

# Crisis at the Pregnancy Center: Regulating Pseudo-Clinics and Reclaiming Informed Consent

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**ABSTRACT:** Crisis Pregnancy Centers (CPCs) adopt the look of medical practices—complete with workers in scrubs, ultrasound machines, and invasive physical exams—to deceive pregnant women into thinking they are being treated by licensed medical professionals. In reality, CPCs offer exclusively Bible-based, non-objective counseling. Numerous attempts to regulate CPCs have faced political roadblocks. Most recently, in *NIFLA v. Becerra*, the Supreme Court held that state efforts to require CPCs to disclose that they are not medically licensed are unconstitutional violations of CPCs’ First Amendment right to free speech. In the wake of that decision, pregnant women in crisis—a disproportionate percentage of whom are low-income women, minority women, or women in vulnerable or dangerous situations—continue to be subject to CPCs’ ideological marketing, masquerading as medical advice.

This Article employs tort law to offer a novel way to regulate CPCs’ deceptive practices. It proposes that women who submit to physical exams or ultrasounds under CPCs’ false pretenses could successfully raise a battery claim. The intimate touching of a woman would most certainly be considered objectively offensive, and while the woman might technically consent to the touching, this consent is meaningless if it is based on misrepresentations. Contrary to popular understanding, the touching need not be intentionally malicious or result in physical injury to the plaintiff.

This Article makes two contributions to the literature. First, it provides a practicable, novel solution to an urgent and timely issue. By relying on private causes of action, this Article’s proposal sidesteps the collective action problems and political willpower obstacles that have long hampered larger-scale attempts to regulate CPCs. It places the injured woman in the driver’s seat and allows her to be compensated for the dignitary harm imposed when CPCs use deception to

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gain access to her body. Second, this Article contributes to robust literatures in torts, informed consent, and medical ethics by reinforcing an increasingly blurry line between medicine and pseudo-medicine. Informed consent means something; it is not merely a vehicle through which ideology can be shoehorned. Where CPCs are not licensed, they should be sued for battery, which honors the individual's dignity and is not deferential to an industry standard of care. Physicians should be allowed to have political voices. So, too, should pro-life activists. But each should have their policy debates, and win or lose them, in the political sphere. It does violence to the physician-patient relationship, and the trust that it requires, when this relationship is leveraged for ideological gains.

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INTRODUCTION

Crisis Pregnancy Centers (CPCs) are nonprofit agencies that purport to provide free services to women who are considering terminating their pregnancies. However, their “paramount, and typically undisclosed, mission is to convince women not to have abortions.”<sup>1</sup> CPCs engage in deliberate efforts to mislead pregnant women.<sup>2</sup> They hold themselves out as secular medical

1. Kathryn Gilbert, *Commercial Speech in Crisis: Crisis Pregnancy Center Regulations and Definitions of Commercial Speech*, 111 U. MI. L. REV. 592, 592 (2013).

2. “False and misleading advertising by clinics that do not provide abortions, emergency contraception, or referrals to providers of such services has become a problem of national importance. This issue has been the subject of a congressional report and proposed federal legislation . . . . The congressional report found that certain pregnancy resource centers ‘frequently fail to provide medically accurate information’ and that ‘the vast majority of pregnancy centers’ contacted during the investigation misrepresented the medical consequences of abortion. The report further concluded that while ‘[t]his tactic may be effective in frightening pregnant teenagers and women and discouraging abortion [.]’ it ‘denies [them] vital health information, prevents them from making an informed decision, and is not an accepted public health practice.’” See *First Resort, Inc. v. Herrera*, 860 F.3d 1263, 1268 (9th Cir. 2017). See also B. Jessie Hill, *Casey Meets the Crisis Pregnancy Centers*, 43 J.L. MED. & ETHICS 59, 64 (2015) (“Numerous reports have indicated that some CPCs use deceptive tactics to dissuade women from

providers, claiming in their advertising to counsel pregnant women on the full range of their reproductive options. CPCs buy Google ad-words like “abortion services”<sup>3</sup> to direct people to their facilities. Their websites feature images of nurses wearing scrubs and standing in front of ultrasound equipment.<sup>4</sup> When you visit the CPC, its lobby resembles that of a health clinic.<sup>5</sup> CPCs have names like “Obria Medical Clinics” or the “Bakersfield Pregnancy Center.”<sup>6</sup> The exam rooms resemble those of doctors’ offices. Before you see a volunteer, you are asked to fill out paperwork, channeling the procedure you would experience before seeing a doctor. To complete the presentation that this is a medical facility, some CPCs even refer to those who seek their services as “patients.”<sup>7</sup>

Given this quite deliberate staging, one would be forgiven for thinking that CPCs are ordinary medical clinics. However, CPCs have a different purpose, which is primarily to counsel against abortion.<sup>8</sup> They are different in terms of the training and licensure their staff is required to receive, which is usually none.<sup>9</sup> They are different in terms of the privacy and safety standards that are imposed upon them by law, which are few.<sup>10</sup> As of June 2018, they are different in terms

choosing abortion, such as providing false information about the risks and effects of abortion, providing false information about the law and availability of abortion, and telling women that their pregnancies are more advanced than they really are.”)

3. Press Release, NARAL PRO-CHOICE AMERICA, *In Response to NARAL Pro-Choice America, Google Removes Deceptive Anti-Choice Ads from Search Engine* (Apr. 28, 2014), [http://www.prochoiceamerica.org/media/press-releases/2014/pr04282014\\_google\\_cpc.html](http://www.prochoiceamerica.org/media/press-releases/2014/pr04282014_google_cpc.html) [https://perma.cc/WB8H-9E5L] (last visited Nov. 19, 2018). See also Press Release, NARAL PRO-CHOICE AMERICA, *66,608 Americans Call on Yellowpages.com to Stop Allowing Deceptive Anti-Abortion Ads* (July 6, 2010), <http://www.commondreams.org/newswire/2010/07/07/66608-americans-call-yellowpagescom-and-superpagescom-stop-allowing-deceptive> [https://perma.cc/WRU3-LXAH] (last visited Nov. 19, 2018).

4. “Well, they are advertising themselves. I looked at one -- a few of them. An exemplary of this is the Fallbrook Pregnancy Resource Center website. And it’s -- I’m fairly sophisticated -- there is a woman on the home page with a uniform that looks like a nurse’s uniform in front of an ultrasound machine. It shows an exam room. The text of the page titled ‘Abortion’ says Fallbrook will educate clients about different abortion methods available, and describe in medical terms different abortion procedures. The website also says clients will be evaluated by nurses and that they follow all HIPAA regulations, which if they’re not a medical provider, they don’t have to follow. If a reasonable person could look at this website and think that you’re giving medical advice, would the unlicensed notice be wrong?” Oral Argument at 13:33, *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [https://perma.cc/4HRK-9JQQ].

5. Alice X. Chen, *Crisis Pregnancy Centers: Impeding the Right to Informed Decision Making*, 19 *CARDOZO J.L. & GENDER* 933, 934 (2013).

6. See OBRIA MEDICAL CLINICS OF SOUTHERN CALIFORNIA, <https://omcsocal.org/> [https://perma.cc/4G86-RT5W] (last visited Dec. 25, 2018); BAKERSFIELD PREGNANCY CENTER, <http://www.bpcpartners.org/> [https://perma.cc/9W7X-UC9C] (last visited Dec. 25, 2018).

7. “[Alternatives Women’s Center] refers to those who seek its services as ‘patients.’” *A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 153 F. Supp. 3d 1168, 1187 (E.D. Cal. 2015), *aff’d*, 669 F. App’x 495 (9th Cir. 2016).

8. Danielle Lang, *Truthful but Misleading? The Precarious Balance of Autonomy and State Interests in Casey and Second-Generation Doctor-Patient Regulation*, 16 *U. PA. J. CONST. L.* 1353, 1390 (2014).

9. Most CPCs are unlicensed facilities and are staffed by volunteers who are not licensed medical professionals. Beth Holtzman, *Have Crisis Pregnancy Centers Finally Met Their Match: California’s Reproductive FACT Act*, 12 *NW. J. L. & SOC. POL’Y* 78, 83 (2017).

10. Given that CPCs are not considered professional medical providers, they would not be subjected to medical malpractice, and held to a professional standard of care, for their negligence. Instead

of the First Amendment protection they are afforded, which is considerably more than that afforded to medical clinics. And, because of all of this, they are different in terms of their lack of accountability when they injure women. Actual medical clinics have safety, training, and compelled disclosure requirements that do not apply to pseudo-clinics like CPCs.

CPCs are typically funded by Christian organizations as well as state and local governments.<sup>11</sup> In some cases, CPCs are subsidized by federal block grants that were developed to aid poor families.<sup>12</sup> The counseling CPCs provide is exclusively pro-life and “Bible-based.”<sup>13</sup> Many CPC volunteers see their job as a religious ministry or calling to do whatever is necessary to convince women to carry their pregnancy to term.<sup>14</sup>

There have been several investigations of CPCs—some from the ivory halls of Congress and some from the glossy pages of *Cosmopolitan* magazine—revealing widespread deceptive CPC practices. In one instance, after asking a pregnant woman to submit urine for a pregnancy test, the staff then spent 45 minutes going over Bible verses, adoption options, and inaccurate descriptions of the embryo’s development in ways that would humanize the fetus. The pregnant woman recounted how “[t]he nurse really, really slowed down during the fetal pain part. She said, ‘[h]ere are the fingertips. The baby feels everything you’re feeling . . .’”<sup>15</sup> During the sonogram, the nurse said the images were not

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they would be held to the lower, “ordinary” negligence standard. Additionally, the many state and local safety ordinances that apply to health clinics—that regulate facilities, licensure, and staffing—do not apply to CPCs. Finally, the Health Insurance Portability and Accountability Act requires that health care providers receive authorization before sharing protected health information with a non-covered entity. *See* 45 C.F.R. § 164.500 (West 2018). Given that CPCs are not “covered entities,” the privacy protections HIPAA affords would not protect pregnant women who visit CPCs, unless the CPC voluntarily complies with HIPAA (which could not be enforced by the U.S. government).

11. “[Real Alternatives, a CPC, has] advised Florida, Minnesota, Nebraska, and North Dakota in establishing state-financed anti-abortion centers, and it helped establish Texas’s multimillion-dollar program, which runs on the same model [as Pennsylvania’s]. In 2014, Real Alternatives won a no-bid contract to operate Michigan’s burgeoning program.” Meaghan Winter, *What Some Pregnancy Centers Are Really Saying to Women with Unplanned Pregnancies*, *COSMOPOLITAN* (July 14, 2015), <http://www.cosmopolitan.com/politics/news/a43101/pregnancy-centers-august-2015/> [<https://perma.cc/8Q5T-XG7S>] (last visited Nov. 19, 2018).

12. ThinkProgress issued a report in 2016 that revealed that many CPCs are funded, in part, through state welfare programs. *See* Bryce Covert & Josh Israel, *The States that Siphon Welfare Money to Stop Abortion*, *THINKPROGRESS* (Oct. 3, 2016), <https://thinkprogress.org/tanf-cpcs-ec002305dd18/#.jllccm8ij> [<https://perma.cc/GU2R-J6RE>] (last visited Nov. 19, 2018).

13. *See, e.g.*, THE AM. ASS’N OF CHRISTIAN COUNSELORS, <https://www.aacc.net> [<https://perma.cc/BUF3-TWE8>] (last visited Nov. 7, 2018). *See also* Callie Beusman, *How Anti-Abortion Zealots Pose as Medical Professionals to Trick Pregnant Women*, *BROADLY* (May 30, 2017), [https://broadly.vice.com/en\\_us/article/pae9ak/how-anti-abortion-zealots-pose-as-medical-professionals-to-trick-pregnant-women](https://broadly.vice.com/en_us/article/pae9ak/how-anti-abortion-zealots-pose-as-medical-professionals-to-trick-pregnant-women) [<https://perma.cc/6DVR-2LUG>] (last visited Nov. 19, 2018).

14. *See, e.g.*, PRESBYTERIANS PRO-LIFE (PPL), <http://www.ppl.org/index.php/ministry-equipping/ministry-development/crisis-pregnancy-ministry> [<https://perma.cc/3BDN-Y7HZ>] (last visited Nov. 19, 2018).

15. Winter, *supra* note 11. There is no evidence that a 6-8 week fetus can feel pain. Maria J. Mayorga-Buiza, Letter to the Editor, *Can Fetus Feel Pain in the Second Trimester? Lessons Learned from a Sentinel Event*, 34 *CHILD NERVOUS SYSTEM* 195, 195 (2018). Even so, CPCs share this inaccurate information with pregnant women.

clear and she needed to do a transvaginal ultrasound. According to the woman, the nurse “didn’t explain anything or say, ‘We’re going to stick this cone inside you.’”<sup>16</sup>

In another instance, a Manhattan CPC kept delaying the return of a pregnant woman’s laboratory results. The CPC insisted she return week after week for various and vague reasons. When this woman became agitated about the delays, she was incorrectly told “not to worry because she could get an abortion in New York at any time.”<sup>17</sup> She eventually went to an obstetrician in severe distress, seeking a late-term abortion that was no longer legal and no longer possible. She sobbed with her obstetrician, who felt powerless to help her.

While these instances may constitute fraud, in many cases the counseling takes on a subtler form of deception. Staff are instructed to use fear tactics and to provide medically unsound information, such as claiming that undergoing an abortion heightens the risk of breast cancer or decreases a woman’s fertility.<sup>18</sup> In some states, legislatures have cooperated with pro-life organizations to create mandatory disclosure “informed consent” laws that require physicians, but not CPCs, to provide clinically inaccurate information<sup>19</sup> (such as the above comment that in the first trimester “the baby feels everything you’re feeling.”). These informed consent statutes have been referred to as targeted regulation of abortion providers, or “TRAP” laws.

Informed consent TRAP laws have been largely upheld as constitutional regulations on professional speech. One of the key issues that this Article will address is the disparate treatment of licensed and unlicensed medical providers in the context of abortion. While physicians can be compelled to provide medically inaccurate or misleading information to patients because they *are* professionals, CPCs cannot be so compelled, because they are *not* professionals. This paradoxical treatment leaves pregnant women vulnerable to harm and obscures the distinction between medicine and pseudo-medicine.

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16. *Id.*

17. Dr. Anne Davis, MD, Remarks at Medical and Legal Aspects of Targeted Regulation of Abortion Providers (TRAP) Laws Symposium (Dec. 1, 2017), [https://www.youtube.com/watch?v=leH4\\_ODK0LA](https://www.youtube.com/watch?v=leH4_ODK0LA) [<https://perma.cc/5X64-5AQC>] (last visited Nov. 19, 2018) (speaking about a patient she saw in New York, who was repeatedly told that she could “get an abortion at any time in New York, and to keep coming back to the CPC.”).

18. “[One study found] that approximately 87% of the centers contacted provided false or misleading information about the health effects of an abortion, including information about a link between abortion and breast cancer, the effect of abortion on future fertility, and the mental health effects of abortion. The second report cited was a January 2008 report by the NARAL Pro–Choice Maryland Fund. NARAL sent volunteers into [CPCs] in Maryland, including Centro Tepeyac, and found that every center visited provided false or misleading information, including ‘false information about abortion risks, misleading data on birth control, and emotionally manipulative counseling.’” *Tepeyac v. Montgomery Cty.*, 5 F. Supp. 3d 745, 749 (D. Md. 2014).

19. See generally Lois Shepherd and Hilary Turner, *The Over-Medicalization and Corrupted Medicalization of Abortion and its Effect on Women Living in Poverty*, 46 J. LAW MED. & ETHICS 672 (2018); see also Michele Goodwin, *The Pregnancy Penalty*, 26 HEALTH MATRIX 17, 19 (2016).

To be sure, not every woman is tricked by CPC tactics.<sup>20</sup> At some point, a woman may realize the advice she is receiving is peculiar: it is not balanced, secular, or objective, as it should be.<sup>21</sup> She might then conclude that this “clinic” is really an elaborate theatrical set for deception. However, because CPCs target under-insured, under-educated, and low-income women,<sup>22</sup> they often encounter women who are not as equipped to ferret out the pseudo-clinical from the clinical. Indeed, low-income women of color might be particularly familiar with the public social judgment that has come with many of their life “choices.”<sup>23</sup> These women unfortunately may be accustomed to receiving patronizing and directive counseling from someone who should be unbiased and neutral. It makes sense then, that undercover investigations have documented that many pregnant women who visit CPCs *actually think* that the advice they are receiving is medical and measured against an industry standard of care.

