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, Medicaid, and block grants mandate pelvic exams as a condition to access to oral contraceptives and sometimes other hormonal methods of birth control. Requiring a pelvic exam, an invasive procedure, infringes upon

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† 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).


¶ 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 matchstick-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 Ortha 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. 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 services to over 7000 family planning clinics nationwide. The average woman, who wants only two children, will use contraceptives for twenty to thirty years of her life. 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. Of the 6.5 million women actually receiving subsidized family planning services, two-thirds do so at clinics supported by Title X funds. While most women prefer to see private physicians, low-income women are often forced to utilize publicly funded family planning clinics instead.

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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. 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.

Title X alone helps American women avoid one million unintended pregnancies each year. Every tax dollar spent for contraceptive services saves three dollars in Medicaid costs for health care for pregnant women and newborns.

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. It is also one of the safest drugs currently marketed. Hormonal contraceptives are by far the most effective method of reversible contraception, 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). Condoms, which are the second most popular and second most effective form of reversible contraception, have a twelve to sixteen

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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.
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)).
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

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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).
23 State regulations mandating pelvic exams are equally prohibited from infringing upon constitutional rights by the Fourteenth Amendment’s Due Process Clause.
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.
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 rates\(^33\) constitute far less than the required efficacy.\(^34\) The cases emphasize the right to determine family size—

\(^{30}\) 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 (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.\textsuperscript{35} Therefore, denying a woman access to hormonal methods of contraception amounts to a ban on effective contraception and is impermissible under\textit{Griswold} and\textit{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\textit{Carey v. Population Services International}.\textsuperscript{36} \textit{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.\textsuperscript{37} In \textit{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.\textsuperscript{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.\textsuperscript{39}

\textbf{2. Right to Bodily Integrity}

The Supreme Court has held that the individual has a dignity interest in bodily integrity.\textsuperscript{40} This principle is “deeply embedded in our... constitutional traditions.”\textsuperscript{41} The prominence of the fundamental right to bodily integrity within the context of substantive due process privacy rights is highlighted by\textit{Roe v. Wade}\textsuperscript{42} and\textit{Planned Parenthood v. Casey},\textsuperscript{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-
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.\(^4^4\) To survive strict scrutiny review, the pelvic exam requirement must be narrowly tailored to serve a compelling governmental interest.\(^4^5\) Although it has been established that the government has a compelling interest in protecting women’s health,\(^4^6\) 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.\(^4^7\) 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.\(^4^8\) 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.\(^4^9\) Mandatory pelvic

\(^4^4\) See supra note 24.
\(^4^6\) 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).
\(^4^7\) See infra note 281; see also infra notes 275–277 and accompanying text.
\(^4^8\) 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).
\(^4^9\) 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,” “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.\(^\text{50}\) 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.\(^\text{51}\) It has since been demonstrated that not only do oral contraceptives not cause endometrial or ovarian cancer, the drugs may actually be 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)).

\(^\text{50}\) 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).

\(^\text{51}\) 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.\textsuperscript{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,\textsuperscript{53} and data suggests otherwise.\textsuperscript{54}

\textit{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{58}

\textsuperscript{52} Family Health Int’l, \textit{What Are the Benefits and Risks of Combined Oral Contraceptives?}, at \url{http://www.fhi.org/en/RH/Pubs/factsheets/OCriskben.htm} (2003) (last visited Feb. 1, 2004); David T. Baird & Anna F. Glasier, \textit{Hormonal Contraception}, 328 New Eng. J. Med. 1543 (1993); Drife, \textit{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., \textit{supra} note 49, at 2238 (citing, inter alia, Sonia Regina Grover & Michael Quinn, \textit{Is There Any Value In Bimanual Pelvic Examination As a Screening Test?}, 162 Med. J. Austl. 408 (1995)).

\textsuperscript{53} Lara V. Marks, \textit{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., \textit{supra} note 49, at 2237–38 (referring to the risk of cervical cancer development or precursor progression as a “theoretical” concern); Hannaford, \textit{supra} note 17, at 325 (stating that “[u]ncertainty also remains concerning the association between pill use and risk of carcinoma of the cervix”).

