prepared financially and socially for parenting and its attendant responsibilities, resulting in fewer unanticipated costs to individuals. It also prevents women and couples from having to make difficult decisions about whether to have abortions and protects society from bearing the abortion- and pregnancy-related costs of women who are financially unprepared for unplanned pregnancies. The pelvic exam requirement's deterrent effect creates increased costs to society and individuals.

1. *Deterrent Effect*

Mandated pelvic exams deter women from obtaining hormonal contraceptives.²⁸⁸ Roughly 15% of women with a high school diploma or

²⁸⁷ Harper et al., *supra* note 74, at 13.

²⁸⁸ Humphrey Taylor, *Survey of and Barriers to Pill Use*, in *THE PILL: FROM PRESCRIP-*

lower education level and 11% of women with at least some college education cite the pelvic exam as a factor in deciding whether to use oral contraceptives.²⁸⁹ In a program providing low income women hormonal contraceptives, 76% of the women said it was important to be able to obtain birth control pills or injections without a pelvic exam, 86% responded favorably to the idea, 75% associated pelvic exams with embarrassment and fear, and 31% reported that these feelings had prevented them from obtaining a pelvic exam at some point.²⁹⁰ In another study, 16.7% of women said they would be more likely to use birth control pills if they did not first have to get a pelvic exam.²⁹¹ A survey conducted in three foreign countries showed that respondents in all countries believed a “user-friendly” process for accessing contraception “should not require a pelvic examination.”²⁹² Although only 56% of clinics dispensing oral contraceptives, 42% of clinics offering injectable contraceptives, and 23% of clinics providing the implant allow delayed pelvic exams, 69% of all women going to clinics for contraceptives choose those clinics, further suggesting women’s aversion to undergoing such an exam.²⁹³

The pelvic exam requirement is also unwise public policy because it reinforces the common but incorrect perception that hormonal methods of birth control are dangerous, deterring use of effective contraception.²⁹⁴ An evaluation of California’s First Stop program, which provided hormonal contraception to women without requiring them to undergo a pelvic exam, concluded that lack of a pelvic exam requirement improves the frequency of women utilizing reproductive health services.²⁹⁵ The program also demonstrated that the provision of contraception without a pelvic exam resulted in a significant improvement in women’s use of ef-

TION TO OVER THE COUNTER, *supra* note 67, at 53, 67 tbl. 9; Best, *supra* note 73, available at <http://www.reproline.jhu.edu/English/6read/6issues/6network/v21-3/nt2131.htm>; MEAD, *supra* note 67, at 5 tbl. 1 (citing pelvic exams as unwarranted psychological barriers to oral contraceptives). Adolescents especially are deterred from obtaining contraception by fear of pelvic exams. See Stewart et al., *supra* note 49, at 2236 (stating that young women often forego medical care to receive contraception when they become sexually active due to anxiety about pelvic exams); Cromer & McCarthy, *supra* note 75, at 292 (citing ELISE F. JONES ET AL., *TEENAGE PREGNANCY IN INDUSTRIALIZED COUNTRIES* (1986)); Shafer, *supra* note 49, at 69; LAURIE SCHWAB ZABIN & SARAH C. HAYWARD, *ADOLESCENT SEXUAL BEHAVIOR AND CHILDBEARING* 67, 73 (1993) (reporting that for 24.8% of adolescents, fear of the examination is a factor in decisions to delay seeking family planning services); Am. Acad. of Pediatrics, Comm. on Adolescence, *supra* note 18, at 134.

²⁸⁹ Taylor, *supra* note 288, at 67 tbl. 9.

²⁹⁰ Harper et al., *supra* note 74, at 16.

²⁹¹ Sable et al., *supra* note 79, at 124. The percentage of women who hold this view is probably much higher, as the women surveyed were presumably disproportionately those who had decided to submit to the exam because they were already at the clinic to obtain contraceptives.

²⁹² Cromer & McCarthy, *supra* note 75, at 287.

²⁹³ Finer et al., *supra* note 6, at 19.

²⁹⁴ Stewart et al., *supra* note 49, at 2232.

²⁹⁵ Harper et al., *supra* note 74, at 13.

fective contraceptive methods after their initial visit to the program: 38% adopted a more effective method than that used before their visits.²⁹⁶

2. Increase in Unwanted Pregnancies and Abortions

The deterrent effect of the pelvic exam requirement results in the use of either nonhormonal contraception or no contraception at all. Nonhormonal methods of contraception are both less effective²⁹⁷ and less desirable for convenience²⁹⁸ and enjoyment²⁹⁹ reasons. The resultant decrease in use of effective contraception increases the number of unintended pregnancies and, thus, forces women and couples to confront difficult decisions about abortion that they would presumably prefer to avoid.³⁰⁰ Currently, of women aged fifteen to forty-four, 28% have had at least one unintended birth and 30% have had at least one abortion.³⁰¹ Furthermore, 54% of unintended pregnancies end in abortion.³⁰² By eliminating the pelvic exam requirement and its accompanying hormonal contraceptive-deterrent effect, the number of unwanted pregnancies and abortions will decrease.