The consequences of this misinformation for the pregnant woman’s health are astronomical, as the CPC postpones necessary clinical treatment. Treatment during pregnancy is extremely time-sensitive, and “[p]rompt obstetric interventions are crucial to prevent intrapartum-related fetal hypoxic injury and maternal morbidity and mortality associated with obstetric emergencies.”<sup>24</sup> Pregnant women can have significant health risks that, if undetected, can lead to the death of the woman, the fetus, or both.<sup>25</sup> Of course, receiving pseudo-clinical

20. “*This is B.S.*, Nicole kept thinking, *but you’re trying to make me think it’s true* . . . . Some women arrive at those centers in search of Christian counseling or free diapers, but the vast majority are looking for professional advice to help them navigate unplanned pregnancies.” Winter, *supra* note 11. (emphasis in original).

21. See Thomas R. McCormick, *Spirituality in Medicine*, Ethics in Medicine University of Washington School of Medicine (Apr. 2014), <https://depts.washington.edu/bioethx/topics/spirit.html> [<https://perma.cc/HC3D-33ZU>] (“[P]rofessional ethics requires physicians to not impinge their beliefs on patients who are particularly vulnerable when seeking health care.”).

22. “CPCs specifically target low-income communities, minority populations, and places with young, vulnerable women, like high schools and colleges.” Brittany A. Campbell, *The Crisis Inside Crisis Pregnancy Centers: How to Stop These Facilities from Depriving Women of Their Reproductive Freedom*, 37 B.C.J.L. & SOC. JUST. 73, 76 (2017). See also Shepherd, *supra* note 19, at 677.

23. “[P]oor women’s private lives are made available for state surveillance and problematization . . . private information about women’s health and economic statuses is gathered and recorded. Their diets are quantified and censured. Their histories with substance abuse, sexual abuse, public assistance, and any form of contact with the state are considered significant and relevant. In essence, a poor, pregnant woman’s privacy interest—that is, her interest in preventing the government from intruding into her personal, intimate affairs—has been violated.” Khiara M. Bridges, *Poor Women and the Protective State*, 63 HASTINGS L.J. 1619, 1622–23 (2012).

24. G. Justus Hofmeyr et al., *Obstetric Care in Low-Resource Settings: What, Who, and How to Overcome Challenges to Scale Up?*, 107 INTL. J. GYN. & OBSTET. S21, S21 (2009).

25. Andrew Healy et al., *Early Access to Prenatal Care: Implications for Racial Disparity in Perinatal Mortality*, 107 OBSTET. & GYN. 625, 625 (2006) (“The establishment of regularly scheduled medical visits for pregnant women represents one of the most important advances in obstetric care in the past century, and its role in reducing fetal death is well established.”). See also *Pregnancy and Prenatal Care*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 15, 2017), <https://www.cdc.gov/healthcommunication/toolstemplates/entertainment/tips/PregnancyPrenatalCare.html> [<https://perma.cc/2DC L-XXN9>] (last visited Nov. 19, 2018) (“Each year, reports of approximately 500 women who died as a result of a pregnancy-related complication are received by the Division of Reproductive Health at CDC.

care also jeopardizes a woman's trust and confidence in the larger health care establishment, as the clinic is no longer exclusively a place for objective health information. This can negatively affect her relationship with medical providers for the rest of her life.

The explosion of CPCs has been attributed to Birthright International, a CPC network organization that was founded in 1968 and has over 400 chapters on three continents.<sup>26</sup> Most CPCs in the United States are linked with an umbrella organization such as Birthright, Care Net, Heartbeat International, or the National Institute of Family and Life Advocates ("NIFLA"). These umbrella organizations are Christian and provide leadership and support to thousands of CPCs. NIFLA, for example, states on its website that it is a

Christian ministry that seeks to glorify God by proclaiming the sanctity of human life, both born and unborn. Through the provision of legal resources and counsel to charitable faith-based Pregnancy Resource Centers (PRCs) and Pregnancy Medical Clinics (PMCs), NIFLA seeks to develop a network of life-affirming ministries in every community across the nation.<sup>27</sup>

While these websites eventually disclose the religious mission of the CPCs, in-person visits often do not provide the same transparent disclosure.

There are thousands of CPCs in the United States.<sup>28</sup> This is a national, large-scale campaign. Heartbeat International, a Christian organization that started out as a telephone hotline and developed into a system of CPCs, currently "serves 1,800 affiliated pregnancy help locations, maternity homes, and non-profit adoption agencies on all 6 inhabited continents."<sup>29</sup> In the United States, CPCs now outnumber abortion clinics 3-to-1, though this number is likely an underestimate.<sup>30</sup> In some states, the ratio is more like 10-to-1.<sup>31</sup>

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There are probably up to 500 additional such deaths that are not identified as being caused by pregnancy.").

26. See *Discover Birthright*, BIRTHRIGHT INT'L, <http://birthright.org/learn/> [<https://perma.cc/5447-NVCP>] (last visited Nov. 19, 2018). See also Chen, *supra* note 5, at 935-36.

27. *About NIFLA*, NIFLA, <https://nifla.org/about-nifla/> [<https://perma.cc/JUG5-6TM3>] (last visited Nov. 19, 2018).

28. Laura Bassett, *What Are 'Crisis Pregnancy Centers,' And Why Does The Supreme Court Care About Them?*, HUFFINGTON POST (Nov. 13, 2017), [https://www.huffingtonpost.com/entry/crisis-pregnancy-centers-supreme-court\\_us\\_5a09f40ae4b0bc648a0d13a2](https://www.huffingtonpost.com/entry/crisis-pregnancy-centers-supreme-court_us_5a09f40ae4b0bc648a0d13a2) [<https://perma.cc/4ZZZ-QNM3>].

29. *Our Story*, HEARTBEAT INT'L, <https://www.heartbeatinternational.org/about/our-story> [<https://perma.cc/J5K6-3UX2>] (last visited Nov. 19, 2018).

30. Jenny Kutner, *How Crisis Pregnancy Centers are Using Taxpayer Dollars to Lie to Women*, SALON (July 14, 2015), [https://www.salon.com/2015/07/14/how\\_crisis\\_pregnancy\\_centers\\_are\\_using\\_taxpayer\\_dollars\\_to\\_lie\\_to\\_women/](https://www.salon.com/2015/07/14/how_crisis_pregnancy_centers_are_using_taxpayer_dollars_to_lie_to_women/) [<https://perma.cc/6ZQD-4X7A>] (last visited Nov. 19, 2018). This number is difficult to confirm, given that many CPCs operate without a license. The number of CPCs is likely even higher in many states.

31. Teddy Wilson, *'Completely Intentional': Fake Clinics Outnumber Abortion Providers 10 to 1 in Texas*, REWIRE.NEWS (May 24, 2018), <https://rewire.news/article/2018/05/24/completely-intentional-fake-clinics-outnumber-abortion-providers-10-1-texas/> [<https://perma.cc/J3EG-2W9B>] (last visited Nov. 19, 2018).



While the stated missions of these organizations appear charitable, and women benefit from the CPCs' provision of free diapers or pregnancy tests, their practices are quite deceptive. Film documentaries, non-profit investigations, investigative journalism, and a 2006 Congressional report, commissioned by Senator Waxman (the "Waxman Report"),<sup>32</sup> have demonstrated that the aim of CPCs is to lure vulnerable, under-insured or uninsured women away from abortion clinics.<sup>33</sup> Given the ideological importance of their mission, CPC staff openly endorse misleading women if it means that fewer abortions will be performed.<sup>34</sup> The success of CPCs depends on how many women they can persuade to carry their pregnancies to term.

To further confuse pregnant women, CPCs are typically located just a few blocks from clinics that *do* counsel on and provide abortions.<sup>35</sup> Some CPCs have bought the exact real estate where Planned Parenthoods were located after aggressive TRAP laws forced the Planned Parenthood clinics to close their doors.<sup>36</sup> However, unlike the Planned Parenthood clinics, which are licensed and thoroughly regulated as medical clinics, CPCs are often not so licensed. Recognizing that many states could close the CPCs under statutes that require health facilities and their staff to be licensed, NIFLA has assisted over 700 CPCs in their conversion into licensed medical clinics.<sup>37</sup> These conversions are a step in the right direction, as additional safeguards come from the CPCs being licensed. However, licensure has not completely halted the deceptive practices

32. See MINORITY STAFF OF H. COMM. ON GOV. REFORM, FALSE AND MISLEADING HEALTH INFORMATION PROVIDED BY FEDERALLY FUNDED PREGNANCY RESOURCE CENTERS 6 (July 2006) (prepared for Rep. Henry A. Waxman). At the Congressman's request, the Special Investigations Division evaluated twenty-three CPCs through anonymous telephone interviews and also reviewed website tactics and advertising methods.

33. *Unmasking Fake Clinics: An Investigation into California's Crisis Pregnancy Centers*, NARAL PRO-CHOICE CALIFORNIA FOUND., [www.prochoiceamerica.org/assets/download-files/cpc-report-2015.pdf](http://www.prochoiceamerica.org/assets/download-files/cpc-report-2015.pdf) [<https://perma.cc/G578-KQN8>] (last visited Nov. 19, 2018).

34. "If you don't hook her right away, she hangs up on you. When she calls and she says 'Do you do abortions?' I say 'Are you calling for yourself or are you calling for your friend?'...and we engage in conversation. Because if she calls and says 'Do you do abortions?' and I say 'No,' click. [The CPC director pantomimes hanging up the phone]. I'm trying to get her in the door. Take control of the conversation . . . I don't mind the criticisms of taking control. 'That doesn't sound fair.' Well too bad!" 12<sup>TH</sup> & DELAWARE (Home Box Office 2010). See also JACKSON (Girl Friday Films 2016).

35. In another scene from *12<sup>th</sup> and Delaware*, a CPC director conducts a training for volunteers in which she emphasizes the value of proximity to a clinic that provides abortions. She tells volunteers: "Clearly our competition is the abortion clinic. We are actually on opposite sides of the street . . . They're not always sure who they're calling anyway." 12<sup>TH</sup> & DELAWARE (Home Box Office 2010). See also Holtzman, *supra* note 9, at 86.

36. These laws impose stringent requirements on abortion clinics that dictate such things as the width of hallways, lighting requirements, square footage requirements for exam space, admitting privileges for physicians at area hospitals, etc. Many clinics have had to close in the wake of these laws, which was the intended effect. See Caitlin E. Borgmann, *Borrowing from Dormant Commerce Clause Doctrine in Analyzing Abortion Clinic Regulations*, 26 HEALTH MATRIX 41, 45 (2016); see also Rachel Suppé, *A Right in Theory but Not in Practice: Voter Discrimination and Trap Laws As Barriers to Exercising A Constitutional Right*, 23 AM. U. J. GENDER SOC. POL'Y & L. 107, 130 (2014). Following *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), many of these TRAP laws might be struck down, but much damage in terms of patient access has already been done.

37. Chen, *supra* note 5, at 935–36.

of CPCs. And, while many of the women who obtain services from CPCs assume they are getting treated by health care professionals who are subject to all that comes with that perception, the CPCs that remain unlicensed are not subjected to the numerous health, safety, and privacy regulations that attend to the regular practice of medicine.<sup>38</sup> There is a great mismatch between the way CPCs present themselves to the public and the way they have presented themselves to the courts.

This Article will proceed in four parts. The first Section will discuss how legislators have attempted to thwart deceptive CPC practices through mandatory disclosure laws, and how these statutes have been successfully challenged on First Amendment grounds. While state consumer protection statutes provide fantastic avenues for correcting CPCs' deception, they have been bafflingly underutilized due to political pressure in conservative states. Local prosecutors are not motivated to bring these consumer protection lawsuits against CPCs. Therefore, the second Section makes the primary argument for a private remedy in tort law. Rather than rely on under-enforced or constitutionally vulnerable consumer protection regulation, this Article advocates for the use of the private, intentional tort of battery to provide redress for the women who have been physically touched by the CPCs and injured by their deceptive practices. There are many advantages to this approach, which puts many injured women in the driver's seat, offers them money damages, and does not require legislative or political cooperation. In Sections III and IV, this Article discusses how states could, but do not, prosecute CPCs for the unlawful practice of medicine without a license, or for the use of FDA-approved devices in unapproved ways. Again, due to the lack of political will to enforce these options, they are not likely to provide an adequate remedy to most American women. The Article then concludes with some forward-looking concerns about the ways that medical informed consent has been hijacked by the pro-life movement. Contrasting how the First Amendment protects CPCs' deceptive speech but is quite limited in its protection of the free speech rights of licensed medical providers, the Article explores some concepts rooted in medical ethics. Namely, this Article acknowledges and articulates a worrying trend in reproductive jurisprudence which blurs the medical with the ideological, shoehorning politics through the mouths of licensed medical providers and doing violence to the physician-patient relationship.

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38. In order to avoid state fines for the unauthorized practice of medicine, some CPCs have begun requiring that their nurses and medical directors maintain active medical licenses.

## I. REGULATING CPCs THROUGH LEGISLATIVELY-COMPELLED DISCLOSURES

A. *Legislators Pass Disclosure Requirements to Curb the Documented, Deceptive Practices of CPCs*

City and county legislators were understandably upset when the Waxman Report and other local investigations revealed the extent to which pregnant women were being misled by CPCs.<sup>39</sup> Many cities and counties have passed ordinances attempting to curb the deception of CPCs through mandatory disclosure requirements.<sup>40</sup> Typically, these ordinances required notices to be placed in the CPC waiting rooms indicating that the clinic is not licensed, or (more constitutionally infirm) stating that the CPC does not refer anyone to abortion services.<sup>41</sup> These types of disclosure requirements have been struck down by the Fourth Circuit and, most recently, by the Supreme Court, for requiring speech that is not narrowly tailored or necessary to fulfill a compelling state interest.<sup>42</sup> Given how much the recent Supreme Court opinion, *NIFLA v. Becerra*, limits future restrictions on CPCs' speech, it will be discussed in some detail below.

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39. Investigations in California, Maryland, Massachusetts, Missouri, New York, North Carolina, Texas, and Virginia all have documented CPCs' intentionally misleading practices. NARAL PRO-CHOICE CAL. FOUND., UNMASKING FAKE CLINICS: THE TRUTH ABOUT CRISIS PREGNANCY CENTERS IN CALIFORNIA (2010), <https://www.sfcityattorney.org/wp-content/uploads/2015/08/Unmasking-Fake-Clinics-The-Truth-About-Crisis-Pregnancy-Centers-in-California-.pdf> [https://perma.cc/GZ2X-PNHQ] (last visited Dec. 25, 2018); NARAL PRO-CHOICE MD. FUND, MARYLAND CRISIS PREGNANCY CENTER INVESTIGATIONS: THE TRUTH REVEALED (2008), <https://maryland.prochoiceamericaaffiliates.org/wp-content/uploads/sites/11/2018/04/crisispregnancycenterreport.pdf> [https://perma.cc/86M9-WRKX] (last visited Nov. 19, 2018); NARAL PRO-CHOICE MASS. & PRO-CHOICE MASS. FOUND., JUST BECAUSE YOU'RE PREGNANT . . . LIES, HALF TRUTHS, AND MANIPULATION AT CRISIS PREGNANCY CENTERS IN MASSACHUSETTS (2011); NARAL PRO-CHOICE N.Y. FOUND. & NAT'L INST. FOR REPROD. HEALTH, "SHE SAID ABORTION COULD CAUSE BREAST CANCER": A REPORT ON THE LIES, MANIPULATIONS, AND PRIVACY VIOLATIONS OF CRISIS PREGNANCY CENTERS IN NEW YORK CITY (2010), <https://www.nirhealth.org/wp-content/uploads/2015/09/cpreport2010.pdf> [https://perma.cc/6RMJ-5TTN] (last visited Nov. 19, 2018); NARAL PRO-CHOICE N.C. FOUND., THE TRUTH REVEALED: NORTH CAROLINA'S CRISIS PREGNANCY CENTERS (2011), [http://pulse.ncpolicywatch.org/wp-content/uploads/2011/10/2011\\_NARAL\\_CPCReport\\_V05\\_web.pdf](http://pulse.ncpolicywatch.org/wp-content/uploads/2011/10/2011_NARAL_CPCReport_V05_web.pdf) [https://perma.cc/RCD6-Z96F] (last visited Nov. 19, 2018); NARAL PRO-CHOICE TEX. FOUND., THE TEXAS "ALTERNATIVES TO ABORTION" PROGRAM: BAD HEALTH POLICY, BAD FISCAL POLICY (2011), <http://www.austintexas.gov/edims/document.cfm?id=163224> [https://perma.cc/3Q58-D8EY] (last visited Nov. 19, 2018); NARAL PRO-CHOICE VA., CRISIS PREGNANCY CENTERS REVEALED, PART II: AN INVESTIGATIVE UPDATE ON VIRGINIA CRISIS PREGNANCY CENTERS (2013); Press Release, NARAL Pro-Choice Mo. Found., *Show Me Truth: NARAL Pro-Choice Missouri Organizes a Community Protest Against Deceptive Health Practices at ThriVe St. Louis* (Feb. 11, 2012) (on file with author).