\textsuperscript{54} E.g., Drife, \textit{supra} note 49, at 34 (citing Baird & Glasier, \textit{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).

\textsuperscript{55} Am. Coll. of Obstetricians & Gynecologists, \textit{Guidelines for Women’s Health Care} 151 (1996) [hereinafter Am. Coll. of Obstetricians & Gynecologists, Guidelines].

\textsuperscript{56} Id.

\textsuperscript{57} Id. at 137.

\textsuperscript{58} Stewart et al., \textit{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. Carrying a pregnancy to term poses a greater risk to women’s health than do oral contraceptives. Having an abortion also carries much higher risks than do oral contraceptives. 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 health and sexual health services, such as screening for sexually transmitted diseases, that are provided by publicly funded clinics. 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.

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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.


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. Women on the pill experience approximately half the incidence of ovarian and endometrial cancer as do nonusers. Oral contraceptive use is also associated with decreased risks of ovarian cysts, uterine fibroids, benign breast disease, and pelvic inflammatory disease. Pill use has the benefit of drastically reducing unwanted pregnancies, particularly ectopic pregnancies. 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 smoke and those for whom there is an absolute contraindication for pill use. None of these factors requires a pelvic exam to detect. 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).


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 mel-litus, 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. 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. International medical guidelines support the safety of providing hormonal contraception without a pelvic exam. European physicians deem pelvic exams irrelevant and unnecessary barriers to contraception accessibility. Even within the United States, many physicians do not favor the required pelvic exam. The FDA, Planned Parenthood, other family planning clinics, and many states allow women to defer the pelvic exam for up to three months after beginning hormonal contraception. The Title X regulations allow a de-
layed pelvic exam if appropriate counseling is provided. Planned Parenthood has recently considered removing the pelvic exam requirement entirely. 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 safe or for whom a pelvic exam may be warranted. 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, infection with an oncogenic type of HPV, or multiple sexual partners. 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 sample 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.


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 “[b]ormanonal 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,\textsuperscript{87} which is detectable by self-collected vaginal swabs.\textsuperscript{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.\textsuperscript{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.\textsuperscript{90} Pap screening is possible without a pelvic exam\textsuperscript{91} 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{94} For instance, women who recently had a pelvic exam from a different provider

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

\textsuperscript{88} Patti E. Gravitt et al., \textit{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, \textit{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, \textit{supra} note 86, at 1847.

\textsuperscript{89} See Reichman, \textit{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).

\textsuperscript{90} Robb-Nicholson, \textit{supra} note 88, at 8.

\textsuperscript{91} Parazzini et al., \textit{supra} note 49, at 888.

\textsuperscript{92} Gravitt et al., \textit{supra} note 88, at 95; Robb-Nicholson, \textit{supra} note 88, at 8.

\textsuperscript{93} Dailard, \textit{supra} note 7, at 8.

\textsuperscript{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., \textit{supra} note 49, at 2223 (citing Int’l Planned Parenthood Fed’n, \textit{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. Because a large number of women who begin taking oral contraceptives will discontinue use shortly thereafter, 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. Furthermore, the mortality rate from cervical cancer in the United States is only one per 100,000 women. 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. 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.” Pelvic exams could also be required “as indicated,” according to physician discretion based on risk factors that can be elicited through an oral medical history, medical records, or other less invasive tests. 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. This process would effectively protect women’s safety without the overinclusiveness of the current regulations.

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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.


107 Shafer, supra note 49, at 71.


109 Private providers already use this discretionary approach of deciding 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. 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. Although some argue that oral contraceptives should be available without a prescription, 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 protecting women’s health, 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. 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).
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.\textsuperscript{116} Under such a standard, the regulation must be substantially related to serving an important governmental objective.\textsuperscript{117} Based on its ineffectiveness at detecting increased risks of adverse effects of oral contraceptives,\textsuperscript{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.\textsuperscript{119} Under rational basis review, the pelvic exam requirement must only be a reasonable way to achieve a legitimate governmental goal.\textsuperscript{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,\textsuperscript{121} resulting in increased incidences of ovarian and endometrial cancer.\textsuperscript{122}

\section*{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

\begin{footnotesize}
\textsuperscript{116} See Susan Frelich Appleton, Standards for Constitutional Review of Privacy-Invading 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”).