3. Increased Costs to Society

Unwanted pregnancies, whether ending in abortion or birth, create costs for individuals³⁰³ and society. Currently, roughly half of all pregnancies in the United States are unintended, including 59% among women between twenty and twenty-four years of age and 78% among never-married women.³⁰⁴ The unintended pregnancy rate is highest among young, low-

²⁹⁶ *Id.*

²⁹⁷ *See supra* note 18.

²⁹⁸ Nineteen percent of women report that condoms make sex less spontaneous. Sable et al., *supra* note 79, at 127.

²⁹⁹ Thirteen percent of women assert that there is no point in getting condoms because men do not like to use them; 25% of women report that condoms make sex less pleasurable. *Id.*

³⁰⁰ *See* 136 CONG. REC. S13,686 (daily ed. Sept. 25, 1990) (statement of Sen. Adams) (asserting that "it is one of the great tragedies of this country that we allow unintended pregnancies, to force very young women, often very poor young women, to a point where they have to make choices that they would not otherwise have to make").

³⁰¹ Stanley K. Henshaw, *Unintended Pregnancy in the United States*, FAM. PLAN. PERSP., Jan.-Feb. 1998, at 24, 24 (reporting 1994 data).

³⁰² *Id.*

³⁰³ For example, unintended conception appears to be a risk factor for violence during pregnancy. Of the women who reported physical violence during pregnancy, almost 70% were women with unwanted or mistimed pregnancies. Additionally, although the direction of causation is unclear, 12% of accidentally pregnant women are abused, whereas only 3% of intentionally pregnant women are abused. Melissa Moore, *Reproductive Health and Intimate Partner Violence*, FAM. PLAN. PERSP., Nov.-Dec. 1999, at 302, 304 (citing J. A. Gazmarian et al., *The Relationship Between Pregnancy Intendedness and Physical Violence in Mothers of Newborns*, 85 OBSTETRICS & GYNECOLOGY 1031, 1031 (1995)).

³⁰⁴ Sable et al., *supra* note 79, at 124 (citing Henshaw, *supra* note 301, at 26 tbl. 1).

income, minority women.³⁰⁵ These are also the women most likely to have financial and social difficulty caring for an unanticipated child.³⁰⁶ In spite of the inability to support a child and the life disruption that can be caused by an unplanned birth, about half of unintended pregnancies result in birth.³⁰⁷ Publicly funded clinics are prohibited from providing abortion services,³⁰⁸ and abortions are even more expensive than initiation of oral contraceptives through a private provider.³⁰⁹ Thus, the economically disadvantaged woman who is denied effective contraception because she declines a pelvic exam and who then becomes pregnant but cannot afford an abortion is left with the far greater expenses of pregnancy and childrearing,³¹⁰ which she is also unable to meet. Consequently, these pregnancies result in increased costs to society because these women and their children require publicly funded services.³¹¹

The pelvic exam itself also increases costs to society. The intensive professional time and equipment necessary to perform the exam make it very expensive.³¹² Public money is used (under Title X) to pay these costs. By eliminating the requirement, administrative costs would decrease, as would the costs of funding pregnancy, childbirth, and abortions for women

³⁰⁵ Henshaw, *supra* note 301, at 24.

³⁰⁶ *Id.* at 29.

³⁰⁷ *Id.*

³⁰⁸ 42 U.S.C. § 300a-6 (2000).

³⁰⁹ The cost of an abortion ranges between \$250 and \$1067, depending on the method used and gestational age. Planned Parenthood Fed'n of Am., *Ask the Experts*, at http://www.teenwire.com/ask/2002/as_20021108p465_abortion.asp (Nov. 8, 2002) (last visited Feb. 1, 2004); Planned Parenthood Fed'n of Am., *Fact Sheet: Abortion After the First Trimester* (June 2001) at http://www.plannedparenthood.org/library/facts/abotaft1st_010600.html (last visited Feb. 1, 2004). Initiation of oral contraceptives through a private provider costs \$50–\$125 for the visit and \$20–\$35 per month for the pill. Planned Parenthood Fed'n of Am., *You and the Pill*, at http://www.plannedparenthood.org/bc/you_and_pill.htm (last visited Feb. 1, 2004).