40. Campbell, *supra* note 22, at 84.

41. *Id.*

42. Holtzman, *supra* note 9, at 79.

### B. CPCs Challenge Disclosures as Violations of Free Speech

The First Amendment, applicable to the states through the Fourteenth Amendment, prohibits the enactment of laws “abridging the freedom of speech.”<sup>43</sup> Consequently, government has “no power to restrict expression because of its message, its ideas, its subject matter, or its content.”<sup>44</sup> Laws that require speakers to communicate a particular message (“content-based” laws) “are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.”<sup>45</sup> However, the Court has held that this does not apply when the government seeks to regulate the commercial or professional speech of participants in the public marketplace.<sup>46</sup> In the past, the Supreme Court “has been wary of claims that regulation of business activity, particularly health-related activity, violates the Constitution.”<sup>47</sup> The key question for regulating CPCs under the First Amendment, therefore, is whether the CPC’s speech is ideological, commercial, or professional.

An ordinance passed by Baltimore’s city council required CPCs to disclose that “the center does not provide or make referral for abortion or birth-control services,” and the disclosure must be “written in English and Spanish,” “easily readable,” and “conspicuously posted in the center’s waiting room or other area where individuals await service.”<sup>48</sup> This was thus a content-based regulation, and if the speaker were ideological, as opposed to commercial or professional, the ordinance would need to satisfy strict scrutiny. A Baltimore CPC and the Catholic archbishop of Baltimore challenged this disclosure requirement as violating their free speech. A federal court in Maryland enjoined enforcement of the ordinance after the Fourth Circuit remanded, demanding greater discovery.<sup>49</sup> Baltimore County appealed this decision, but the appellate court has not yet ruled on the matter.

In *Centro Tepeyac v. Montgomery County*, a CPC challenged the Maryland county’s requirement that CPCs warn women that “the Center does not have a licensed medical professional on staff” and “the Montgomery County Health Officer encourages women who are or may be pregnant to consult with a licensed

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43. U.S. CONST. amend. I.

44. *Police Dept. of Chicago v. Mosley*, 408 U.S. 92, 95 (1972).

45. *Reed v. Town of Gilbert, Ariz.*, 135 S. Ct. 2218, 2226 (2015).

46. More will be said *infra*, at Section I.B.3 about the application of the *Zauderer* precedent to CPCs speech. See *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 650–53 (1985).

47. See *Nat’l Inst. Of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2381 (2018) (Breyer, J., dissenting).

48. *Greater Baltimore Ctr. For Pregnancy Concerns, Inc. v. Mayor & City Council of Baltimore*, 721 F.3d 264, 271 (4th Cir. 2013).

49. The district court’s hasty decision cannot be excused by its ruling that any commercial speech regulated by the Ordinance ‘is inextricably intertwined with otherwise fully protected speech,’ thus triggering strict scrutiny. *Id.* at 287.

health care provider.”<sup>50</sup> Despite acknowledging that “context matters” and courts must look to “the effect of the compelled statement [on the listener],”<sup>51</sup> the district court emphasized that the speech that was being regulated occurred not on websites or through advertising, but in the CPC’s waiting room, and “within *Centro Tepeyac*’s four walls, much closer to their ideological message.”<sup>52</sup> They then struck down the ordinances as violating the CPC’s free speech rights. The Fourth Circuit found that, as content-based compelled speech, the county ordinance failed to pass strict scrutiny.<sup>53</sup>

California’s Reproductive FACT Act (“the FACT Act”)<sup>54</sup> fared better in the lower federal courts, in part because it technically applied to all non-profit community clinics offering pregnancy counseling offices, rather than just those that are unlicensed or pro-life.<sup>55</sup> In addition, the statute did not include any language about the state’s preference regarding where women received their pregnancy care, or that they were encouraged to see a licensed provider.<sup>56</sup> The stated aims were clearer as well: to make sure California women were apprised of state-funded reproductive services in a timely fashion, and were made aware of how to access them.<sup>57</sup> The legislative findings acknowledged that “pregnancy decisions are time sensitive,” and so the state must supplement their public health education with materials placed in the clinic offices.<sup>58</sup>

50. 5 F. Supp. 3d 745, 748 (D. Md. 2014).

51. *Id.* at 758.

52. *Id.* at 760.

53. 683 F.3d 591, 594 (4th Cir. 2012), *on reh’g en banc sub nom. Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184 (4th Cir. 2013).

54. CAL. HEALTH & SAFETY CODE §§ 123470-123473 (Deering 2018).

55. The Act did have exemptions for certain facilities, which, if not included, may have proved fatal to the Act. The first exemption was for clinics operated by a federal agency, and was included so the Act was not federally pre-empted. The second exemption was for clinics that participated in California’s “Family Planning, Access, Care, and Treatment Program” (Family PACT program). *Id.* § 123471(c). To participate in the Family PACT program, a clinic must provide “the full scope of family planning . . . services specified for the program,” CAL. WELF. & INST. CODE § 24005 (Deering 2018), including sterilization and emergency contraceptive pills. *Id.* § 24007.

56. It does seem odd, however, that the state interest in protecting women’s health would not allow states to encourage women to see a licensed medical provider for their pregnancy care. Pregnancy is a medical condition, with significant risk of complication and even death. It seems like an entirely legitimate use of the states’ public health police power to encourage women to be seen by someone who was professionally trained and licensed.

57. “The legislature was concerned with women who may not be aware that certain health options are available to them, and wanted to ensure women in California are informed of the full range of free and low-cost services available to them when they make their reproductive decisions. In this way, the Act more closely resembles informed consent cases than deceptive advertising cases.” *See A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 153 F. Supp. 3d 1168, 1209 (E.D. Cal. 2015), *aff’d*, 669 F. App’x 495 (9th Cir. 2016), *cert. granted, judgment vacated sub nom. See also* CAL. HEALTH & SAFETY CODE § 123470 (Deering 2018).

58. *A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 153 F. Supp. 3d 1168, 1208 (E.D. Cal. 2015), *aff’d*, 669 F. App’x 495 (9th Cir. 2016), *cert. granted, judgment vacated sub nom. See also* CAL. HEALTH & SAFETY CODE § 123470(a)-(c) (Deering 2018), which provide in part, “(a) All California women, regardless of income, should have access to reproductive health services . . . (c) Because pregnancy decisions are time sensitive, and care early in pregnancy is important, California must supplement its own efforts to advise women of its reproductive health programs. In California, low-

1. *NIFLA v. Becerra in the Ninth Circuit*

The Act contained two critical parts. The first part required any pregnancy counseling center that was not licensed as a medical facility to conspicuously place a notice in the entrance of the facility, at least 8.5 inches by 11 inches in size and written in no less than 48-point type font, that stated that the facility “was not licensed as a medical facility and had no licensed medical provider.” They were also required to post this statement on billboards and any advertising materials for the CPC.<sup>59</sup> Failure to comply resulted in a \$500 fine for the first offense, and \$1,000 fines thereafter.<sup>60</sup> This part of the Act will be referred to hereinafter as the “unlicensed disclosure” provision.

The second part of the Act required licensed facilities to disclose that California has free or low-cost state-funded family planning options. Specifically, covered clinics must post in their waiting rooms, in printed materials, or digitally at check-in that “California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].”<sup>61</sup> The stated reason for the Act was California’s desire that women have immediate access to California’s “comprehensive family planning services and pregnancy-related care through the Medi-Cal and the Family PACT programs.”<sup>62</sup> This part of the Act will be referred to as the “licensed disclosure” provision.

A handful of California CPCs petitioned for an injunction, to prevent the state of California from enforcing either part of the statute. They claimed that both provisions violated their rights to free speech under the U.S. Constitution. The district courts and Ninth Circuit denied the injunctions.<sup>63</sup>

Given the state’s consumer and health protection reasons for passing the law, the Ninth Circuit held that the *unlicensed* disclosure survived strict scrutiny and was viewpoint neutral.<sup>64</sup> As for the licensed disclosure, the Ninth Circuit agreed

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income women can receive immediate access to free or low-cost comprehensive family planning services and pregnancy-related care through the Medi-Cal and the Family PACT programs. However, only Medi-Cal providers who are enrolled in the Family PACT program are authorized to enroll patients immediately at their health centers.”

59. CAL. HEALTH & SAFETY CODE § 123472(b)(1) (Deering 2018).

60. CAL. HEALTH & SAFETY CODE § 123473 (Deering 2018).

61. CAL. HEALTH & SAFETY CODE § 123472(a)(1) (Deering 2018).

62. “Because pregnancy decisions are time sensitive, and care early in pregnancy is important, California must supplement its own efforts to advise women of its reproductive health programs. In California, low-income women can receive immediate access to free or low-cost comprehensive family planning services and pregnancy-related care through the Medi-Cal and the Family PACT programs.” CAL. HEALTH & SAFETY CODE § 123470 (Deering 2018).

63. Nat’l Inst. Of Family & Life Advocates v. Harris, 839 F.3d 823 (9th Cir. 2016) *rev’d and remanded sub nom.* Nat’l Inst. Of Family & Life Advocates v. Becerra, 138 S. Ct. 2361 (2018).

64. A few district courts found the licensed disclosure to be a regulation of professional, not ideological speech, and therefore subject to heightened, but not strict, constitutional review. *See* Mountain

that this provision regulated professional speech, and thus was subject to (and survived) intermediate scrutiny. As the Ninth Circuit was only applying intermediate scrutiny to this part of the Act, it held that the compelled speech need not be *the least* restrictive means necessary, and “[the notice] does not contain any more speech than necessary, nor does it encourage, suggest, or imply that women should use those state-funded services. The Licensed Notice is closely drawn to achieve California’s interests . . . .”<sup>65</sup> According to the Court of Appeals, the petitioners could not demonstrate likely success on the merits of their First Amendment free speech claims for either part of the Act, so the injunction was denied.<sup>66</sup>

The CPCs petitioned the Supreme Court for review, and in 2017, certiorari was granted in *NIFLA v. Becerra*.<sup>67</sup> The Court certified the question of whether the Act’s compelled speech requirements violate CPCs’ right to free speech under the First Amendment to the U.S. Constitution. The case would resolve the conflict between the Fourth and Ninth Circuits as to how to classify the relevant speech and the appropriate level of scrutiny to apply. Oral arguments were heard in the spring of 2018, and the opinion was issued in June of 2018.

## 2. *The Supreme Court Protects CPCs’ Right to Deceive by Holding that They are Not Medical Providers*

The Supreme Court had a different interpretation of both the applicable precedent and the statute itself. The majority granted the CPCs’ injunction, prohibiting enforcement of the Act.<sup>68</sup> Justice Thomas wrote for the majority, finding that both parts of the Act “likely violated” the CPCs’ right to free speech.<sup>69</sup> The Court achieved this result by making a series of creative but disingenuous moves. Each of these moves rested on the factually inaccurate and easily disprovable assumption that the CPCs are not practicing medicine or providing medical services.

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*Right to Life, Inc. v. Becerra*, 692 F. App’x 807, 808 (9th Cir. 2017); *Livingwell Med. Clinic, Inc. v. Harris*, 669 F. App’x 493, 493-95 (9th Cir. 2016); *A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 153 F. Supp. 3d 1168, 1199 (E.D. Cal. 2015), *aff’d*, *A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 669 F. App’x 495 (9th Cir. 2016). *See also* *Centro Tepeyac v. Montgomery Cty.*, 722 F.3d 184, 189 (4th Cir. 2013) (“The court observed that content-based speech regulations ordinarily are subject to strict scrutiny, but that lesser degrees of scrutiny may apply where the speech at issue is, inter alia, commercial or professional.”).

65. *Nat’l Inst. of Family & Life Advocates*, 839 F.3d at 842.

66. “California has a substantial interest in the health of its citizens, including ensuring that its citizens have access to and adequate information about constitutionally-protected medical services like abortion. The California Legislature determined that a substantial number of California citizens may not be aware of, or have access to, medical services relevant to pregnancy.” *Nat’l Inst. Of Family & Life Advocates v. Harris*, 839 F.3d 823, 841 (9th Cir. 2016).

67. *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 464 (2017).

68. *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

69. *Id.* at 2380.

The cornerstone of petitioner's argument was that CPCs were not medical providers and what they do is not considered a medical intervention. There is a mismatch, then, between how CPCs present themselves before the Supreme Court, and how they are presenting themselves to the public. It was this mismatch that the state of California sought to rectify with its Act, by requiring CPCs to disclose their true unlicensed nature. And, given that the case was resolved at the preliminary injunction phase, without much fact-finding, it is this very mismatch that the CPCs successfully exploited before the Supreme Court to deem their speech more protected than that of a licensed physician.

Consider this telling exchange between NIFLA's attorney, Michael Farris, and Justice Ginsburg. Justice Ginsburg was evidently trying to understand why the state of California could not compel a CPC to offer accurate and non-misleading medical information to pregnant women, something constitutionally permissible under *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>70</sup>

Justice Ginsburg: "But why isn't this also informed consent? . . . So—so that the patient will know what are the array of services available to her?"

Michael Farris: "Your Honor, the services provided by our licensed centers are not medical interventions."<sup>71</sup>

Petitioner's attorney conceded that if the state of California considered CPCs to be practicing medicine, they could prosecute them for the unauthorized practice of medicine.<sup>72</sup> However, NIFLA's attorney also stated that they do not think they are practicing medicine or providing medical interventions, despite their stated compliance with HIPAA requirements that only apply to medical covered entities, or their provision of pregnancy tests, counseling, exams, or ultrasounds, any of which would constitute the practice of medicine in any state.<sup>73</sup> To reiterate, what the CPCs advertise themselves as providing, and what they actually provide, should be considered medical services, interventions, and the practice of medicine in every single U.S. state. The CPCs' definition of "the practice of medicine" finds no support under any existing state law.

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70. 505 U.S. 833 (1992).

71. Oral Argument at 01:51, *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [<https://perma.cc/4HRK-9JQQ>].

72. Oral Argument at 17:39, *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [<https://perma.cc/4HRK-9JQQ>].

73. Oral Argument at 19:51, *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [<https://perma.cc/4HRK-9JQQ>]. More will be said about the unlawful practice of medicine, and the state's ability to prosecute CPCs under this authority. See discussion *infra* Section IV.



a. Is the CPC Speaking as a Commercial, Ideological, or Medical Entity?

The classification of the speech is central for First Amendment analyses. This is a particularly difficult task in the present case, as CPCs demonstrate aspects of all three types of speech: commercial, professional, and ideological. It is therefore no surprise that there was a conflict between the district courts about how to classify the speech of CPCs. While the distinctions between each type are not as clear as they once were, federal precedent has mostly assumed that these categories were mutually exclusive.

If the CPCs were engaged in purely commercial speech, the statutes in question would traditionally be subject to mere rational basis review.<sup>74</sup> Under rational basis, the state need only offer a plausible basis for the legislation that is minimally connected to the Act. In effect, this means the CPCs would not be given First Amendment protection when they are misleading consumers or when the compelled speech serves to ensure the provision of accurate information.<sup>75</sup> The main objective in the analysis of compelled commercial speech is “the protection of the consumer’s interest in the free flow of truthful commercial information.”<sup>76</sup>

The Supreme Court has recently complicated these traditional distinctions a bit, however, offering greater protection to some forms of commercial speech. In *Sorrell v. IMS*, the Court applied “heightened” scrutiny to a Vermont consumer protection statute that prohibited data-miners and pharmaceutical manufacturers from selling or using a doctor’s prescribing information.<sup>77</sup> Understanding the information disclosure objective of commercial speech regulation helps to explain *Sorrell*, where the Court found that *restrictions* on commercial speech (rather than the more typical compelled speech) violated the First Amendment.<sup>78</sup> In this same case, Justice Breyer reminded the majority that the courts should exercise caution before applying heightened scrutiny “whenever such a program burdens speech” as this would frustrate separation of powers and “distort or undermine legitimate legislative objectives.”<sup>79</sup> Even though *Sorrell* was about restricting rather than compelling speech, this case can be read as signaling an erosion of the typical deference afforded to state consumer-protection statutes.