\textsuperscript{117} Craig v. Boren, 429 U.S. 190, 197 (1976).

\textsuperscript{118} See supra Part III.B.1.


\textsuperscript{120} Williamson v. Lee Optical, 348 U.S. 483 (1955).

\textsuperscript{121} See supra Part III.B.1.c.

\textsuperscript{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.
\end{footnotesize}
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, pelvic inflammatory disease, or cancer. 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. However, while women are subjected to invasive preventive care at family planning clinics, men are not. Men are not

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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).


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.\(^\text{127}\) Rather, the regulations impose prostate exams on men only “as appropriate.”\(^\text{128}\) 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.\(^\text{129}\) Just as Viagra and condoms\(^\text{130}\) 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,\(^\text{131}\) to engage in nonprocreative sex.\(^\text{132}\)
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 exam 135 of only one distinctly identifiable group stigmatizes 136 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-

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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.\textsuperscript{139}

\textbf{a. Gender Impact}

Restrictions on access to oral contraceptives uniquely burden women.\textsuperscript{140} “Control of reproduction is the sine qua non of women’s capacity to live as equal people.”\textsuperscript{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 \textit{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.’”\textsuperscript{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,”\textsuperscript{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.\textsuperscript{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 inferiority\textsuperscript{145} as does the differential treatment of racial minorities found by the Supreme Court to create an

\begin{footnotesize}
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\item \textsuperscript{139} 42 C.F.R. § 59.5(3) (2002).
\item \textsuperscript{140} See Sunstein, \textit{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)).
\item \textsuperscript{141} Law, supra note 60, at 1028.
\item \textsuperscript{142} 141 F. Supp. 2d 1266, 1273 (W.D. Wash. 2001) (quoting Stanton v. Stanton, 421 U.S. 7, 14–15 (1975)); \textit{see also} Kristine M. Baber & Katherine R. Allen, \textit{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”).
\item \textsuperscript{143} See Appleton, \textit{supra} note 116, at 18 (referring to society’s perception of the “welfare queen” as the “least deserving of the poor”); Dorothy Roberts, \textit{Killing the Black Body: Race, Reproduction, and the Meaning of Liberty} 17, 111 (1997); Catherine Albiston, \textit{The Social Meaning of the Norplant Condition: Constitutional Considerations of Race, Class, and Gender}, 9 Berkeley Women’s L.J. 9, 17 (1994).
\item \textsuperscript{144} See, e.g., Ralph Gardner, Jr., \textit{Mom vs. Mom}, N.Y. Mag., Oct. 21, 2002, at 21 (citing examples of children embarrassed by their mother’s stay-at-home status).
\item \textsuperscript{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”).
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impermissible brand of inferiority and implied caste system. 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 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. In Skinner v. Oklahoma, the Supreme Court held that the right to procreate is too fundamental to be distributed according to a caste system 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.” 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. Minority women are also more likely to depend specifically on publicly funded family planning clinics for their contraceptive services. Additionally, minority women are more likely to experience contraceptive failure, rendering the availability of highly effective contraception

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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.
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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{156} The fourfold impact of the requirement upon minorities over Caucasians\textsuperscript{157} 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.”\textsuperscript{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 purposes\textsuperscript{159} 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.\textsuperscript{160} Compelling arguments have been made that govern-

\begin{itemize}
  \item \textsuperscript{154} Alan Guttmacher Inst., Fulfilling the Promise, supra note 8, at 48, available at http://www.guttmacher.org/pubs/fulfill.pdf.
  \item \textsuperscript{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)).
  \item \textsuperscript{156} See infra Part V.D.
  \item \textsuperscript{157} See supra note 134.
  \item \textsuperscript{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).
  \item \textsuperscript{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”).
\end{itemize}
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. 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. 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.’” Additionally, the “protection” of women through the “pedestal/cage” has historically been key in the oppression of women, and biological differences have served as a prime justification for the subjugation of women.