³¹⁰ The cost of pregnancy on average is \$6,400 and the cost of childrearing is estimated to be \$8,951 per year for lower-class families. See Women's Issues, *Unplanned Pregnancy—How Much Does It Cost?* (cost of pregnancy), available at <http://www.womensissues.about.com/library/unplanned/blkeepcost.htm> (last visited Feb. 1, 2004); Kindell, *supra* note 132, at 415 (cost of childrearing). This expense occurs in the form of both health risks and monetary costs. The risks in childbirth of permanent damage to health and to life itself are vastly greater than the risks of abortion (approximately seven times greater in childbirth than in first trimester abortion), and the health risks of both pregnancy and childbirth are exacerbated in an unwanted pregnancy. Law, *supra* note 60, at 1017 (citing Scot Lebolt et al., *Mortality from Abortion and Childbirth: Are the Statistics Biased?*, 248 JAMA 192 (1982); Cates, *Legal Abortion: The Public Health Record*, 215 SCI. 1586, 1587 (1982); Scot Lebolt et al., *Mortality from Abortion and Childbirth: Are the Populations Comparable?*, 248 JAMA 188 (1982)). Alternatively, a woman could give her unintended child up for adoption, but this still involves psychological costs. See Colker, *supra* note 211, at 352 (citing Steven McLaughlin et al., *Do Adolescents Who Relinquish Their Children Fare Better or Worse Than Those Who Raise Them?*, FAM. PLAN. PERSP., Jan.-Feb. 1998, at 25, 25).

³¹¹ Gold, *supra* note 10, at 5; see also Henshaw, *supra* note 301, at 29.

³¹² Shafer, *supra* note 49, at 69.

who would otherwise become pregnant through lack of access to effective contraception and then require financial assistance.

B. *Perpetuation of Gender Stereotypes*

Good public policy seeks to eliminate or weaken gender stereotypes that perpetuate patriarchal gender hierarchy.³¹³ The pelvic exam requirement maintains gender stereotypes because it decreases the autonomy of women, derails education and career goals, and forces undesired maternal roles and responsibilities upon women.

1. *Decreased Autonomy of Women*

The pelvic exam requirement perpetuates stereotypes of women as submissive and dependent because it decreases their autonomy over their fertility, causing them to lose physical, social, and financial independence and power.³¹⁴ The denial of hormonal contraception upon refusal of a pelvic exam leaves women in the uncomfortably vulnerable position of relying upon birth control methods which are at least partly within their partners' control.³¹⁵

In situations of forced sex, women are particularly vulnerable to an undesired pregnancy because their aggressors are unlikely to use contraception.³¹⁶ Abused women in general are less likely than nonabused women to report having used condoms during their last sexual encounter,³¹⁷ and studies of young women indicate that the degree of "wantedness" of their first voluntary intercourse is positively correlated with the probability of contraceptive use.³¹⁸ Given the frequency of unwilling sex,³¹⁹ particularly

³¹³ See *United States v. Virginia*, 518 U.S. 515, 534 (1996) (discussing the impermissibility of sex classifications that perpetuate gender role stereotypes).

³¹⁴ HHS's Statement of Regulatory and Deregulatory Policies explicitly states in its "overall priorities" that it is statutorily obligated to help disadvantaged Americans maintain independence. 62 Fed. Reg. 57,043, 57,043 (Oct. 29, 1997).

³¹⁵ All nonhormonal contraceptive methods but the IUD require at least the patience—if not the assistance—of the male partner. Cf. Sable et al., *supra* note 79, at 127 tbl. 2 (citing the need to trust one's partner as a barrier to condom use by thirty-five percent of women surveyed).

³¹⁶ Joyce Abma et al., *Young Women's Degree of Control over First Intercourse: An Exploratory Analysis*, FAM. PLAN. PERSP., Jan.-Feb. 1998, at 12, 12.

³¹⁷ Moore, *supra* note 303, at 304 (citing J. Greenberg, *Childhood Sexual Abuse and Risk of STDs in Women: Intervention Strategies* (paper presented at the National Conference on Violence and Reproductive Health, Atlanta, GA, June 1999)).

³¹⁸ Abma et al., *supra* note 316, at 15–16.

³¹⁹ Fourteen percent of women report having had forced sexual contact with someone their own age. Iviva Olenick, *Women Exposed to Childhood Abuse Have Elevated Odds of Unintended Pregnancy as Adults*, FAM. PLAN. PERSP., Jan.-Feb. 2000, at 47, 47. Presumably this percentage increases when forced contact with someone of a different age group is included. A survey of women seeking pregnancy tests revealed 2.3% were seeking them as a result of forced sex. Sable et al., *supra* note 79, at 127 tbl. 2.

among younger women, this problem is substantial.³²⁰ Victims of intimate partner violence may be or may perceive themselves to be rendered powerless by abuse, which could make it difficult to negotiate condom use with their partners.³²¹ Research suggests that abuse affects women's ability or motivation to prevent an unintended first pregnancy.³²² The cycle of physical vulnerability is then perpetuated because women who do become pregnant are then at a greater risk of experiencing domestic violence.³²³ Furthermore, women who are sexual abuse victims may be particularly averse to an intrusive pelvic exam.³²⁴

Even in situations of consensual sex, women often fail in their efforts to negotiate use of contraception with their partners,³²⁵ oftentimes "due to economic dependence, social norms, and fear of physical violence."³²⁶ Moreover, even when both sexes understand the strengths and

³²⁰ Because recipients of publicly funded family planning services tend to be younger women, 136 CONG. REC. S13,685 (daily ed. Sept. 25, 1990) (statement of Sen. Adams), the especially high rate of unwilling sex among this age group underscores the need for provision of controllable and reliable hormonal contraception at publicly funded clinics. Twenty-six percent of teenage girls cite being "force[d] . . . against their will" as the reason they "often" have sex; sixty-one percent of teenage girls report that pressure from a boyfriend is the reason they "often" have sex. The Kaiser Fam. Found., Survey on *Teens and Sex: What They Say Teens Today Need To Know, and Who They Listen to*, available at <http://www.kff.org/youthhisvstds/1159-teench.cfm> (last visited Feb. 1, 2004).