In the case of California’s FACT Act, federal courts applied the traditional framework for commercial speech. In *First Resort v. Herrera*, the Ninth Circuit

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74. *A Woman’s Friend Pregnancy Res. Clinic v. Harris*, 153 F. Supp. 3d 1168, 1199 (E.D. Cal. 2015), *aff’d*, 669 F. App’x 495 (9th Cir. 2016).

75. The *Central Hudson* test informs the proper regulation of commercial speech.

76. *United States v. United Foods, Inc.*, 533 U.S. 405, 426 (2001).

77. 564 U.S. 552 (2011).

78. *Id.* at 564.

79. *Id.* at 584-85 (Breyer, J., dissenting).

held that whether speech is commercial “does not hinge solely on whether the [CPCs have] an economic motive.”<sup>80</sup> Under this view, even speech that is provided by volunteers can be classified as commercial as it is spoken in a “marketplace” for reproductive services. And if it is commercial, the Act would be a permissible regulation on the dissemination of false or misleading statements.<sup>81</sup>

Professional speech, on the other hand, has traditionally been afforded intermediate review. This was justified because professionals, “through their education and training, have access to a corpus of specialized knowledge that their clients usually do not” and that clients put “their health or their livelihood in the hands of those who utilize knowledge and methods with which [they] ordinarily have little or no familiarity.”<sup>82</sup> Intermediate review meant that the regulation need not be the least restrictive necessary to further a compelling state interest. As the Act applied both to licensed and unlicensed facilities, there was at least some argument that the speech is not professional, particularly when it is compelled by CPCs that have no professional or licensed staff.<sup>83</sup> But given that the CPCs presented themselves as medical providers, and did offer some professional services such as diagnosing pregnancies and offering ultrasounds, there was also an argument that they were engaged in professional speech. The Ninth Circuit adopted this latter argument, finding the CPCs to be engaged in professional speech.<sup>84</sup>

The Fourth Circuit disagreed even further and found CPCs’ speech to be ideological due to their pro-life agenda.<sup>85</sup> This interpretation was bolstered by the fact that the CPCs offered free services and products. Ideological speech is afforded the greatest First Amendment protection. It is assumed that the state’s purpose in compelling this speech is the most suspicious. Given this, restrictions on ideological speech are subjected to strict scrutiny, and absent compelling state interests, and a statutory scope that is narrowly tailored to address those state interests, the restriction will fail.

The problem, of course, and the reason for the disparate treatment among federal courts, is that CPCs exhibit aspects of commercial, professional, and ideological speech. To the outside layperson, they appear to be a medical clinic,

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80. *First Resort, Inc. v. Herrera*, 860 F.3d 1263, 1273 (9th Cir. 2017).

81. *Id.* at 1273-74.

82. *Nat’l Inst. of Family & Life Advocates v. Harris*, 839 F.3d 823, 839 (9th Cir. 2016), *rev’d and remanded sub nom.* *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

83. Daniel Halberstam, *Commercial Speech, Professional Speech, and the Constitutional Status of Social Institutions*, 147 U. PA. L. REV. 771, 772-73 (1999).

84. *Nat’l Inst. of Family & Life Advocates v. Harris*, 839 F.3d 823, 839 (9th Cir. 2016), *cert. granted in part sub nom.* *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 464, 199 L. Ed. 2d 328 (2017), *and rev’d and remanded sub nom.* *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018).

85. *Greater Baltimore Ctr. for Pregnancy Concerns, Inc. v. Baltimore*, 721 F.3d 264, 285 (4th Cir. 2013).

but to the sophisticated courts and attorneys, who have access to much more information about the mission and funding of CPCs, they are obviously ideological. And while they usually do not charge for their services, they are still at least partially commercial in that they are competing with licensed medical providers in the marketplace to offer a reproductive service.

b. The Supreme Court Classifies CPC Speech as Ideological

While the classification was far from obvious, then, the Supreme Court decided to treat CPCs' speech as ideological. It did so by largely ignoring the way CPCs hold themselves out to the public and ignoring that much of what they do is a professional service. It also distinguished between speech and conduct, holding that precedent allowing greater regulation of professionals was targeted at professional speech that is incident to a professional service. This proved pivotal, as it allowed the Court to distinguish precedents upholding TRAP laws and other compelled disclosures in the marketplace of licensed physicians.

3. *The Unlicensed Disclosure Provision*

Given that CPCs advertise to the public for services, the unlicensed disclosure provision should have been uncontroversial. States have long recognized an interest in promoting consumer protection and regulating commerce to promote public health and safety. More specifically, the Supreme Court has also recognized the importance of ensuring that consumers know whether they are visiting a licensed medical provider.<sup>86</sup> The state's interest has been considered stronger than the individual practitioner's freedoms.<sup>87</sup>

Even if CPCs were not considered medical providers, regulations on professional speech have often been upheld to protect consumers. The Court has recognized that professionals can be required to provide "purely factual and uncontroversial information about the terms under which . . . services will be available."<sup>88</sup> In *Zauderer*, the Court upheld a requirement that attorneys disclose their contingency-fee payment structure to potential clients. The Court reasoned that the

constitutionally protected interest in *not* providing any particular factual information in his advertising is minimal . . . [and] warning[s] or

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86. *Dent v. West Virginia*, 129 U.S. 114 (1889).

87. *Id.*

88. *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 650-53 (1985).

disclaimer[s] might be appropriately required . . . in order to dissipate the possibility of consumer confusion or deception.<sup>89</sup>

In *NIFLA*, the majority stated that the *Zauderer* precedent did not apply because *Zauderer* applied only to purely factual information. Here, the Court stated that “information about *state*-sponsored services—including abortion, [are] hardly an ‘uncontroversial’ topic.”<sup>90</sup> But this is where they reveal their category error and confuse the speaker (ideological, controversial pro-life group) with the speech (which *is* purely factual and should not itself be considered controversial).<sup>91</sup> The Court then claimed that even if *Zauderer* did apply, however, the Act still failed, as the disclosures were “unjustified or unduly burdensome,”<sup>92</sup> especially as applied to a CPC’s advertising materials.<sup>93</sup> They did so by focusing on the cost of compliance to CPCs.

Even though the majority classified the speech as ideological and unduly burdensome, it did not stop there. It decided to go further, and rejected the distinction between professional and non-professional speech, questioning lower-court analyses to the extent they applied an intermediate level of scrutiny. The Court reasoned that professional speech is “a difficult category to define with precision.”<sup>94</sup> By imposing a licensure requirement, this “gives the States unfettered power to reduce a group’s First Amendment rights.”<sup>95</sup>

Perhaps the most puzzling part of the majority’s opinion was the asymmetrical finding by the Court that the harm to pregnant women from CPCs’ deception was imaginary, and the harm to the CPCs by enforcing the Act was very real. In finding that the licensed disclosure provision was perhaps responding to a “purely hypothetical harm,”<sup>96</sup> the Court ignored the briefing by the state and its legislative findings in passing the Act, which documented the extent to which women were being misled by CPCs. The legislature had provided ample evidence of harm, which the Court ignored.<sup>97</sup>

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89. *Id.* at 651.

90. *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2367 (2018).

91. Previously, the Court had acknowledged that different types of content might be treated differently, even if still content-based and all subjected to strict scrutiny.

92. *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2372 (quoting *Zauderer*, 471 U.S. at 651).

93. *Id.* at 2373-76.

94. *Id.* at 2375.

95. *Id.*

96. *Id.* at 2377.

97. In finding that the harm here may be “purely hypothetical,” and the disclosure unnecessary, the Court seems to be considering the availability of other state options for curbing deceptive practices, such as the ability of the state to prosecute for the unlawful practice of medicine or under general state consumer protection laws. However, the bill specified the harm the Reproductive FACT Act was meant to address, namely that “In 2012, more than 2.6 million California women were in need of publicly funded family planning services. More than 700,000 California women become pregnant every year and one-half of these pregnancies are unintended. In 2010, 64.3 percent of unplanned births in California were publicly funded. Yet, at the moment they learn that they are pregnant, thousands of women remain unaware of the public programs available to provide them with contraception, health education and counseling, family planning, prenatal care, abortion, or delivery. Because pregnancy decisions are time sensitive, and care

In contrast, the harm to the CPCs from having to comply with the Act was considered by the Court to be “unjustified or unduly burdensome.”<sup>98</sup> The Court then reasoned that “[e]ven if the State had presented a nonhypothetical justification, the FACT Act unduly burdens protected speech,” as “[i]t imposes a government-scripted, speaker-based disclosure requirement” that applies regardless of whether the CPCs disclose their non-licensed status on their website.<sup>99</sup> Of course, this assumes that everyone has access to these advertisements before entering the CPC.

#### 4. *The Majority Places Much Consumer Protection Law at Constitutional Risk*

By describing the disclosure in this way, the Court cast too wide of a net, rendering many consumer protection statutes unconstitutional. As Breyer’s dissent correctly points out, this aspect of *NIFLA* has the potential for sweeping impact outside of the abortion context, as “virtually every disclosure law could be considered ‘content based,’ for virtually every disclosure law requires individuals to speak a particular message.”<sup>100</sup>

The majority responds that “[c]ontrary to the suggestion in the dissent, we do not question the legality of health and safety warnings long considered permissible, or purely factual and uncontroversial disclosures about commercial products.”<sup>101</sup> But if the FACT Act is not considered a regulation to protect health and safety, it is hard to imagine what would be. The majority’s opinion offers no guidance on this score. Why is the Act not directed at protecting public health?

The Court’s confusing reasoning could invalidate many state regulations, of such things as cigarettes, securities, guns, or environmental pollutants, on First Amendment grounds. States typically do not require non-polluters to state that they are non-polluting, or that non-cigarettes do not contain nicotine. If passing legislation that targets the deceivers is considered impermissible “government-scripted” content discrimination, then much regulation of controversial products or industries would be unconstitutional. And the majority’s general disclaimer that this is not what they meant “seem[s] more likely to invite litigation than to provide needed limitation and clarification.”<sup>102</sup>

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early in pregnancy is important, California must supplement its own efforts to advise women of its reproductive health programs. In California, low-income women can receive immediate access to free or low-cost comprehensive family planning services and pregnancy-related care through the Medi-Cal and the Family PACT programs.” See 2015 Cal. Stat. Ch. 700.

98. *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2372 (quoting *Zauderer*, 471 U.S. at 651).

99. *Id.* at 2377.

100. *Id.* at 2380 (Breyer, J., dissenting). “[M]uch, perhaps most, human behavior takes place through speech and because much, perhaps most, law regulates that speech in terms of its content, the majority’s approach at the least threatens considerable litigation over the constitutional validity of much, perhaps most, government regulation.” *Id.*

101. *Id.* at 2376.

102. *Id.* at 2381 (Breyer, J., dissenting).

This holding is quite disturbing and far-reaching. CPCs create deceptive advertising, and then cannot be required to correct it. Imagine if a gun manufacturer misled consumers to believe that a gun could do things that it could not do, or was safer than it was. Then, imagine the state passing a law requiring the manufacturer to correct this deception. Under the Supreme Court's opinion in *NIFLA*, the statute could be presumptively unconstitutional, as the subject matter is controversial (guns) and the disclosure might cost the gun manufacturers money. This would, of course, ignore the fact that it was the actions of the gun manufacturers that created the deception in the first place. This paradoxical outcome should be alarming to anyone concerned about deceptive advertising.

### 5. *The Licensed Disclosure Provision*

The Supreme Court also found that the second part of the Act likely violated the CPCs' right to free speech. As with the unlicensed disclosure, the bulk of the constitutional work was done when it classified the CPCs' speech as ideological rather than professional. Recall that in *Zauderer*, professional speech could be regulated for consumer protection.<sup>103</sup>

#### a. To Distinguish *Casey*, CPCs Deemed To Not Be Providing Medical Services, and the Licensed Disclosure was Not Informed Consent

The Court made it clear that the licensed disclosure is not "an informed consent requirement or any other regulation of professional conduct."<sup>104</sup> This is because it is not tied to the provision of a "medical procedure," and applies to all interactions between a CPC and a pregnant woman.<sup>105</sup> Of course, this is a very narrow reading of informed consent doctrine, as licensed doctors can be and have been required to provide information to women that is disconnected from a medical procedure. For example, when physicians provide information about the likely side effects of medications, something they are legally required to do, this disclosure would not be part of medical informed consent under the *NIFLA* framework. Likewise, outside of the health care context, employers can be required to post safety notices in their break-rooms that do not directly apply to their employee's immediate conduct, and restaurants that serve alcohol can be required to post notices about the risks of drinking alcohol, regardless of whether a patron orders any alcoholic beverages. Never before have health disclosures

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103. *Zauderer v. Office of Disciplinary Counsel of Supreme Court of Ohio*, 471 U.S. 626, 651 (1985).

104. *Nat'l Inst. of Family & Life Advocates*, 138 S. Ct. at 2373.

105. *Id.*

needed to be immediately tied to the speaker's conduct to pass First Amendment scrutiny.

The requirement that the health and safety disclosure be limited to those instances where a “medical procedure” is immediately to be performed also reflects a very narrow, and incorrect, reading of what it means to practice medicine. Under this definition, pediatricians, geriatricians, general practitioners, infectious disease doctors, and many other specialties rarely practice medicine. These are considered “cognitive” specialties where procedures are not typically performed, and instead health care is discussed and monitored, and referrals are made. These physicians would almost certainly dispute the idea that medical services are only rendered, and informed consent is only required, when a procedure is about to be performed. To say that only “procedures” amount to medical services is bizarre and incorrect. It is also dismissive of the large majority of health care providers, who never perform, or bill for, any procedures, and yet who are still legally required to maintain a license to practice medicine. Further, if a CPC provides medical services at any point, which they do when diagnosing a pregnancy, conducting physical exams, or performing ultrasounds, it should be deemed a medical clinic. There is no such thing as a part-time or fractional medical clinic. After all, just because a physician fills out forms for patients who want to play sports or paperwork for insurance billing, these non-procedure activities do not render the clinic a non-clinic. It is completely at odds with the concept of the “practice of medicine” to think of a medical clinic as only providing medical services when a physician is cutting open a patient.

Of course, there was more to this rhetorical move than merely dodging *Zauderer*. It was critical to find that CPCs were not practicing medicine in order to distinguish the informed consent precedent specific to abortion. *Casey* made it quite clear that the state could require providers to offer non-misleading and accurate information as part of informed consent to abortion, and that this requirement would not violate due process or free speech.<sup>106</sup> But because the Supreme Court did not view the CPCs as medical providers, they did not apply *Casey*. The FACT Act disclosures, they reasoned, could be made in the lobby of the pseudo-clinic, before any medical procedures were technically provided. There was no medical procedure being performed *yet*, and because the CPCs are not medical providers, there may never be any medical service provided. Apparently, to the *NIFLA* majority, informed consent is only triggered moments before an abortion procedure is about to be performed—and not as part of general reproductive counseling.<sup>107</sup> In oral argument, Justice Sotomayor recognized the problem with this, asking “how’s [what a CPC does] different from what a doctor

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106. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 882 (1992).

107. This is surprising, as courts have held that providing women counseling and prenatal vitamins constitutes the practice of medicine, to which regular tort law informed consent would attach.

does? When you go in for a pregnancy, you see the doctor, and the doctor will describe, hopefully, the benefits of a pregnancy and perhaps its risk because, depending—not all pregnancies are without complications. So this is consulting about a medical condition. How is that any different than *Casey*? You come in to talk to an—a doctor about abortion.”<sup>108</sup> NIFLA’s attorney responded that this was different because *Casey* applied to doctors, and NIFLA is not a medical provider. Justice Sotomayor responded, “now you’re redefining medicine.”<sup>109</sup> Indeed.

If the Court had focused on the reasonable perspective of the listener, and analogized the CPCs to medical providers, it would have been fairly simple for the Court to allow the disclosures as part of the proper regulation of medicine and/or professional speech. It is patently unjust to allow CPCs to deceive women, and then not allow states to correct this deception through disclosure requirements that target the deception where it occurs.