The constructs of law have historically supported the dominance of men and subservience of women by creating separate spheres for the sexes and enacting limits on women’s power to control reproductive capacity. 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)).
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. Virginia170 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)).
170 Id. at 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).
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/fpapp/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. 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. 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. One possible motivation is the perpetuation of minorities’ poverty by enlarging already financially disadvantaged families. At the other end of the spectrum, legislators and providers may paternalistically presume that minorities are incapable of making the “right” decisions. 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. A plausible theory of discriminatory governmental purpose is that the lack of abortion services under Title X, in addition to the lack

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 Albistin, supra note 143, at 19.
183 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, which, unlike abortion, is covered by Title X funds.

The myriad of historical examples of discrimination against minorities and legislation implicating reproductive issues for minorities 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. In its early years, contraception distribution was associated with eugenics and racial genocide, and, as acknowledged in current Title X provisions themselves, government-sponsored programs of the 1960s and 1970s coerced thousands of women, who were vastly disproportionately minorities, into sterilization. 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, which affect minority women more frequently than nonminority women.

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-

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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.


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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{196} Finally, courts’ actions concerning reproduction indicate a possible discriminatory intent against minority women.\textsuperscript{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.

\textit{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,\textsuperscript{198} and there are violations arguably based on race.\textsuperscript{199} Additionally, while gender-based classifications are generally subject to an intermediate level
of scrutiny, 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.

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.” Without thoroughly examining the justification for race- or gender-conscious measures, there is no way to determine which classifications are motivated by malicious intent. 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.

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. The Court did acknowledge that our country’s history of sex discrimination warrants heightened scrutiny for gender-based classifications. 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. The Court further asserted that the “demanding” burden of justification rested on the state and could not be satisfied with a “hypothesized” justification.

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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,” 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. Gender should qualify as a suspect classification, 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. 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.

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. It is even possible that the

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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.
court will utilize only rational basis review because the limitation of rights only occurs where women have benefited from federal funds.\textsuperscript{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.\textsuperscript{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 doctrine\textsuperscript{217} is that “the government may not deny a benefit to a person because [s]he exercises a constitutional right.”\textsuperscript{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.\textsuperscript{219}


\textsuperscript{216}See supra Part III.B.

\textsuperscript{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\textit{ 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.

\textsuperscript{218}See\textit{ Chemerinsky, supra} note 26, at 946 (quoting\textit{ Regan v. Taxation with Representation of Wash.}, 461 U.S. 540, 545 (1983)).

\textsuperscript{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 right\textsuperscript{220} 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 benefit\textsuperscript{221} received by those who qualify under financial status requirements.\textsuperscript{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.\textsuperscript{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],”\textsuperscript{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.


\textsuperscript{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.

\textsuperscript{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).

\textsuperscript{223} Nelson, supra note 127, at 89.

\textsuperscript{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. Sullivan227) 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

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225 Id.
226 432 U.S. 464 (1977) (upholding a state regulation granting Medicaid benefits for childbirth but denying such benefits for nontherapeutic abortions).
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-pressureing 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, 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. The Court has found it impermissible for the government to present a choice of only “the lesser of the two evils.” 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 coercive 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. 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. 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

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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)).


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.

health and is a substantial obstacle that deters many women from obtaining effective contraception. 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. 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. Contraceptive method preference also implicates religious beliefs and prohibitions. Supporting these arguments is the logic of *Planned Parenthood Federation of America v. Schweiker*, 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. An even stronger argument exists for invalidating the pelvic exam requirement because the privacy rights of adult women weigh more heavily against

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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.
243 *Id.* at 663–65.
the government’s interests than do those of adolescents.\textsuperscript{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.\textsuperscript{245} Under the rationale of \textit{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.\textsuperscript{246}

\textbf{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.”\textsuperscript{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.”\textsuperscript{248} In contrast, women have not merely a right to choose to use effective contraceptives\textsuperscript{249} but a constitutional entitlement of access to them, free from unjustified governmental interference.\textsuperscript{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.”\textsuperscript{251}

\textsuperscript{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, \textit{supra} note 60, at 1096 n.23 (citing \textit{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)).

\textsuperscript{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).

\textsuperscript{246} See \textit{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); \textit{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).