³²¹ Moore, *supra* note 303, at 304 (citing Sandra L. Martin, *Women in Prenatal Care/ Substance Abuse Treatment Program: Links Between Domestic Violence and Mental Health*, 2 MATERNAL & CHILD HEALTH 85, 85-94 (1998)).

³²² Olenick, *supra* note 319, at 48. A strong correlation exists between childhood sexual abuse and adolescent pregnancy: between fifty and sixty-five percent of teenage mothers have been victims of childhood sexual abuse or assault. Arons, *supra* note 60, at 1118 n.181.

³²³ AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 88; see also *Planned Parenthood of S.E. Pennsylvania v. Casey*, 505 U.S. 833, 889 (1992) (citing the district court's finding that "[m]ere notification of pregnancy is frequently a flash-point for battering and violence within the family. The number of battering incidents is high during the pregnancy and often the worst abuse can be associated with pregnancy.").

³²⁴ Women who are the victims of sexual abuse demonstrate a heightened aversion to bodily intrusion. See Jennifer Burian, *Helping Survivors of Sexual Abuse Through Labor*, (explaining how, for victims of sexual abuse, gynecological clinic visits so resemble their abuse that they are often virtually intolerable, and quoting one victim as saying, "I have to be half dead before I go . . . a yearly pelvic is about once every three to four years") at <http://www.gentlebirth.org/archives/abuselbr.html> (last visited Feb. 1, 2004); see also AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES, *supra* note 55, at 142 (acknowledging the need for sensitivity in performing exams on women who have been the victims of sexual assault, due to their vulnerability).

³²⁵ Sable et al., *supra* note 79, at 127 (finding that thirteen percent of women report that their partners will not use condoms); see ALAN GUTTMACHER INST., FULFILLING THE PROMISE, *supra* note 8, at 37, (citing that a barrier to successful contraception is male partners' lack of support for birth control choices) available at <http://www.guttmacher.org/pubs/fulfill.pdf>. This is especially problematic for women within lower socioeconomic groups, as many men in these groups view pregnancy as enhancing their masculinity. Renata Forste & Julie Morgan, *How Relationships of U.S. Men Affect Contraceptive Use and Efforts to Prevent Sexually Transmitted Diseases*, FAM. PLAN. PERSP., Mar.-Apr. 1998, at 56, 57.

³²⁶ Sable et al., *supra* note 79, at 129 (citing D. Worth, *Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail*, 20 STUD. IN FAM. PLAN. 297, 297-307 (1989)).

weaknesses of contraceptive alternatives,³²⁷ men and women have different priorities when choosing contraceptive methods,³²⁸ and each sex perceives greater efficacy in the method more within his or her respective control.³²⁹ Research shows that men's involvement in decisions about contraception, sex, and childbearing strongly affects contraceptive behavior and that use of male-controlled methods continues to increase, despite the fact that female-controlled methods are generally more effective.³³⁰ Female power in intimate relationships is positively correlated with use of contraception, while decreased female power is associated with decreased contraceptive use.³³¹

Even when their partners do use contraception, women may still feel vulnerable without access to hormonal contraception because nonhormonal methods are less effective.³³² When alcohol use, spontaneity, or other factors result in voluntary (though perhaps impulsive or regrettable) unprotected sex, women are left with the possibility of pregnancy which would have been prevented by hormonal contraception.³³³

Unintended pregnancies resulting from women's lack of control over fertility further decrease women's autonomy because unplanned pregnancies increase poverty levels of individual women.³³⁴ This leads to financial dependence upon male partners, family members, and/or public welfare. This loss of autonomy can be easily alleviated by the use of hormonal contraceptive methods because their reliability and female-based control allow women to prevent almost all unintended pregnancies.³³⁵

³²⁷ William R. Grady et al., *Contraceptive Characteristics: The Perceptions and Priorities of Men and Women*, FAM. PLAN. PERSP., July-Aug. 1999, at 168, 174.

³²⁸ Men value protection against STDs more than women do, while women view prevention of pregnancy as the single most important factor in choice of contraceptive method. *Id.* at 171.

³²⁹ *See id.* at 172 (finding that seventy-five percent of women and sixty-seven percent of men believed the pill to be "very good" at pregnancy prevention, while twenty-nine percent of women and forty-six percent of men believed condoms to be "very good" at pregnancy prevention).

³³⁰ Grady et al., *supra* note 327, at 168.