With *Zauderer* and *Casey* out of the way, the Court still needed to demonstrate that the regulation was not narrowly tailored. Here, the Court missed a step by suggesting (but not finding) that the Act discriminated based on viewpoint and interpreting any evidentiary ambiguity in favor of NIFLA. While “the Government bears the burden of proof on the ultimate question [of the statute’s] constitutionality,”<sup>110</sup> the Court was overly dismissive of California’s evidence regarding the need for tailoring its statute in the way that it did. Namely, the Court dismissed the evidence that a public outreach campaign would be ineffective and would leave many women vulnerable to the CPC’s deceptive practices.<sup>111</sup>

NIFLA argued that the Act discriminated based on viewpoint because it exempted facilities that enroll patients in state-funded reproductive programs, which include abortion. By exempting these clinics, they argued, “the statute unnecessarily imposes a disproportionate burden upon facilities with pro-life views, the very facilities most likely to find the statute’s references to abortion

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108. Oral Argument at 14:55, *Nat’l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [<https://perma.cc/4HRK-9JQQ>].

109. *Id.* at 17:00.

110. *Ashcroft v. ACLU*, 542 U.S. 656, 666 (2004).

111. “The record also shows the licensed facilities notice requirement is appropriately tailored to advance the interest of ensuring that pregnant women are informed about their health care options. Indeed, the requirement is narrowly tailored. As the Legislature recognized, pregnancy decisions are time sensitive and care early in pregnancy is critical. Thus, women need to be notified of available resources as soon as possible. *See* Assem. Bill No. 775, § 1(a)-(d). The time-sensitive nature of pregnancy makes other policy options—such as a statewide advertising campaign, for example—unavailable to the Legislature. As the author of AB 775 stated, the most effective way to make sure that pregnant women obtain the information and services they need during pregnancy in a timely way is to require a licensed health care facility to provide the required notice, especially if the facility does not provide the full spectrum of health care services.” *Defendants’ Opposition to Plaintiffs’ Motion for Preliminary Injunction* at 32, *Nat’l Inst. of Family & Life Advocates v. Kamala Harris*, 2015 WL 13649183 (S.D. Cal. Nov. 13, 2015) (No. 3:15-cv-02277-JAH-DHB).



morally abhorrent.”<sup>112</sup> But, as Breyer points out in his dissent, the evidentiary record was insufficient on this score. The district court found that the exemption made sense because the exempted clinics “provide the entire spectrum of services required of the notice.”<sup>113</sup> Absent discovery, there was no evidence that the Act disproportionately and unfairly impacted CPCs. True, poor pregnant women might visit exempt clinics, and they might benefit from the disclosure that the state offers low-cost or free reproductive options. But there was nothing in the record to suggest that the exempt clinics were not *already* providing this information, as respondents claimed.<sup>114</sup>

The Court reasoned that if the state interest was in informing women that state-funded public health options were available, California should have required all clinics to disclose this availability, and not just those that fail to offer the relevant services. In oral argument, the state’s attorney attempted to argue that it limited the compelled speech to only those speakers necessitating the disclosure. The Act *could* have been deemed over-inclusive if it had required clinics providing abortion and contraception to advertise the availability of state-funding for the same, without any evidence that this disclosure was necessary. Indeed, in discussing the unlicensed disclosure, the *NIFLA* Court recognized that “disclosures [must] remedy a harm that is ‘potentially real not purely hypothetical’ and the remedy must extend “no broader than reasonably necessary.”<sup>115</sup> The state of California argued that it targeted the CPCs because that is where the deception existed, as there was no documented failure to inform women of state-funded reproductive services by private clinics offering general obstetric services. Regardless, the appearance of regulating a pro-life perspective

112. Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 2388-89 (2018) (citing Brief for Petitioners 31-37).

113. See Nat’l Inst. of Family & Life Advocates v. Harris, No. 15CV2277 JAH(DHB), 2016 WL 3627327, at \*10 (S.D. Cal. Feb. 9, 2016), *aff’d*, 839 F.3d 823 (9th Cir. 2016), *cert. granted in part sub nom.* Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 464, 199 L. Ed. 2d 328 (2017), *and rev’d and remanded sub nom.* Nat’l Inst. of Family & Life Advocates v. Becerra, 138 S. Ct. 2361, 201 L. Ed. 2d 835 (2018), *and rev’d in part, vacated in part sub nom.* Nat’l Inst. of Family & Life Advocates v. Becerra, 902 F.3d 900 (9th Cir. 2018). For defendants’ arguments on this point, see also Defendants’ Opposition to Plaintiffs’ Motion for Preliminary Injunction at 24-25, Nat’l Inst. of Family & Life Advocates v. Kamala Harris, 2015 WL 13649183 (S.D. Cal. Nov. 13, 2015) (No. 3:15-cv-02277-JAH-DHB). “The notice requirement is also narrowly tailored to the stated interest of ensuring that pregnant women are aware of the full spectrum of pregnancy-related health care services in California because the specific language of the notice speaks to that entire spectrum. In other words, the notice does not simply mention ‘abortion.’ Rather, the notice inclusively refers to ‘comprehensive family planning services’ (including all FDA-approved methods of *contraception*), *prenatal care*, and *abortion* for eligible women.’ § 123472(a)(1). To put it another way, the notice does not express a particular opinion or view, or make a specific recommendation. It simply conveys the objective range of information—no more.” *Id.*

114. Nat’l Inst. of Family & Life Advocates v. Harris, 839 F.3d 823, 844-45 (9th Cir. 2016); *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2377.

115. *Nat’l Inst. of Family & Life Advocates*, 138 S. Ct. at 2377 (citing *Ibanez v. Florida Dep’t of Business & Professional Regulation*, 512 U.S. 136, 146 (1994); *In re R.M.J.*, 455 U.S. 191, 203 (1982); *accord* *Virginia Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 772 n.24 (1976); *Bates v. State Bar of Arizona*, 433 U.S. 350, 384 (1977); *cf. Zauderer*, 471 U.S. at 649 (rejecting “broad prophylactic rules” in this area)).

led the Court, and Justice Kennedy in his concurrence,<sup>116</sup> to find that this part of the legislation was probably viewpoint discrimination, and, at the very least, was “wildly underinclusive,”<sup>117</sup> and thus failed strict scrutiny.<sup>118</sup>

### C. *NIFLA Allows Ideological Speakers to Deceive*

The problem with classifying the speech of CPCs is that they are less deceptive in the disclosures they provide online. After requiring several clicks, the CPC website will state that they do not provide abortions and they counsel from a pro-life, Christian perspective. However, many of the women seeking a CPC’s services might never visit its website. If they do, they might not read the fine print in the online disclaimers, or successfully click through the pseudo-clinical content to get to their ideological disclosures. This disparity allows CPCs to advertise as medical clinics but be regulated as ideologues.

In finding that the CPCs are ideological speakers, the Court ignored the perspective of the listener. As one scholar explained, “the state’s regulatory authority may be triggered by the fact that an individual holds herself out as a professional, whether she is actually a professional or not.”<sup>119</sup> This suggests that the clandestine intent of the speaker should not control. If the listener reasonably believes, based on the objective manifestations of the speaker, that the speaker is professional, then the speaker’s private, secretive ideology should not provide for greater First Amendment protection. This view makes abundant sense if the state’s interest in passing the disclosure ordinance was to protect consumers. Unfortunately, this is not the approach that the majority took in *NIFLA*.

Given how politicized access to abortion has become, it is no surprise that the First Amendment has protected politicized speech around abortion services. However, the *NIFLA* opinion goes further than necessary to protect deception. In so doing, the opinion signals to legislatures that consumer protection statutes cannot provide an effective remedy against CPCs’ deceptive practices. Even if California gathered sufficient evidence that demonstrated the need to correct CPC’s deceptive practices, the state would still face the hurdle of this speech being considered purely ideological. Further, the current Court sent strong

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116. *Id.* at 2379 (Kennedy, J., concurring) (“It does appear that viewpoint discrimination is inherent in the design and structure of this Act.”).

117. *Id.* at 2375 (quoting *Brown v. Entm’t Merchs. Ass’n*, 564 U.S. 786, 802 (2011)).

118. *Id.* at 2375-76.

119. Hill, *supra* note 2 at 62 (“In *Lowe*, the investment adviser had been de-registered and therefore was no longer technically a licensed professional, but neither Justice White nor Justice Stevens, writing for the majority, seemed to consider this fact relevant to whether he was engaged in professional speech. Similarly, the Fourth Circuit, in considering whether a county could require fortune tellers to have permits and pay fees in order to operate, applied professional speech standards, although the notion of including fortune tellers in the same category as doctors and lawyers may, at first glance, seem to be a stretch. In placing this label on the fortune-teller’s speech, the court emphasized the personalized nature of the client relationship and the special need for consumer protection, which meant that the state could require her speech to be licensed.”).

signals that they would dismiss public health state interests as not being sufficiently compelling. This indicates a tremendous amount of judicial deference to the CPCs' speech. If states want to effectively curb CPCs' deceptive practices, they will need to pursue other avenues.

## II. REGULATING CPCs THROUGH TORT LAW

### A. *Legal Tools Discussed Thus Far Require the Political Will of Elected Officials*

There are myriad legal tools in the arsenal of the state attorneys general or legislators who would like to eliminate the misleading practices of pseudo-clinics, such as CPCs.

The biggest disadvantage to the public consumer protection statutes that will be discussed, *infra*, at Section IV, is that each requires the political will of elected officials to prosecute CPCs. A private individual cannot prosecute a CPC that deliberately misleads women, engages in the unauthorized practice of medicine, or promotes unapproved uses of an FDA-approved device. Unfortunately, elected officials, including county or state prosecutors, frequently choose not to champion the rights of women or support women's reproductive choices. This means that private women, especially those who live in conservative states, cannot rely on these consumer protection statutes and regulations to challenge the CPCs. Without a legal remedy, the rights these measures seek to protect are meaningless.

### B. *Tort Law Puts the Injured Party in the Driver's Seat*

It is in this space, where something is either under-regulated or regulations are under-enforced, that the law of torts does its best and most useful work. This Article advocates that individual women should sue CPCs in tort law for the intentional tort of battery. While this approach presents its own challenges related to the emotional and financial burdens of litigation, as well as the fact that the litigation comes after the harm has occurred, it still has significant advantages over passively waiting for prosecution under consumer protection statutes. Tort law puts the injured party in the driver's seat. In contrast to public actions, which typically involve the remedy of injunctions, a battery lawsuit allows the plaintiff to receive some compensation from the CPCs, which might include punitive damages. Finally, it does not in any way undermine public officials' ability to enforce deceptive CPC practices through other means. Tort law can work in tandem with public efforts to minimize the deceptive and harmful practices of CPCs. But, when officials sit on their hands and allow consumers to be deceived, torts are a terrific remedy.

A tort claim would function something like the following. Any time that a woman is touched by a CPC staff member, if the touching is only consented to through deception by the CPC, she should be able to prevail on a civil battery claim. Battery honors the individual's dignity and is not deferential to an industry standard of care, unlike a case for medical malpractice, which would apply only if the CPCs were licensed, professional health care providers.

Before explaining why the battery tort is such a great tool for women who have been injured by a CPC to seek redress, this Article will discuss the history and purpose behind this old intentional tort, and the ways in which TRAP laws have perverted the doctrine of battery and informed consent. The use of battery in this context might help redefine and reclaim this doctrine, to challenge the frequent pro-life blurring of the medical with the ideological. Informed consent means something; it is not merely a vehicle through which to shoehorn ideology.

### C. *The History of Battery and its Elements*

The battery cause of action is one of the oldest torts, and has deep roots in our common law's desire to protect the personal dignity of individuals and their ability to decide how, by whom, and under which circumstances they are touched. This is one of the most basic rights in our common law. To make out a civil claim of battery, a plaintiff must prove that each of these elements is more likely than not to have occurred: (1) the defendant intentionally touched the plaintiff (2) in a way that was objectively harmful or offensive and (3) the plaintiff did not consent to the touching, nor was it privileged (say, as part of a lawful police arrest).<sup>120</sup>

Pregnant women who were misled about the purpose of their visit to the CPC may bring battery claims against the CPC staff who touched them in offensive ways, violating their personal dignity.<sup>121</sup> A pregnant woman who is examined by a CPC volunteer and physically touched—including having her pulse taken, but especially undergoing a vaginal exam or ultrasound—could rather easily make out a battery claim if she reasonably finds the touching offensive because she consented to the touching under false pretenses.<sup>122</sup> The minority of women who are not touched by CPC staff, perhaps because they came in for counseling and left before being seen by one of their volunteers, would not be able to bring a battery claim. However, it is the physical touching and examination of pregnant

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120. 6 AM. JUR. 2D *Assault and Battery* § 85 (2018).

121. W. Page Keeton et al., PROSSER AND KEETON ON THE LAW OF TORTS § 9, 41 (5th ed. 1984) (“The element of personal indignity involved always has been given considerable weight. Consequently, the defendant is liable not only for contacts which do actual physical harm, but also for those relatively trivial ones which are merely offensive and insulting.”); RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 101 (AM. LAW INST., Tentative Draft No. 1, 2014).

122. Campbell, *supra* note 22, at 75 (“The nurse attempted an external ultrasound, but because she claimed that the images were unclear, the nurse told Nicole she needed to perform a transvaginal scan instead, without explaining the intricacies of the procedure.”).

women that leads to the dangers this Article seeks to prevent, as the pregnancy evaluations and exams are the pseudo-medical activities that create the false sense that the pregnant women are being seen by licensed physicians. Where women are only receiving pamphlets, there is less of a risk that they will delay obtaining proper medical care as a result.

1. *Plaintiffs Do Not Need to Prove the CPCs Physically Injured Them*

Contrary to popular understanding, the intentional touching need not bruise or physically injure the plaintiff if the claim is for *offensive* touching.<sup>123</sup> The “grievance consists in the offense to the dignity involved in the unpermitted and intentional invasion of the inviolability of his person and not in any physical harm done to his body.”<sup>124</sup> Examples of offensive touching include spitting in someone’s face,<sup>125</sup> removing someone’s hat,<sup>126</sup> or tackling someone too aggressively in a junior-high football league.<sup>127</sup>

Further, the plaintiff need not even be aware at the time that a battery took place. The insult to the plaintiff’s integrity “is as keenly felt by one who only knows after the event that an indignity has been perpetrated upon him as by one who is conscious of it while it is being perpetrated.”<sup>128</sup> Thus, a surgeon who examines an anesthetized person without her consent could be liable for a battery. So too could a man who kisses a woman, without waking her, while she is asleep.<sup>129</sup>

2. *Plaintiffs Do Not Need to Prove that the CPC Had Malicious Intent*

To satisfy the intentional component of the battery claim, courts merely require that the touching was voluntary and the defendant intended to make contact with someone’s person. This just means that the actor’s movement cannot be the result of an automatic reflex, such as a knee-jerk reaction, epileptic seizure, or coercion.<sup>130</sup> There is no required intent to injure or offend, and there is no need to prove that the actor was “inspired by any personal hostility.”<sup>131</sup> Indeed, even a friendly practical joke can lead to a battery claim.<sup>132</sup> While courts continue to bungle this standard, it remains the black letter common law,

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123. Richard J. Kohlman, *Assault and Battery*, 1 AM. JUR. PROOF OF FACTS 613 (3d ed. 2017).  
 124. RESTATEMENT (SECOND) OF TORTS § 18 (AM. LAW INST. 1965).  
 125. *Alcorn v. Mitchell*, 63 Ill. 553 (1872); *Draper v. Baker*, 21 N.W. 527 (1884).  
 126. *Seigel v. Long*, 53 So. 753 (1910).  
 127. *Koffman v. Garnett*, 574 S.E.2d 258 (2003).  
 128. RESTATEMENT (FIRST) OF TORTS § 18 (AM. LAW INST. 1934).  
 129. *Id.*  
 130. RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 101 (AM. LAW INST., Tentative Draft No. 1, 2014).  
 131. RESTATEMENT (SECOND) OF TORTS § 13 (AM. LAW INST. 1965).  
 132. *Id.* § 19; *see also id.* § 20 (1965); *Fuerschbach v. Southwest Airlines*, 439 F.3d 1197, 1209 (Cal. 2006).

endorsed by the Restatement of Torts, that defendants need not intend to cause a harmful touching.<sup>133</sup> They need merely intend to touch the plaintiff, in a way that *turns out to be* harmful or offensive.<sup>134</sup>

### 3. *Plaintiffs Must Prove the Touching Was Objectively Offensive*

To be objectively offensive, the touching must offend a community standard of what is considered appropriate. It is not enough that the individual herself be subjectively offended. Thus, a hug might not be objectively offensive, so long as it was not accompanied by other inappropriate language or intimidation. Touching someone's shoulder in a crowded subway would likely also fail to be objectively offensive. The context matters greatly, and courts factor in the "usages of a decent society," "polite manners," and touching that is "customary . . . in the course of life."<sup>135</sup> The factfinder should consider any power imbalance, exploitation, or subordination in determining whether the touching is offensive.