\textsuperscript{247} Sunstein, \textit{Unconstitutional Conditions Doctrine, supra} note 126, at 593 n.2 (citing \textit{Laurence Tribe, American Constitutional Law} § 10-8, at 681 & n.29 (2d ed. 1988)).


\textsuperscript{249} Griswold v. Connecticut, 381 U.S. 479 (1965).


\textsuperscript{251} Sullivan, \textit{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. Because this right of access exists and the government has acknowledged a duty to provide access to effective contraception for the poor, it does not have the power to refuse to fulfill this duty. 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 contraception because the pelvic exam requirement's irrational and discriminatory nature makes it unjustifiable under any level of review.

Even if a greater power includes any lesser power where both serve the same purpose, 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 pregnancies and allow women to lead independent lives. 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

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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/full.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. 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 contra-
ception. 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 con-
stitutional entitlements. Unlike the abortion context, the government has
acknowledged a duty to provide poor women with the effective contra-
ception to which they are constitutionally entitled. The argument that it
may refuse to subsidize oral contraceptives for those who decline a pel-
vic 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 con-
stitutes a penalty if the condition is unrelated to the benefit. In the
abortion funding cases, the Supreme Court held that the lack of funding
for abortions with public medical insurance was merely a nonsubsidy. How-
However, it conceded that the government’s withdrawal of general wel-
fare benefits or all Medicaid benefits 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 prescription renders the exam con-
dition a penalty on the exercise of a constitutional right. In sum, the pel-
vic exam requirement is unconstitutional because it is impermissibly co-
ercive 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 Maher v. Roe, 432 U.S. 464, 474 n.8 (1977); see also Sullivan, supra note 138, at 1464.
264 Maher, 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.

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 services . . . .

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.”).


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.

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 reinstitution 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

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/pis/opap93-1.pdf; Nat’l Cervical Cancer Coalition, supra note 80, available at http://www.nccc-online.org/ppaps_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 women—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, the exclusive purpose of Title X is to provide family planning services. Within this narrowly defined objective, the primary goals are prevention of unintended pregnancy and improvement of maternal health. HHS’s construction of the statute to require pelvic exams is arbitrary and capricious because women do not need a pelvic exam to serve Congress’s goal of preventing unintended pregnancy or improving maternal health. In fact, the requirement is manifestly contrary to congressional intent in enacting Title X because its deterrent effect results in increases in unwanted pregnancies and greater risks to maternal health. 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 use renders it arbitrary and capricious.

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 capricious.


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. 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. 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. 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.” 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.

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. 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. The program also demonstrated that the provision of contraception without a pelvic exam resulted in a significant improvement in women’s use of ef-

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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.
effective 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 effective 297 and less desirable for convenience 298 and enjoyment 299 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 individuals 303 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-

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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”).
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. These are also the women most likely to have financial and social difficulty caring for an unanticipated child. 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. Publicly funded clinics are prohibited from providing abortion services, and abortions are even more expensive than initiation of oral contraceptives through a private provider. 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, 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.

The pelvic exam itself also increases costs to society. The intensive professional time and equipment necessary to perform the exam make it very expensive. 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.

Henshaw, supra note 301, at 24.
Id. at 29.
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).
Gold, supra note 10, at 5; see also Henshaw, supra note 301, at 29.
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. The pelvic exam requirement maintains gender stereotypes because it decreases the autonomy of women, derailed 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. 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.

In situations of forced sex, women are particularly vulnerable to an undesired pregnancy because their aggressors are unlikely to use contraception. Abused women in general are less likely than nonabused women to report having used condoms during their last sexual encounter, 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. Given the frequency of unwilling sex, particularly

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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 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. 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. Research suggests that abuse affects women’s ability or motivation to prevent an unintended first pregnancy. The cycle of physical vulnerability is then perpetuated because women who do become pregnant are then at a greater risk of experiencing domestic violence. Furthermore, women who are sexual abuse victims may be particularly averse to an intrusive pelvic exam.