³³¹ Abma et al., *supra* note 316, at 17 (citing S.R. Jorgensen et al., *Dyadic and Social Network Influences on Adolescent Exposure to Pregnancy Risk*, 42 J. MARRIAGE & FAM. 141 (1980)).

³³² While condoms are the most common and the most effective form of nonhormonal contraception used, thirty-eight percent of women feel they "aren't a good method because they can break." Sable et al., *supra* note 79, at 127; *see also* MEAD, *supra* note 67, at 4 (emphasizing the psychological benefits for women on the pill who know they are protected by an extremely effective form of birth control).

³³³ Sable et al., *supra* note 79, at 127 (finding that ten percent of women seeking pregnancy tests reported contraception was not used because the sex was spontaneous).

³³⁴ Gold, *supra* note 10, at 5, available at http://www.guttmacher.org/journals/tgr_archive.html. *See generally* HAROLD L. SHEPPARD, EFFECTS OF FAMILY PLANNING ON POVERTY IN THE UNITED STATES (W. E. Upjohn Inst. for Employment Research ed., 1967).

³³⁵ *See* Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (noting that the availability of a reliable way to prevent unintended pregnancies would go a long way toward ameliorating the costs and health consequences of the unwanted pregnancy for the mother, the child, and society as a whole, including economic and social

In short, access to hormonal contraception allows women to be assured of almost complete protection from pregnancy at all times, even if freedom from unwanted sexual intercourse and adequate bargaining power with consensual partners cannot be guaranteed. This control over fertility leads to autonomy in other aspects of life, including financial and social independence.³³⁶ Public policy should encourage increased autonomy of women not just for ideological reasons but because it benefits individuals and society.³³⁷ The pelvic exam requirement results in decreased female autonomy and should therefore be eliminated.

2. *Derailment of Education and Career Goals*

The increase in unwanted pregnancies that results from the contraceptive-deterrent effect of the pelvic exam requirement perpetuates stereotypes of women as uneducated and financially dependent on men.³³⁸ Unintended childbearing reduces women's ability to complete their educations and participate in the work force.³³⁹ Women who find themselves pregnant are often forced to drop out of school, limiting their career options and earning potential.³⁴⁰ Women already in the work force may be compelled to change jobs or stop working in order to accommodate the responsibilities of parenthood. For mothers who do continue on their intended trajectory, career goals may be thwarted because of many employers' attitudes toward working mothers, which affect hiring, promotion, and responsibility-allocation decisions.³⁴¹

It is only worthwhile for women to make career investments if the chance of becoming unintentionally pregnant can be essentially eliminated.³⁴² Control over fertility allows women to achieve education and

consequences which prevent women from participating fully and equally in the marketplace of ideas).

³³⁶ See 136 CONG. REC. S13,685 (daily ed. Sept. 25, 1990) (statement of Sen. Adams) (acknowledging that control over one's life through the ability to make responsible plans about having children is "the beginning of success").

³³⁷ Autonomy over life and body has been found to account for increased use of effective contraceptive methods in women, reducing the costs to society of unwanted pregnancies and abortions. See Sable et al., *supra* note 79, at 130.

³³⁸ Women who do not work outside the home have been characterized as "one man away from disaster." KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 176 (1984).

³³⁹ Gold, *supra* note 10, at 5, available at http://www.guttmacher.org/journals/tgr_archive.html.

³⁴⁰ See 136 CONG. REC. S13,677 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy); *id.* at S13,684 (statement of Sen. Jeffords).

³⁴¹ This type of impermissible discrimination is difficult to prove. See Daniel R. Ortiz, *The Myth of Intent in Equal Protection*, 41 STAN. L. REV. 1105 (1989); Law, *supra* note 60, at 1006. A woman's only true "remedy" for the damage she may suffer is the ability to prevent herself from ending up in such a vulnerable position.

³⁴² CLAUDIA GOLDEN & LAWRENCE F. KATZ, *THE POWER OF THE PILL: ORAL CONTRACEPTIVES AND WOMEN'S CAREER AND MARRIAGE DECISIONS 2* (Nat'l Bureau of Econ. Research, Working Paper No. 7527, 2000).

career goals and their attendant social and financial independence.³⁴³ The pelvic exam requirement is an unwarranted obstacle to fertility control that results in derailed goals for women and is, therefore, bad public policy.

3. *Forced Maternal Roles and Responsibilities*

The increase in unintended pregnancies resulting from the pelvic exam requirement perpetuates gender stereotypes of women as “naturally” maternal because it leads to forced maternal roles and responsibilities for those women whose beliefs, values, or decisions preclude abortion and weigh against adoption. For many women, the role of motherhood may be uncomfortable or simply undesired.³⁴⁴ The responsibilities of motherhood are far from insignificant.³⁴⁵ To impose these responsibilities upon women simply because they are averse to pelvic exams is unjustifiable: it robs women of autonomy and perpetuates the notion that womanhood equals maternity.³⁴⁶ The pelvic exam's effect of strengthening gender role stereotypes renders it a bad public policy choice.