There is nothing customary or polite about allowing a stranger to touch your body, assess your medical situation, and offer personal reproductive advice—all under false pretenses. No one could say that it is unreasonable to be offended by such things. When we agree to the *most intimate* form of examination, and the most intimate form of counseling, it is not unreasonable to only do so when we think the person touching us is a licensed medical provider. A reasonable jury could easily find the touching by CPC staff offensive, even if a few pregnant women testified for the defense that they were not personally offended by fraudulent touching at the pseudo-clinics.<sup>136</sup> Just as it does not matter whether one person might not find an uninvited kiss, or blowing smoke in one's face, offensive, it does not matter whether a minority of women find the touching unobjectionable. The question for the courts is whether it is *objectively reasonable* for this plaintiff to be offended by the violation of her personal dignity, once she realizes the real motivation of the CPC.

It is hard to imagine a touching that could be more offensive—asking a woman to expose her belly or submit to a vaginal exam, revealing private information about a pregnancy or a fetus that is growing inside of her (and possibly information about miscarriage or anatomical defects). If the woman agrees to this, it is almost always because she considers this to be a clinical

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133. RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 101 (AM. LAW INST., Discussion Draft, 2014).

134. "The fact that the Wagners allege that Mr. Giese could not have intended to harm her, or understood that his attack would inflict injury or offense, is not relevant to the analysis of whether a battery occurred. So long as he intended to make that contact, and so long as that contact was one to which Mrs. Wagner had not given her consent, either expressly or by implication, he committed a battery." *Wagner v. Utah Dep't of Human Servs.*, 122 P.3d 599, 610 (Utah 2005).

135. *Id.* at 609 ("[F]or example, someone who shakes his hand against his silent wishes has not committed a harmful or offensive contact.").

136. *Glover v. Opleman*, 178 F. Supp. 2d 622, 641 (W.D. Va. 2001).

encounter, and not an ideological one. If the CPC's deceptive touching is not a violation of one's dignity and right to control who gets to touch oneself, then it is hard to see what would be. The only way a judge could find that this sort of unconsented-to touching was *not* a battery would be by misapplying the common law of civil battery for political ends. Indeed, the CPCs must know that women would not otherwise consent to such touching, or they would not work so hard, and fight all the way up to the Supreme Court, to deceive women in their advertising practices. Why do the CPCs try to take control of the conversation and mislead women about the nature of their services? Because they know that without the misleading tactics, they would not be granted access to pregnant women's bodies.

#### 4. *Misrepresentations Vitiates Consent*

In some states, the plaintiff needs to prove that the touching was not consented to, while in other states this is an affirmative defense the defendant must raise. Either way, if it is shown that the plaintiff reasonably misunderstood the purpose of the touching, due to misrepresentations by the defendant, then consenting to the medical exam or procedure will not bar her claim. Courts have long recognized that a plaintiff might have technically consented to a blood draw, for example, but thought the blood draw was for medical purposes. If the blood draw were instead for law enforcement purposes, the consent is invalid.<sup>137</sup>

The "crux of a battery claim is an absence of consent on the part of the plaintiff."<sup>138</sup> Consent is contextual. A famous Torts treatise even uses a medical example to make this point. It states: the "plaintiff who consents to manipulation of her body in the belief that it is for medical purposes, when in fact it is only for the sexual gratification of the defendant," can have a cause of action for battery.<sup>139</sup> You could substitute "sexual gratification" for "attempting to do God's work" and the same premise holds. The action for battery recognizes that the individual has a right to exclude others from touching her and to control the way they do so. Full stop.

There are four different types of consent applicable to our facts, and satisfying the criteria for any of them would preclude liability: actual consent; apparent or implied consent; constructive consent; and the emergency doctrine.<sup>140</sup> However, none of these categories of consent apply to preclude liability for the CPCs. First, there is no actual (express or implied) consent in the

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137. O'Brien v. Synnott, 72 A.3d 331, 335-36 (Vt. 2013).

138. Shaw v. Brown & Williamson Tobacco Corp., 973 F. Supp. 539, 547 (D. Md. 1997).

139. DAN B. DOBBS ET AL., THE LAW OF TORTS § 111 (2d ed. 2018).

140. RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 111 (AM. LAW INST., Discussion Draft, 2014).

case where a pregnant woman is never explicitly told that the medically costumed volunteer is in fact unlicensed.<sup>141</sup>

Likewise, the CPC cannot rely on “reasonably apparent consent,” or implied consent.<sup>142</sup> While a patient might consent to “ordinary physical contacts that are medically necessary” when she visits her doctor for her annual physical, consent to the CPC cannot be inferred from the facts. In the oft-cited case of *O’Brien v. Cunard S.S. Co.*,<sup>143</sup> the evidence that plaintiff held out her arm to be vaccinated, in a line of people exiting a ship, demonstrated not only that the defendant reasonably believed that she consented, but also that she *did* consent. This sort of implied consent is not present here; the pregnant woman is not implicitly consenting to a medical exam by the CPC. She is consenting to an exam by a different person and in a different context.

While a defendant would not be liable for battery if a reasonable person in the position of the actor believes that the would-be plaintiff consented to the actor’s otherwise tortious conduct,<sup>144</sup> it would be unreasonable for a CPC staff member to believe that the pregnant woman had truly consented, given the CPC’s ideological agenda. As mentioned above,<sup>145</sup> CPC staff are trained in applying deceptive practices to persuade women to carry the fetus to term. CPCs take advantage of these women’s relative lack of education, money, and insurance to deceive them into thinking they are receiving medical, as opposed to ideological, care. Given their deceptive playbook, and the fact that they do not tell pregnant women who appear at their clinics that they are unlicensed medical providers who do not provide the full range of reproductive services, consent to the touching cannot be inferred or apparent from the facts. Indeed, given how CPCs deliberately locate very near Planned Parenthoods and adopt clinically-sounding names, the very reasonable and clear intention of CPCs is to gain access to women’s bodies through deception, not informed consent.

Further, as discussed above under the “objectively offensive” element of battery, there is no constructive consent either. Several courts have recognized that “in a crowded world, a certain amount of personal contact is inevitable, and must be accepted. Absent expression to the contrary, consent is assumed to all those ordinary contacts which are customary and reasonably necessary to the

141. “Express consent may be given by words or affirmative conduct and implied consent may be manifested when a person takes no action, indicating an apparent willingness for the conduct to occur. The consent must be to the ‘defendant’s conduct, rather than to its consequences.’ A plaintiff’s consent is not effective if ‘the consenting person was mistaken about the nature and quality of the invasion intended by the conduct.’” *Barnes v. Am. Tobacco Co.*, 161 F.3d 127, 148 (3d Cir. 1998).

142. “If words or conduct are reasonably understood by another to be regarded as consent, they constitute apparent consent and are as effective as consent in fact...In determining whether conduct would be understood by a reasonable person as indicating consent, the customs of the community are to be taken into account.” *Dubbs v. Head Start, Inc.*, 336 F.3d 1194, 1219 (10th Cir. 2003).

143. 28 N.E. 266 (Mass. 1891).

144. RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 115 (AM. LAW INST., Discussion Draft, 2014).

145. See *supra* note 35 and accompanying text.



common intercourse of life.”<sup>146</sup> Examples of this include touching someone while hastily exiting a building during a fire alarm or brushing up against someone on a crowded bus. In those circumstances, there is something like a social necessity argument, as affordable public transportation requires “minor contact between passengers.”<sup>147</sup> Commuters are thought to consent to this touching, as they are aware of the crowded nature of most public transit and nonetheless agree to this mode of transportation. But there is no such social consent in the present case. Pregnant women are not agreeing to a certain amount of battery in order to take advantage of a public good.

Finally, emergency consent is not applicable. The emergency consent doctrine “reflects a narrow set of circumstances in which the actor reasonably believes that plaintiff *would* have consented, if he or she had the opportunity to do so, *and* in which it is imperative not to wait to see whether plaintiff really does consent.”<sup>148</sup> In the kinds of cases contemplated here, there is plenty of time to obtain the pregnant woman’s consent. Failure to do so is not because there is an urgent, life-threatening clinical need that prevents asking the woman. The only reason the consent is not explicit is because the CPCs appreciate that they will lose access to women’s bodies if they are transparent about their ideological purpose.

Thus, CPCs cannot avail themselves of any of the relevant types of consent to preclude their liability. CPCs that misled a woman into thinking that the purpose of the exam was to diagnose a pregnancy, or to offer medical counseling or advice, when the real purpose is to counsel the woman on pro-life, Christian ideology, would most certainly be liable in battery. To reiterate, where the consent to a procedure or touching is premised on fraud or misrepresentations, there is no valid consent.<sup>149</sup>

### 5 *Battery Claims Do Not Balance the Rights to Batter Against the Right Not to Be Battered*

Contrary to the First Amendment analysis in *NIFLA* or the structure of consumer protection or even medical malpractice laws, which might give too much deference to the defendant’s viewpoints or purpose, here, the reasons *why*

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146. RESTATEMENT (THIRD) OF TORTS: INTENTIONAL TORTS TO PERSONS § 117 (AM. LAW INST., Discussion Draft, 2014).

147. *Id.* The Restatement adds, “Minor contact between passengers is reasonably necessary to achieve that [affordable and efficient public transit] social value.” *Id.*

148. *Id.* § 118.

149. “The plaintiff’s purported consent is ineffective to bar her claim if it is induced by misrepresentation or is given under a material mistake of which the defendant is or should be aware. The mistake is frequently though not always induced by the defendant’s fraud or misrepresentation. Many cases decided in many settings summarize the point by saying that ‘fraud vitiates consent’ or that consent is ineffective if given as a result of fraud, meaning that the plaintiff in such a case can recover.” DOBBS ET AL., *supra* note 139.

the defendant battered the plaintiff are largely irrelevant.<sup>150</sup> When the touching is not consented to, courts do not balance the interests of the batterer against the interests of the battered. The battery cause of action is about protecting the inviolate dignity of the individual person. In keeping with this, battery is not a paternalistic or ideological doctrine. The defendant cannot argue that they failed to disclose a material fact about the procedure in order to avoid any psychological harm to the plaintiff.<sup>151</sup> Where the First Amendment may be interpreted in a way that protects misleading practices by CPCs, battery does not spare defendants who deliberately mislead.

#### D. *The Relationship Between Battery and Informed Consent*

In recent years, many states have passed special informed consent laws that are exclusive to the abortion context. These Targeted Regulation of Abortion Provider (TRAP) laws require abortion providers to say specific things to pregnant women as part of the informed consent process. Given that informed consent as a legal and ethical doctrine developed from the tort of battery, it will be useful to discuss how this occurred, in order to understand how these TRAP laws pervert the very notion of informed consent.

Historically, informed consent suits began as intentional torts for unconsented-to touching by physicians, even where the care received was not negligent. One of the first cases to recognize the trespass to persons against a surgeon who operated on someone without her consent was *Schloendorff v. Society of New York Hospital*.<sup>152</sup> In this 1914 case, the plaintiff claimed that the hospital staff removed her stomach tumor while she was under anesthesia, despite her explicit requests that they not do so.<sup>153</sup> In deciding that the hospital could be liable for a battery, if not for negligence, Judge Cardozo famously stated that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages.”<sup>154</sup> A 1913 Oklahoma case further recognized that the skillful removal of a patient’s bone could constitute a battery, where the patient had not consented

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150. “[M]any torts that are classified as intentional differ from torts of negligence not so much because they represent a more serious degree of fault, but because they exhibit a type of fault not appropriately governed by the ‘reasonable care’ paradigm: They focus on protection of carefully defined interests (such as freedom from confinement, and choice about medical treatment or other physical touchings), while they limit legal protection to the most deliberate kinds of intrusions on these interests.” Kenneth W. Simons, *A Restatement (Third) of Intentional Torts?*, 48 ARIZ. L. REV. 1061, 1100 (2006).

151. *Kohoutek v. Hafner*, 383 N.W.2d 295, 299 (Minn. 1986).

152. *Schloendorff v. Soc’y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

153. *Id.*

154. *Id.*

to its removal.<sup>155</sup> Thus, even where there is not negligence, there can be a medical battery.

In the medical context, the intentional tort has morphed into a negligence cause of action in all but a few states.<sup>156</sup> This is because enough of a norm has developed through medical ethics and practice to say that the failure to provide relevant medical information to a patient, about the purpose and risks of their treatment, is now a breach of the professional standard of care. The American Medical Association has issued an ethics opinion, which states that “informed consent to medical treatment is fundamental in both ethics and law.”<sup>157</sup> For medical professionals, what started as a battery is now considered medical malpractice. Where CPC facilities and staff are licensed as medical providers in their states, then, pregnant women should sue them for ordinary negligence *and* medical malpractice. Because it is recognized that medical providers should inform women of the purpose of their care, as well as the risks and benefits of any procedures, an informed consent claim should be easy to demonstrate. Importantly, while the Supreme Court declared in *NIFLA* that CPCs are not practicing medicine, and therefore the informed consent requirements of *Casey* did not apply, it is up to the states, and not federal courts, to determine whether entities are practicing medicine and subjected to professional malpractice claims under state law.<sup>158</sup>

*Canterbury v. Spence*, one of the early cases to describe the tort of informed consent, stated that “[t]rue consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.”<sup>159</sup> Today, making out a case for informed consent requires proving that the defendant breached a standard of care in terms of what reasonable physicians would share with a patient, or what prudent patients would find material to their decision to elect or

155. *Rolater v. Strain*, 137 P. 96, 97 (Okla. 1913).

156. “Often informed consent claims blur into malpractice claims.” JANET DOLGIN & LOIS SHEPHERD, *BIOETHICS AND THE LAW* 59 (Wolters Kluwer ed., 2d ed. 2009). See Bryan J. Warren, *Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach*, 38 DUQ. L. REV. 917, 918 (2000); see also *Sard v. Hardy*, 379 A.2d 1014 (Md. 1977). But see *Perez v. Hu*, 87 N.E.3d 1130, 1135 (Ind. Ct. App. 2017) (“Lack of informed consent is viewed as a battery claim if there is an alleged complete lack of consent to medical treatment, but otherwise it is ‘regarded as a specific form of negligence for breach of the required standard of professional conduct.’”); *Strachan v. John F. Kennedy Memorial Hosp.*, 507 A.2d 718 (N.J. Super. Ct. App. Div. 1986).

157. Code of Medical Ethics Opinion 2.1.1, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/informed-consent> [<https://perma.cc/6ARD-Z9WT>] (last visited Nov. 19, 2018).

158. The joint opinion in *Casey* explained that the law regulated speech only “as part of the *practice* of medicine, subject to reasonable licensing and regulation by the State.” *Casey*, 505 U.S. at 884. (emphasis added). Indeed, the requirement that a doctor obtain informed consent to perform an operation is “firmly entrenched in American tort law.” *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990). See, e.g., *Schloendorff v. Society of N.Y. Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (explaining that “a surgeon who performs an operation without his patient’s consent commits an assault.”).

159. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

forego treatment.<sup>160</sup> The former standard asks what information a reasonable physician would provide, and reflects the idea that physicians cannot read patients' minds to know what each would subjectively want to know. The latter "prudent patient" standard is applied in a slight minority of states, and focuses on the "risks, benefits, and options that a reasonable patient would want to know in reaching a treatment decision."<sup>161</sup> It is rooted in patient autonomy, and recognizes that while the physician may have expertise in clinical decision-making, she is not an expert in what reasonable patients would want to have disclosed.

### 1. *TRAP Laws Pervert the Doctrine of Informed Consent*

Ironically, an article about abortion access could not address battery and informed consent without recognizing the absurd turns the doctrine has taken under states' TRAP laws. TRAP laws are

part of anti-abortion activists' strategy to chip away at the legal availability of abortion . . . by heavily regulating the practice of providing abortions. These laws are examples of abortion exceptionalism, in which abortion is singled out for more restrictive government regulation as compared to other, similar procedures.<sup>162</sup>

Legislators often justify these TRAP laws as being necessary for true informed consent, and many TRAP laws are placed in sections of the state code that apply to medical informed consent generally. A majority of states have such laws, which place requirements on abortion providers "that are more demanding than for any other medical procedure."<sup>163</sup> Occasionally, these TRAP laws pervert the legal and ethical doctrine of informed consent.