Even in situations of consensual sex, women often fail in their efforts to negotiate use of contraception with their partners, oftentimes “due to economic dependence, social norms, and fear of physical violence.” 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 “forced[d] . . . against their will” as 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 flashpoint 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/fulfil.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 Disease, 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,\textsuperscript{327} men and women have different priorities when choosing contraceptive methods,\textsuperscript{328} and each sex perceives greater efficacy in the method more within his or her respective control.\textsuperscript{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.\textsuperscript{330} Female power in intimate relationships is positively correlated with use of contraception, while decreased female power is associated with decreased contraceptive use.\textsuperscript{331}

Even when their partners do use contraception, women may still feel vulnerable without access to hormonal contraception because nonhormonal methods are less effective.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{335}


\textsuperscript{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.

\textsuperscript{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).

\textsuperscript{330} Grady et al., supra note 327, at 168.

\textsuperscript{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)).

\textsuperscript{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).

\textsuperscript{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).


\textsuperscript{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. Public policy should encourage increased autonomy of women not just for ideological reasons but because it benefits individuals and society. 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. Unintended childbearing reduces women’s ability to complete their educations and participate in the work force. Women who find themselves pregnant are often forced to drop out of school, limiting their career options and earning potential. 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.

It is only worthwhile for women to make career investments if the chance of becoming unintentionally pregnant can be essentially eliminated. Control over fertility allows women to achieve education and consequences which prevent women from participating fully and equally in the marketplace of ideas.


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).


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.

career goals and their attendant social and financial independence. 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. The responsibilities of motherhood are far from insignificant. 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. 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. Under this requirement, a woman may not be pressured or coerced to accept a particular contraceptive method. Rather, there must be a real choice of contraceptives made available under Title X, allowing women to exercise reproductive autonomy. 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-

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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).
348 Off. of Population Affairs, supra note 108, § 5.1; see also Dailard, supra note 7, at 8.
ning services readily available to all persons desiring such services 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. 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. As the pelvic exam requirement is a barrier to program recipients’ equal access to reliable contraception, 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. 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-interest . . .

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-
sions for the patient. Moreover, drugs with even more likely and more serious side effects\footnote{An example is corticosteroids. See, e.g., University of Washington Orthopedics and Sports Medicine, \textit{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, \textit{Corticosteroids} (discussing the risks of corticosteroids), at http://www.ehendrick.org/healthy/000374.htm (last visited Feb. 1, 2004).} are prescribed every day to people who have not even been advised of their risks.\footnote{See \textit{supra} Part VII.A.1.} 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.”\footnote{42 C.F.R. § 59.5(b)(3)(iii) (1999).} 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.\footnote{See \textit{supra} Part VII.A.1.} Such inconsistency in law is confusing and constitutes bad public policy.

\section*{D. Cost-Benefit Analysis}

Cost-benefit analysis suggests that elimination of the pelvic exam requirement would be good public policy.\footnote{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).} The harm caused by the pelvic exam requirement—as measured by the psychological distress inflicted by a pelvic exam\footnote{See \textit{Mead, supra} note 67, at 12 (discussing the “psychological effects of having to undergo a pelvic exam”).} and the deterrent effect of the requirement\footnote{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., \textit{supra} note 33, 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., \textit{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 \textit{Shafer, supra} note 49, at 71–72.}—is so disproportionate to any benefit derived from it\footnote{See \textit{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., \textit{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 \textit{Shafer, supra} note 49, at 71–72.} that it is clearly discordant with a cost-benefit analysis.\footnote{Based on such an analysis, the Institute for Women’s Policy Research (“IWPR”) has recently taken the official position.}
of encouraging the FDA to make oral contraceptives available over the counter, despite the acknowledged potential risks associated with foregoing gynecological exams.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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-

\textsuperscript{365} Letter from Barbara Gault, Associate Director of Research, IWPR, to the FDA (June 27, 2000) (on file with author).
\textsuperscript{366} Stewart et al., \textit{supra} note 49, at 2232.
\textsuperscript{367} Edelman & van Os, \textit{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).
and receive a prescription without the exam. 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. 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. 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. The requirement for pelvic exams was established in 1976, but the oral contraceptives typically prescribed now are newer and safer. 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, 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.”

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

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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).


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).


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 & Kenreich, 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.

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”).