C. *Consistency with Related Laws*

Good public policy maximizes consistency among laws to strengthen the legal system. The pelvic exam requirement, however, creates unjustified inconsistencies with related areas of law, including voluntariness in Title X programs and medical decisions.

Title X requires that services be voluntary.³⁴⁷ Under this requirement, a woman may not be pressured or coerced to accept a particular contraceptive method.³⁴⁸ Rather, there must be a real choice of contraceptives made available under Title X, allowing women to exercise reproductive autonomy.³⁴⁹ For some, the pelvic exam removes this choice and coerces women into foregoing effective contraceptive methods. As a result, the goal of the program—to “assist in making comprehensive, voluntary family plan-

³⁴³ One of the specifically articulated goals of Title X family planning clinics is to enable women to complete their educations by avoiding unwanted pregnancies. 136 CONG. REC. S13,677 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy).

³⁴⁴ See *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (noting that “[b]eing pregnant . . . is not a state that is desired by all women or at all points in a woman's life”).

³⁴⁵ See BABER & ALLEN, *supra* note 142, at 102 (arguing that “the responsibility of bearing and caring for children has limited women's autonomy and ability to participate in activities that enhance their personal development and their social and economic status”).

³⁴⁶ See generally MARDY S. IRELAND, *RECONCEIVING WOMEN: SEPARATING MOTHERHOOD FROM FEMALE IDENTITY* (1993) (discussing the existence of an implicit assumption that motherhood is intrinsic to adult female identity).

³⁴⁷ 42 C.F.R. § 59.5(a)(2) (2002).

³⁴⁸ OFF. OF POPULATION AFFAIRS, *supra* note 108, § 5.1; see also Dailard, *supra* note 7, at 8.

³⁴⁹ Dailard, *supra* note 7, at 8, available at http://www.guttmacher.org/journals/tgr_archive.html.

ning services readily available to all persons desiring such services”³⁵⁰— is not met: elimination of hormonal methods of contraception from women’s options results in neither comprehensive service availability nor voluntary method choice.

Title X provisions also specify that acceptance of family planning services must not be a “prerequisite to eligibility for or receipt of any other service or assistance from or participation in any other programs” of the clinic.³⁵¹ By requiring the reproductive health service of a pelvic exam as a prerequisite to the separate service of provision of contraceptives, the voluntariness mandate of Title X is threatened. Accessibility to family planning services is also required under Title X.³⁵² As the pelvic exam requirement is a barrier to program recipients’ equal access to reliable contraception,³⁵³ it is inconsistent with HHS’s own rules surrounding Title X.

As in other areas of medical care, women should have the right to make their own medical decisions concerning contraception.³⁵⁴ Title X regulations specify:

The primary purpose of counseling in the family planning setting is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive issues and to enhance their capacity to arrive at a decision that reflects their considered self-interest³⁵⁵

This language indicates an intent for the client to make her own health care decisions—specifically in choosing a method of contraception—in light of the risks and benefits surrounding each option. The role of the counselor is limited to providing the information necessary for the patient to make a decision; it does not include the authority to make deci-

³⁵⁰ Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572, § 6(c), 84 Stat. 1506 (1970).

³⁵¹ 42 U.S.C. § 300a-5 (2000).

³⁵² Title X program guidelines state that “[f]amily planning programs should, whenever possible, provide or coordinate access to services” OFF. OF POPULATION AFFAIRS, *supra* note 108, § 9.5.

³⁵³ See *supra* Part IV.

³⁵⁴ See Stewart et al., *supra* note 49, at 2235 (arguing that it is unethical to withhold hormonal contraception from women who decline a pelvic exam because they should have the right to make their own informed decisions about care, and stating that “[i]n other areas of medical care, [restricting patients’ ability to make medical decisions] would not be perceived as appropriate”); Law, *supra* note 60, at 1020 (arguing that leaving the decision about abortion to the medical judgment of the pregnant woman’s physician gives doctors undue power).

³⁵⁵ OFF. OF POPULATION AFFAIRS, *supra* note 108, § 8.2.

sions for the patient. Moreover, drugs with even more likely and more serious side effects³⁵⁶ are prescribed every day to people who have not even been advised of their risks.³⁵⁷ Therefore, in accordance with both Title X requirements and the prevailing practice of allowing that patients make their own medical decisions, the pelvic exam requirement should be eliminated for its inconsistency.

Another requirement of Title X is that its programs "promote continued participation in the project by persons to whom family planning services may be beneficial."³⁵⁸ The deterrent effect of the pelvic exam requirement discourages continued participation in Title X projects by many women to whom family planning services would be beneficial.³⁵⁹ Such inconsistency in law is confusing and constitutes bad public policy.