For example, under the guise of "informed consent," many states require physicians to provide specific, and sometimes misleading, information to women. An analysis of the mandatory pre-abortion informed consent materials in 23 states revealed that 45 percent of the statements about first trimester fetal development were medically inaccurate.<sup>164</sup> Examples of inaccuracies included

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160. "In slightly over half the states, the legal standard for disclosure to patients is that which a 'reasonable medical practitioner' would provide. This professionally defined standard is often that of the locality in which the practitioner works, or a similar locality. The disclosure standard in most other jurisdictions is that which would be sought by a prudent or reasonable patient, a standard that emphasizes the value of patient autonomy over that of professional judgment." Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 916 (1994).

161. DOLGIN, *supra* note 156, at 49-50.

162. Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 2-3 (2012).

163. *Id.* at 13.

164. Cynthia Daniels, et al., *Informed or Misinformed Consent, Abortion Policy in the United States*, 41 J. OF HEALTH POL., POL'Y & L. 181, 193 (2016).

statements such as “brain activity can be recorded” at four-weeks’ gestation, or other statements that reported “baby-like” behaviors before they could be seen.<sup>165</sup>

In addition to misinformation related to the development of the fetus, Missouri requires that the physician inform the pregnant woman that “[t]he life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being.”<sup>166</sup> Of course this blurs objective clinical information with religious ideology. It is ethically unsound to ask physicians to deliver propaganda for conservative legislators, shrouded in the veil of professional judgment. In any event, this uses the legitimate and professional voices of physicians as shoehorns for ideology, by erroneously treating it like other forms of medical informed consent.

In Texas, women must be incorrectly told that having an abortion “may make it difficult or impossible to become pregnant in the future or carry a pregnancy to term.”<sup>167</sup> In South Dakota, women are given information that abortion increases the risk of infertility, without making it clear that only a highly unlikely complication will increase this risk.<sup>168</sup> Indiana provides some caveats, but the informed consent materials nonetheless leave the reader with the impression that abortion carries with it an increased risk of infertility and complications with future pregnancies.<sup>169</sup> Of course, this depends greatly on the gestational age of the fetus. Unqualified statements about abortion causing infertility are medically inaccurate, and yet physicians are required to share this false data in at least four states.<sup>170</sup> In Indiana, pregnant women must be told that the fetus must be either buried in an “established cemetery” or “cremated” by the abortion clinic.<sup>171</sup>

In thirteen states, women must be instructed on the ability of a fetus to feel pain.<sup>172</sup> In Utah, physicians must share with pregnant women the puzzling statement that “substantial medical evidence” has shown that the “fetus is capable of feeling pain,” and thus anesthesia must be provided if the abortion is

165. *Id.* at 191, 195.

166. MO. DEP’T OF HEALTH & SENIOR SERVICES, MO. INFORMED CONSENT BOOKLET, <http://health.mo.gov/living/families/womenshealth/pregnancyassistance/pdf/InformedConsentBooklet.pdf> [<https://perma.cc/V7XW-YBZ8>].

167. TEX. DEP’T OF HEALTH, A WOMAN’S RIGHT TO KNOW 17 (2003), <http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf> [<https://perma.cc/3JHP-YAMG>].

168. S.D. CODIFIED LAWS § 34-23A-10.1 (2017).

169. IND. STATE DEP’T OF HEALTH, ABORTION INFORMED CONSENT BROCHURE 6, [https://www.in.gov/isdh/files/Abortion\\_Informed\\_Consent\\_Brochure.pdf](https://www.in.gov/isdh/files/Abortion_Informed_Consent_Brochure.pdf) [<https://perma.cc/AZT3-VSVB>].

170. *Counseling and Waiting Periods for Abortion*, GUTTMACHER INSTITUTE, Oct. 2018, <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion> [<https://perma.cc/GK7T-BRDG>].

171. IND. STATE DEP’T OF HEALTH, *supra* note 169, at 11.

172. GUTTMACHER INSTITUTE, *supra* note 170. For a constitutional analysis, see I. Glenn Cohen & Sadath Sayeed, *Fetal Pain, Abortion, Viability, and the Constitution*, 39 J. L., MED., & ETHICS 235 (2011).

performed after 20 weeks' gestation.<sup>173</sup> First, there is no substantial evidence of this,<sup>174</sup> and second, providing anesthesia would impose a significant risk on the pregnant woman and the fetus that may not be clinically justified. Requiring anesthesia after 20 weeks, for every pregnancy, violates norms of professional ethics, as the physician should not do harm to the patient that is not balanced by some corresponding benefit.<sup>175</sup>

The presence of these “fetal pain” laws is even more confounding given that full-term, natural childbirth can be very painful for the baby. Objectively, this is a stressful event. Their 40 week skulls are compressed, their heart rate increases, and their bodies are mangled—but there is no requirement that a vaginal delivery be preceded by anesthesia in Utah or elsewhere. The discrepancy between the requirement that physicians administer anesthesia during abortions at 20 weeks, but not at full-term vaginal deliveries, reveals the true purpose behind these laws—to discourage women's reproductive choices. Requiring a doctor to deliver this message again blurs the line between the clinical and the ideological. This is quite dangerous in a society predicated on secular delivery of health care and freedom of religious exercise. Indeed, the informed consent laws of Missouri are presently being challenged by a religious group that claims that in their view, human life does not begin at conception, and the informed consent materials violate the Establishment Clause by endorsing Christian ideology.<sup>176</sup>

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173. UTAH CODE ANN. §§ 76-7-305, 76-7-308.5 (Deering 2018) (“ . . . [s]ubstantial medical evidence from studies concludes that an unborn child who is at least 20 weeks gestational age may be capable of experiencing pain during an abortion procedure . . . and the physician “shall administer an anesthetic or analgesic to eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed.”).

174. Madeleine Verriotis et al., *The Development of the Nociceptive Brain*, 338 NEUROSCIENCE 207, 208 (2016) (“How and when this complex brain network develops to encode noxious stimuli and create the experience of pain is an important area of current research.”). See also Curtis Lowery et al., *Neurodevelopmental Changes of Fetal Pain*, 410 SEMINARS IN PERINATOLOGY 275, 275 (2009) (“Mature thalamocortical projections are not present until 29 to 30 weeks, which has led many to believe the fetus does not experience emotional ‘pain’ until then. Pain requires both nociception and emotional reaction or interpretation.”).

175. See Andrea Smardon, *Abortion Providers in Utah Adapt to New Anesthesia Requirement*, NPR, April 7, 2016, <https://www.npr.org/2016/04/07/473416741/abortion-providers-in-utah-adapt-to-new-anesthesia-requirement> [<https://perma.cc/5422-EC6M>]. Medical ethics requires respect for autonomy and beneficence toward patients. These are “two of the fundamental principles” that govern patient interactions. Beneficence requires physicians to promote good and act in the best interest of the patient's health. Thus, physicians should not do things that harm patients, with very little benefit. See Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J.L. MED. & ETHICS 85, 86 (2010).

176. *Doe v. Greitens*, 530 S.W.3d 571 (Mo. Ct. App. 2017). See also Linley Sanders, *Abortion Rights Fight Has an Unlikely Champion: The Satanic Temple*, NEWSWEEK, Oct. 6, 2017, <http://www.newsweek.com/satanic-temple-pushes-abortion-fight-missouri-supreme-court-679779> [<https://perma.cc/Y2CU-8X6E>].

## 2. TRAP Laws Ignore Casey's Dicta on Informed Consent

The 1992 Supreme Court case *Planned Parenthood of Southeastern Pennsylvania v. Casey* made it clear that states can require physicians to inform women seeking abortion about the physiological development of the fetus or the risks of the abortion procedure.<sup>177</sup> However, this was conditioned on the information being truthful and non-misleading,<sup>178</sup> and allowing the physician to use her judgment to customize the information to the particular patient.<sup>179</sup> The *Casey* Court made their reasoning explicit: it was not to add extraordinary informed consent in the abortion arena, but to place informed consent on equal footing with other areas of medicine. The message was that informed consent in abortion should be “no different” and the doctor-patient relation was “entitled to the same solicitude it receives in other contexts.”<sup>180</sup> Further, in recognizing that previous abortion informed consent laws had been struck down, the Court distinguished those in *Casey* by stating that Pennsylvania’s laws were not “designed to dissuade the woman from having an abortion” and did not “impose a rigid requirement that a specific body of information be given in all cases, irrespective of the particular needs of the patient.”<sup>181</sup> In *NIFLA*, the Court narrowed the holding of *Casey* so that it only applied to licensed medical providers immediately before providing an abortion procedure.

Legislators who have passed TRAP laws that require physicians to provide medically inaccurate or misleading information have ignored this important dicta from *Casey*.<sup>182</sup> The part of *Casey* getting more attention is the general requirement that a TRAP law not place an “undue burden” on the exercise of the woman’s right. *Casey*’s undue burden test holds that “a provision of law is invalid, if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion.”<sup>183</sup> The Circuits were somewhat split in terms of

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

178. *Id.*

179. “Critical to our decisions in *Akron* and *Thornburgh* to invalidate a governmental intrusion into the patient-doctor dialogue was the fact that the laws in both cases required *all* doctors within their respective jurisdictions to provide *all* pregnant patients contemplating an abortion a litany of information, regardless of whether the patient sought the information or whether the doctor thought the information necessary to the patient’s decision.” *Rust v. Sullivan*, 500 U.S. 173, 203 (1991).

180. *Casey*, 505 U.S. at 884.

181. *Id.* at 882.

182. Indeed, following *Whole Women’s Health v. Hellerstedt*, these types of TRAP laws will be under greater scrutiny. Given that *Whole Women’s Health* stated that courts can look to common sense and the actual effects of TRAP laws on a woman’s constitutional rights, as opposed to speculating about whether the state’s interests are narrowly tailored, it will be crucial to collect data on how TRAP laws unduly burden the right to terminate. See *Whole Women’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2317 (2016) (“Courts are free to base their findings on commonsense inferences drawn from the evidence.”).

183. *Casey*, 505 U.S. at 878. However, as John Robertson has pointed out, “finding an improper purpose to stop abortion or burden women will be rare, given the legitimate fetal-protection, health, and autonomy concerns that might motivate legislators . . .” John A. Robertson, *Science Disputes in Abortion Law*, 93 TEX. L. REV. 1849, 1852 (2015). Instead, as the Supreme Court recognized in *Whole Women’s*

how to interpret this language and how much deference to give to empirical evidence to demonstrate an undue burden. However, the Supreme Court in *Whole Women's Health* offered guidance, stating that “[c]ourts are free to base their findings on commonsense inferences drawn from the evidence.”<sup>184</sup> Regardless of how future courts interpret this important test, however, legislators have deliberately ignored it, and *Casey*'s dicta on informed consent, when fashioning pro-life TRAP laws.<sup>185</sup> This is perhaps because they were setting up legal challenges to *Casey* itself, anticipating the replacement of Justice Kennedy on the Supreme Court.<sup>186</sup>

Informed consent is not some slippery placeholder that means whatever you want it to mean. It has a history and specific content. Informed consent means that accurate, relevant information will be shared with a competent patient, who will have adequate time to process it, understand it, and then use this information to make a voluntary medical decision.<sup>187</sup> According to the American Medical Association's Opinion on this matter, “[s]uccessful communication in the patient-physician relationship fosters trust and supports shared decision making,” and thus physicians must “[p]resent relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information.”<sup>188</sup> The pregnant woman's decision can be neither voluntary nor informed if it is based on misrepresentations. But this is precisely what many TRAP laws, and deceptive CPCs, do.

As Judith Daar correctly points out, the “informed consent” TRAP laws blur ethical clinical judgment with legislative ideology. According to Professor Daar, informed consent is not well supported when TRAP laws “foist a scripted message displaying the state's moral repugnance to the proposed treatment

*Health*, the second prong of the undue burden test may be met with empirical, common sense data on the actual effect these laws have on women's access to abortion.

184. *Whole Women's Health*, 136 S. Ct. at 2317.

185. For a recent example, see the 2018 proposed bill in the Utah state legislature making abortion illegal at any point in the pregnancy, if the purpose is to terminate a fetus with Trisomy 21. The legislators were advised by the state's legislative advisory committee that this bill would violate *Casey*, but the sponsors pursued it nonetheless. See Luke Ramseth, *Here's What You Need to Know About Utah's Proposed Down Syndrome Abortion Ban*, Salt Lake Trib. (March 4, 2018), <https://www.sltrib.com/news/health/2018/03/04/heres-what-you-need-to-know-about-utahs-proposed-down-syndrome-abortion-ban/> [<https://perma.cc/KSN2-G89G>].

186. While not the focus of this article, the replacement of Justice Kennedy with Justice Kavanaugh, nominated by President Trump, is likely to move the Supreme Court in a significantly more conservative direction as it relates to reproductive rights. Justice Kennedy had three times affirmed the basic holding of *Roe v. Wade*—by signing on to the majority of *Casey*; by assuming it was controlling in the *Carhart* opinion that he wrote; and in signing on to the opinion in *Whole Women's Health*. For a brief summary of Justice Kavanaugh's position on reproductive rights, and *Roe v. Wade*, see Clare Foran & Joan Biskupic, *Where Brett Kavanaugh Stands on Key Issues*, CNN (Oct. 6, 2018), <https://www.cnn.com/2018/07/09/politics/kavanaugh-on-the-issues/index.html> [<https://perma.cc/LDC5-UDK4>]; see also Ian Millhiser, *The Supreme Court Just Gave Us Its First View of How It Will Handle Abortion in the Kavanaugh Era*, THINKPROGRESS (Dec. 10, 2018), <https://thinkprogress.org/supreme-court-abortion-kavanaugh-05ac30d8b22a/> [<https://perma.cc/UKZ4-KGJD>].

187. See generally Schuck, *supra* note 159, at 902-05.

188. Code of Medical Ethics Opinion 2.1.1, *supra* note 157.



plan.”<sup>189</sup> Scholars in medical ethics have generally agreed that this requires physicians to “commit an untenable ethical and professional wrong—deceiving their patients by providing false information and withholding empirically derived, evidence-based clinical data.”<sup>190</sup> Even so, as Jessie Hill points out, “courts tend to be highly permissive” of TRAP laws, while “they have often been more skeptical of disclosure requirements imposed on [CPCs].”<sup>191</sup> It is this federal First Amendment jurisprudence protecting CPC deception that begs for a private, state tort remedy.

### *E. The Practical Advantages of Battery Over Negligence Claims*

Battery places the victim of the harm in the driver’s seat, allowing her to decide whom to sue and for how much. Battery also entitles the plaintiff to potential punitive damages, in addition to any damages for her pain and suffering or dignitary harm.<sup>192</sup> While punitive damages are rare, they are more likely to be awarded in intentional tort cases where there is willful misconduct, malice, or reckless disregard for the rights of others.<sup>193</sup> If the jury finds that the particular CPC defendant willfully misled the plaintiff in order to get her to carry her pregnancy to term, then punitive damages might be warranted. This could make the lawsuit more attractive for plaintiffs’ attorneys to take on a contingency basis, which might improve access to justice for low-income women.

Given that most states follow the physician-standard for informed consent, these cases will often require expert testimony as to what the physician *should* have disclosed. It can often be difficult for plaintiffs to find a physician who will testify against another local physician in this regard. Further, even under the patient-standard, in order to prove the causation element of negligence the plaintiff needs to prove that, had she been adequately informed, she would have chosen to do something different. It is often difficult to prove causation, even where the patient could prove that some information was negligently withheld. Will the jury believe the claim that the patient would have chosen differently?

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189. Judith Daar, *Distinctions in Disclosure: Mandated Informed Consent in Abortion and ART*, 43 J.L. MED. & ETHICS 255, 256 (2015).

190. Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, 39 HASTINGS CTR REP. 21, 21 (2009).

191. Hill, *supra* note 2, at 60 (“Thus, in contrast to the strict scrutiny that applies to compelled speech in the context of what may be called ‘public discourse,’ the Court implied that only rational basis review is applicable to restrictions and speech requirements in the professional speech context, at least where, as in *Casey*, the speech is found to be truthful, nonmisleading, and relevant to the woman’s decision.”).

192. See RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 46 (AM. LAW. INST. 2012) (“An actor who by extreme and outrageous conduct intentionally or recklessly causes severe emotional harm to another is subject to liability for that emotional harm and, if the emotional harm causes bodily harm, also for the bodily harm.”); Kohlman, *supra* note 123.

193. JOHN C.P. GOLDBERG, ANTHONY J. SEBOK & BENJAMIN C. ZIPURSKY, TORT LAW: RESPONSIBILITIES AND REDRESS 536-37 (4th ed. 2016).