D. Cost-Benefit Analysis

Cost-benefit analysis suggests that elimination of the pelvic exam requirement would be good public policy.³⁶⁰ The harm caused by the pelvic exam requirement—as measured by the psychological distress inflicted by a pelvic exam³⁶¹ and the deterrent effect of the requirement³⁶²—is so disproportionate to any benefit derived from it³⁶³ that it is clearly discordant with a cost-benefit analysis.³⁶⁴ Based on such an analysis, the Institute for Women's Policy Research ("IWPR") has recently taken the official position

³⁵⁶ An example is corticosteroids. *See, e.g.*, University of Washington Orthopedics and Sports Medicine, *Corticosteroids for Arthritis* (Frederick A. Matsen III, ed.), available at <http://www.orthop.washington.edu/arthritis/medications/corticosteroids/05> (last modified Mar. 8, 2002) (last visited Feb. 1, 2004); Hendrick Health System, Abilene Texas Hospital, *Corticosteroids* (discussing the risks of corticosteroids), at <http://www.ehendrick.org/healthy/000374.htm> (last visited Feb. 1, 2004).

³⁵⁷ For example, hospitalized patients who are given medication, rather than a prescription to fill at a pharmacy, may not be fully informed of the medications' risks because no labeling accompanies the drugs.

³⁵⁸ 42 C.F.R. § 59.5(b)(3)(iii) (1999).

³⁵⁹ *See supra* Part VII.A.1.

³⁶⁰ The legislature has acknowledged the significance of a cost-benefit ratio in its decisions surrounding implementation of Title X family planning programs. 136 CONG. REC. S13,677 (daily ed. Sept. 25, 1990) (statement of Sen. Kennedy).

³⁶¹ *See* MEAD, *supra* note 67, at 12 (discussing the "psychological effects of having to undergo a pelvic exam").

³⁶² *See supra* Parts III.B.1.c, VII.A.1, VII.A.3, and VII.B.

³⁶³ This is especially true respecting the newer forms of contraception, which contain less estrogen (or none at all) than older forms and are deemed to be much more tolerable and beneficial for women. Seeley et al., *supra* note 33, <http://www.mhhe.com/biosci/ap/seeleyap/repro/reading8.mhtml>.

³⁶⁴ *See* Trussell et al., *supra* note 18, at 502 (arguing that the economic savings and social benefits of contraception justify providing broader contraceptive coverage in family planning clinics where patients are informed about the contraceptives and voluntarily consent to their use); Stewart et al., *supra* note 49, at 2236 (suggesting that the health impact of a missed pelvic exam is less significant than the health impact of delayed or less effective contraception). The harm caused by the pelvic exam requirement outweighs the benefits even more obviously in asymptomatic, adolescent women. *See* Shafer, *supra* note 49, at 71–72.

of encouraging the FDA to make oral contraceptives available over the counter, despite the acknowledged potential risks associated with foregoing gynecological exams.³⁶⁵ IWPR's research has indicated that the benefits of oral contraceptive use are so great that eliminating physician contact and counseling entirely would be warranted.

The proposal of this Article entails even fewer risks to women's health, as elimination of the pelvic exam requirement would not only not preclude, but would encourage, health care visits. There, counseling on the risks of the drug's use would be given to women, the opportunity for other health care services would be presented, and detection of contraindications to use and monitoring for resultant adverse effects would be provided through means less intrusive than a pelvic exam. In short, the consensus developed during the last decade supports eliminating the requirement of pelvic exams prior to prescription of oral contraceptives in order to establish good public policy.³⁶⁶

VIII. PROPOSAL FOR CHANGE

An alternative method for providing oral contraceptives to women in publicly funded clinics exists that would constitute good public policy and would not impermissibly infringe upon women's constitutional rights. In fact, this process would facilitate women's exercise of their constitutional right to reproductive autonomy via access to effective contraception. Under this proposal for change, physicians would be required to advise women of the possible risks associated with taking the drug without first undergoing a pelvic exam that could detect potential increased risks of side effects. Physicians would also be allowed, or even required, to encourage pelvic exams to promote the government's and women's interest in protecting their health.³⁶⁷

While a proposal to permit physicians to require pelvic exams when they deem it beneficial would be consistent with some arguments of this Article and would not unjustifiably infringe upon the constitutional rights involved, women should have complete power to veto pelvic exams and still receive their preferred method of contraception. Thus, after having been fully advised of the risks of choosing to forego a pelvic exam and begin an oral contraceptive regimen, a competent, adult woman would be able to sign an informed consent and waiver of physician and manufac-

³⁶⁵ Letter from Barbara Gault, Associate Director of Research, IWPR, to the FDA (June 27, 2000) (on file with author).

³⁶⁶ Stewart et al., *supra* note 49, at 2232.

³⁶⁷ Edelman & van Os, *supra* note 105, at 58 (stating that users of oral contraceptives "should be advised of these risks and encouraged to have periodical cervical evaluation," although not as a prerequisite to the drug's use).

turer liability³⁶⁸ and receive a prescription without the exam.³⁶⁹ The rationale is as follows: while guidelines and physician advice are important sources of information, the risk-benefit ratio associated with a drug's use will vary for each individual based on personal values and priorities.³⁷⁰ The individual—not the physician—should ultimately make the determination of her clinical management, as she is the one who must live with the effects of that determination.³⁷¹ This is particularly true where there is no absolute contraindication to her use of the drug; the decision whether to use oral contraceptives is instead based on a weighing of factors. Furthermore, the established guidelines may not account for recent scientific data.³⁷² The requirement for pelvic exams was established in 1976, but the oral contraceptives typically prescribed now are newer and safer.³⁷³ Recent studies have concluded that either there is no causal link between the drugs and cervical cancer or it is limited to a small subset of women who meet identifiable criteria,³⁷⁴ such that “pelvic examinations . . . are not necessary for identifying women who should avoid [hormonal contraception] or need further evaluation before a decision about hormone use is reached.”³⁷⁵

Consistent with this proposal, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated in 1982 that “the judgment about which choice will best serve well-being properly belongs to the patient” and that a physician must mention all alternatives to the patient, even if they are treatments which

³⁶⁸ Such a procedure is used in other areas of the law. RESTATEMENT (SECOND) OF TORTS § 402A, cmt. k (1965) (providing that where the danger involved in the use of a product is unavoidable and the utility great, a drug manufacturer's liability may be avoided with proper warnings of the product's risk).

³⁶⁹ Stewart et al., *supra* note 49, at 2236–38 (suggesting that women, rather than policymakers, are the appropriate decisionmakers concerning oral contraceptive use and arguing that women who are informed about the implications of a decision to forego a pelvic exam prior to beginning oral contraceptives should have the right to make that decision).

³⁷⁰ Angela Mills, *Avoiding Problems in Clinical Practice After the Pill Scare*, 5 HUM. REPROD. UPDATE 639, 650 (1999), *reprinted in* REPRODUCTIVE CHOICES IN 2000: THE RELATIVE SAFETY OF CURRENT ORAL CONTRACEPTIVES 77, 88 (Robert Geoffrey Edwards & Jean Cohen eds., 2000) (stating that the utilization of guidelines in determining clinical management concerning contraception carries a risk of being too impersonal due to its failure to account for variations in risk-benefit ratios across couples).

³⁷¹ *Id.* (recognizing the woman's preference as an important factor for determining clinical management that is often neglected when guidelines concerning prescription decisions are utilized, and arguing that physicians' decisions are often imbued with their own personal prejudices or concerns and slanted in relation to their exposure to the general media).

³⁷² *Id.* (arguing that for guidelines concerning prescription of oral contraceptives to be useful, they must be reviewed and adjusted as new scientific data becomes available).

³⁷³ See, e.g., Arons, *supra* note 60, at 1125 n.207 (citing Linda Timm Wagner & Charlotte A. Kenreigh, *Choosing Oral Contraceptives*, 216 AM. DRUGGIST 64, 64–65 (1999)); Seeley et al., *supra* note 33, <http://www.mhhe.com/biosci/ap/seeleyap/repro/reading8.mhtml>.

³⁷⁴ See *supra* Parts III.B.1.a and III.B.3; see also, e.g., Arons, *supra* note 60, at 1125 n.207 (citing Wagner & Kenreigh, *supra* note 373, at 64–65).

³⁷⁵ Stewart et al., *supra* note 49, at 2238.

the physician does not favor, so long as they are supported by “respectable medical opinion.”³⁷⁶ International medical standards support the safety of oral contraceptive use without a pelvic exam.³⁷⁷ Many physicians and family planning service providers within the United States support elimination of the pelvic exam requirement³⁷⁸ and urge periodic updating of recommendations concerning reproductive health care services based on scientific evidence.³⁷⁹ These authorities constitute “respectable medical opinion” and, therefore, justify mandating provision of oral contraceptives without a pelvic exam as an available option under the position of the President’s Commission.

The benefits of eliminating the pelvic exam requirement would be widespread and long-lasting. In the absence of any rational reason for its maintenance, it is unjustifiable to burden women with a barrier to services that takes its toll at both the individual and societal level. Removal of this requirement will protect substantive due process rights to contraception access, reproductive autonomy, and bodily privacy. Converting the exam requirement into an option will enforce the constitutional mandate for equal protection of women’s and minorities’ rights and uphold the prohibition against unconstitutional conditions on the exercise of fundamental privacy rights. In accordance with the crucial common goal of implementing beneficial public policy, the outdated pelvic exam requirement must be eliminated.

³⁷⁶ Rachel Benson Gold, *Conscience Makes a Comeback in the Age of Managed Care*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Jan. 1998, at 1, 1, available at http://www.guttmacher.org/journals/tgr_archive.html (last visited Feb. 1, 2004).

³⁷⁷ See *supra* note 82; see also Harper et al., *supra* note 74, at 13.

³⁷⁸ See *supra* note 76 and accompanying text.

³⁷⁹ E.g., Stewart et al., *supra* note 49, at 2238 (stating that “decisions should not be made unacknowledged and by default because of historical beliefs perpetuated without scrutiny” and arguing that “recommendations for services that should comprise well-woman care should be updated periodically, based on sound scientific evidence”).