In these respects, a battery claim is easier to prove. The battery plaintiff need not prove that the physician had a duty to disclose anything, that the failure was a breach of a professional standard of care, or that she would have chosen not to have the exam had she known its true nature.<sup>194</sup> The battery cause of action is much more protective of the physical integrity of the plaintiff and does not balance this interest against the rights of the defendant. In a battery claim, there is no deference to the community or industry practices of defendants.

Given that the petitioner in *NIFLA* claimed that it was not providing medical care, a civil plaintiff could cite this when arguing that an informed consent claim would be inappropriate for a plaintiff who is seen at an unlicensed CPC. But, more appropriately, the problem with an informed consent claim is that the defendant CPC is not a medical provider, and the elaborate ethical canons that have developed for physicians do not apply to unlicensed CPCs. The CPC plaintiff is not technically a patient, even if she thinks that she is. It is the unique position of the physician, and the sanctity of the physician-patient relationship, that has led to the development of informed consent as a claim. You cannot bring an informed consent-style claim against your auto-mechanic or plumber, nor can you bring one against a CPC. Instead, you would need to prove battery or ordinary negligence by the defendant. Under ordinary negligence, given that the plaintiff would be arguing that inadequate information was shared, this claim would be framed as a “failure to warn” type of claim.

Failure to warn claims are notoriously difficult to win. This is because the common law does not impose affirmative duties to protect or warn on just any defendant; there must be a special relationship between the parties. Historically, the special relationship has been one where there is a power imbalance between the plaintiff and defendant, where the defendant is a fiduciary of the plaintiff, or where the plaintiff puts her safety or person in the custody of the defendant. The classic “special relationship” that give rise to a duty to warn are landlord/tenant, doctor/patient, and business/customer relationships.

The CPC facility, in taking on a pseudo-clinical function and holding its doors open to the public to provide counseling services, would quite likely be considered in a “special relationship” with the pregnant woman. Thus, the CPC would likely be under a duty to protect and warn the women it sees in its pseudo-clinic, even when it is unlicensed. This could create obvious duties to provide accurate and complete information to the woman. However, this argument would depend on the judge and her notions of what makes for good public policy. The judge makes decisions about whether there is a duty by looking to a long list of factors. Given the political context in which abortion cases are decided, and the

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194. See *Kohoutek v. Hafner*, 383 N.W.2d 295, 299 (Minn. 1986).

historical inability for judges to treat abortion as unexceptional in tort,<sup>195</sup> the negligence cause of action against CPCs is not as desirable as a battery claim.

Moreover, damages in a negligence or informed consent case might be modest. Typically, negligence damages are awarded to pay for economic expenses and pain and suffering that result as a consequence of the breach. However, many states limit the amount of pain and suffering damages that can be awarded and might limit the economic damages if they are framed as caring for a healthy, unwanted, child. Such claims are unfortunately referred to as “wrongful birth” claims.

If the negligence case is framed as a failure to provide adequate information that resulted in the birth of a child, some states prohibit this type of claim because, in their view, the birth of a child can never be an injury.<sup>196</sup> States are about evenly split on whether they will allow for some recovery for the cost of raising a child when the traditional negligence elements are met.<sup>197</sup> Some states will only allow for compensatory damages for child-rearing expenses when the child that is born has severe disabilities. This makes “wrongful birth” claims exceptional, when in reality calculating the damages from child care and medical expenses are quite ordinary, but courts have struggled with the philosophical implications of allowing the birth of a child to be an injury.<sup>198</sup> If, instead, the claim is brought as a battery claim, the plaintiff will dodge this philosophical bullet. However, depending on the jurisdiction, the plaintiff may not be able to receive damages for regular child-rearing expenses.

#### IV. REGULATING CPCs AS PRACTICING MEDICINE WITHOUT A LICENSE

##### A. *Medical Licensing Laws Protect the Public and Have Been Deemed Constitutional*

*NIFLA* teaches states they will need to pursue other non-pregnancy-specific options if they want to protect their citizens from deceptive CPC practices. The next option that will be explored is the prosecution of CPCs for the unlicensed practice of medicine. Even the petitioners in *NIFLA* acknowledged this possibility, though they seemed confident that they were not practicing medicine. Assuming, *arguendo*, that *NIFLA* does not practice medicine under a free speech

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195. Judges struggle to apply basic tort concepts about compensatory damages to wrongful birth cases, given that the successful wrongful birth claim requires the parents to argue that they would have had an abortion had the physician informed them of material clinical information. See generally *Kassama v. Magat*, 792 A.2d 1102, 1117 (Md. 2002); *Procanik v. Cillo*, 478 A.2d 755, 763 (N.J. 1984); *Turpin v. Sortini*, 643 P.2d 954, 958 (Cal. 1982).

196. CHARLES KRAUSE, ALFRED GANS & MONIQUE LEAHY, 2A AM. L. OF TORTS §§ 9:27-28 (2018) (“The major obstacle to an infant plaintiff’s claim in such a case is the determination of damages.”).

197. *Id.* § 9:27.

198. *Schirmer v. Mt. Auburn Obstetrics & Gynecologic Assoc., Inc.*, 844 N.E.2d 1160, 1165 (Ohio 2006) (“Birth of a normal, healthy child cannot be an injury to her parents.”).

analysis, many states would likely disagree that CPCs are not practicing medicine. In a bit of a taunt, NIFLA's attorney granted that "[i]t's illegal to pretend to practice medicine without a license," so "[i]f that's what's going on here, surely California would have found a way to [prosecute CPCs] before now."<sup>199</sup> Of course, this is a different remedy, with different applicable standards and constitutional review, but it is something California, and other states, could and should do.

Every state prohibits the unauthorized practice of medicine, and then defines what constitutes the "practice of medicine" for that state.<sup>200</sup> New York has a representative law, which defines the practice of medicine as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."<sup>201</sup> In some states, like Ohio, "holding out of one's self as being engaged in the practice of medicine shall be regarded as practicing the same,"<sup>202</sup> such that advertising or claiming to the public "to be a practitioner of medicine and surgery, or any of its branches"<sup>203</sup> would be a violation. Thus, CPCs' diagnostic reproductive services and counseling would violate Ohio's statute. Of course, the state licensing board and local prosecutors would have to decide that they wanted to bring such a claim, as there is not a private right of action. This requires the political will of elected officials. But enforcing these statutes does not pose any First Amendment challenges. Even an extremely conservative and anti-regulation Supreme Court would struggle to wiggle out from established precedent that permits this kind of regulation.

In 1889, in *Dent v. West Virginia*,<sup>204</sup> the Supreme Court upheld a West Virginia statute that made it a misdemeanor to practice, or attempt to practice, medicine without being qualified or a graduate of a reputable medical college.<sup>205</sup>

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199. Oral Argument at 17:45, *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S. Ct. 2361 (2018) (No. 16-1140), <https://www.oyez.org/cases/2017/16-1140> [<https://perma.cc/4HRK-9JQQ>].

200. In the mid 1970s, several state courts upheld convictions of acupuncture practitioners for the unauthorized practice of medicine, as the insertion of needles was considered minor surgery and the use of needles to reduce pain constituted the practice of medicine. *See* *People v. Amber*, 349 N.Y.S.2d 604 (Sup. Ct. 1973); *State v. Won*, 528 P.2d 594 (Or. Ct. App. 1974); *State v. Wilson*, 528 P.2d 279 (Wash. Ct. App. 1974). A Washington state court easily found that acupuncturists practiced medicine under the plain language of the statute, as they "offer services to people with various afflictions and tell them they can help them feel better." *See* *State v. Pac. Health Ctr., Inc.*, 143 P.3d 618, 626 (Wash. Ct. App. 2006). Chiropractors have also been prosecuted for failing to comply with state licensing regulations when their practice exceeded the scope of their permit or they used the title "physician" or "doctor," which implied graduation from an allopathic, accredited medical school. *See* *State v. Rich*, 339 N.E.2d 630, 632 (Ohio 1975).

201. N.Y. EDUC. LAW § 6521 (McKinney 2018).

202. *State v. Farrand*, 120 N.E.2d 469, 470 (Ohio Ct. App. 1952).

203. OHIO REV. CODE ANN. § 4731.41 (West 2018).

204. 129 U.S. 114 (1889).

205. William P. Gunnar, *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?*, 14 ANNALS HEALTH L. 329, 338 (2005). *See also* Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 214 (1999).

The punishment for each offense could include a \$5,000 fine, or a 12-month imprisonment in the county jail.<sup>206</sup> The prohibition on practicing medicine without a proper degree or license was considered by the Supreme Court to be within the state’s power to protect its citizens from the “consequences of ignorance and incapacity, as well as of deception and fraud.”<sup>207</sup> Medical licensing laws have also survived most constitutional challenges, specifically claims of unconstitutional limitation of the free exercise of religion<sup>208</sup> and violations of due process.<sup>209</sup> There are limits on regulation of the medical profession.<sup>210</sup> However, requiring medical licensure for clinics engaged in medical services would almost certainly be upheld. The key, of course, would be in making the threshold determination that CPCs are practicing medicine without a license.

The penalties imposed for violating modern regulations vary from state to state.<sup>211</sup> In California,<sup>212</sup> any person who practices “any system or mode of treating the sick or afflicted” or who “diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person” without a required certificate may be liable for a fine of up to \$10,000, imprisonment for a period of up to one year, or both. In New Hampshire,<sup>213</sup> on the other hand, violations may be penalized by receiving a cease and desist order or a fine of up to \$50,000.<sup>214</sup> In Utah, practicing medicine without a license would generate a meager civil money penalty of not more than \$5,000,<sup>215</sup> which again reflects the weak political will of the state in enforcing these practices. Some of these fines are modest enough that they might be easy for the CPCs to pay. Alternatively, the state could pursue imprisonment in some states, like California, but this is politically very unpopular and therefore quite unlikely. Given the type of remedies involved, it is unsurprising that California has not yet chosen to prosecute CPCs for the unlawful practice of medicine. The action is not likely to yield meaningful consumer protection where CPCs can merely pay the fine or obtain a medical license and continue to mislead.

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206. Dent, 129 U.S. at 232.

207. *Id.* at 122.

208. *Smith v. People*, 117 P. 612 (Colo. 1911).

209. *Hitchcock v. Collenberg*, 140 F. Supp. 894 (D. Md. 1956).

210. A North Carolina law that required physicians to present pregnant women with a sonogram of their fetus and describe the fetus in real-time, even if the woman actively “avert[s] her eyes” and “refus[es] to hear,” was found to go beyond the extent permitted for reasonable regulation of the medical profession, while simultaneously threatening harm to the patient’s psychological health, interfering with the physician’s professional judgment, and compromising the doctor-patient relationship. *Stuart v. Camnitz*, 774 F.3d 238, 242-45 (4th Cir. 2014) (holding that the North Carolina ultrasound law violated the First Amendment).

211. For an overview, see 118 AM. JUR. PROOF OF FACTS 3d 215 (2018).

212. CAL. BUS. & PROF. CODE § 2052 (Deering 2018).

213. N.H. REV. STAT. ANN. § 329:24 (2018).

214. *Id.*

215. UTAH CODE ANN. § 58-67-301 (West 2018).

Unlicensed CPCs may run afoul of the medical licensing laws of the state, as the diagnosis of pregnancy, the discussion of prenatal care, and the use of ultrasound imaging will easily constitute the practice of medicine.<sup>216</sup> While CPCs might employ volunteer nurses and physicians, they would need to be licensed and in good standing in each state, and the facility itself would need to be licensed as a medical facility.

*B. New York Investigates CPCs for the Unauthorized Practice of Medicine*

In May of 2013, the Attorney General of New York issued a subpoena on Evergreen Association, which operates twelve CPCs in the New York City area. The purpose of the investigatory subpoena was to determine whether the CPCs were engaged in the unauthorized practice of medicine. A series of public hearings conducted in 2010 and 2011 by the New York City Council found that Evergreen “engaged in conduct which could constitute the unauthorized practice of medicine, including evaluating fetal health and requesting the medical history of clients.”<sup>217</sup> Meanwhile, a televised news segment reported that “Evergreen made diagnoses of gestational age and situated its centers in medical buildings making them appear like medical offices.”<sup>218</sup> The subpoena was meant to uncover whether the CPCs should be fined, as they did not appear to have any licensed medical staff.

Evergreen attempted to quash the subpoena as a politically motivated attack on their constitutional right to advocate against abortion. It claimed that the Attorney General lacked a factual basis for issuing the subpoena. In June 2017, the Appellate Division of the Supreme Court of New York found that the Attorney General had “amply demonstrate[d]” that a “legitimate factual basis existed for the Attorney General to conduct his investigation and issue the subpoena to determine whether Evergreen is engaged in the unauthorized practice of medicine,” as he had adduced evidence “that Evergreen’s centers were set up to look like medical offices, staff members were dressed in scrubs or lab coats, a medical history was taken from clients, diagnoses of pregnancies, ectopic pregnancies, and gestational age were made, and medical advice was given, including false advice.”<sup>219</sup>

The investigation could proceed, but, because Evergreen is a CPC with ideological roots, the court had to make sure the organization’s freedom of speech and association were not unduly chilled. Therefore, the court limited the scope of the document requests to ensure they were narrowly tailored to target

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216. See AM. JUR. PROOF OF FACTS, *supra* note 211. *But see* Albini v. Connecticut Med. Examining Bd., 72 A.3d 1208, 1214 (Conn. App. 2013) (holding that midwifery assistance for normal pregnancies does not constitute the practice of medicine).

217. Evergreen Ass’n, Inc. v. Schneiderman, 54 N.Y.S.3d 135, 138 (N.Y. App. Div. 2017).

218. *Id.*

219. *Id.* at 142.

only Evergreen's provision of medically-related services.<sup>220</sup> The Attorney General could not request documents about the overarching corporate structure or funding of Evergreen Association, unless those individuals were related to the provision of medical care.

The investigation by the Attorney General of New York is a step in the right direction to protect the health of the women of New York. Given that many CPCs provide confirmation of pregnancy and gestational age of the fetus and offer prenatal vitamins, ultrasounds, and counseling on sexually transmitted diseases,<sup>221</sup> it is alarming that some continue to do this without having medically licensed staff. There is great potential for substandard care and resulting harm, as women delay seeing licensed clinicians. These are the precise kinds of risks the state medical licensing statutes were drafted to address.

## V. REGULATING CPCs BY CHALLENGING THE USE OF FDA-APPROVED DEVICES IN UNAPPROVED WAYS

### A. *The Co-Opting of the Ultrasound Device*

In theory, FDA enforcement could also provide a means for curbing CPCs' deceptive practices. One of the chief ways that CPCs deceive pregnant women is by advertising that they provide free ultrasounds. This is a major selling point, especially for low-income women who seek their services. And given that the biggest risk factor in failing to receive adequate prenatal care is poverty and lack of insurance, this was precisely why California passed the FACT Act, requiring disclosure of California's state-funded pregnancy treatment options.<sup>222</sup> Recognizing that their niche market was the underinsured, a CPC trainer advised trainees to tell callers asking about abortion care that, while the CPC does not offer abortion services, it does provide free ultrasounds that the woman will need to have before she can get abortion care.<sup>223</sup> From the pro-life perspective, providing a guided ultrasound is "crucial to the explicit task of persuading the woman not to abort."<sup>224</sup> The idea is based in part on an unproven premise that women who abort their fetuses are doing so thoughtlessly. Once the woman sees,

220. *Id.* at 146.

221. Chen, *supra* note 5, at 936-37.

222. Nat'l Inst. of Family & Life Advocates v. Harris, 839 F.3d 823, 841 (9th Cir. 2016) ("The California Legislature determined that a substantial number of California citizens may not be aware of, or have access to, medical services relevant to pregnancy. This includes findings that in 2012, 2.6 million California women were in need of publicly-funded family-planning services, and that thousands of pregnant California women remain unaware of the state-funded programs that offer an array of services, such as health education and planning, prenatal care, and abortion.").

223. Winter, *Save the Mother, Save the Baby, An Inside Look at a Pregnancy Center Conference*, COSMOPOLITAN (April 6, 2015), <http://cosmopolitan.com/politics/a38642/heartbeat-international-conference-crisis-pregnancy-centers-abortion> [<https://perma.cc/Z9HA-RCFN>].

224. Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 375 (2008).

via ultrasound, the heartbeat and perhaps the head, fingers, and toes of *her* fetus, she will be forced to emotionally confront the life she is about to terminate and will change her mind.

Pro-life advocates have relied heavily on the persuasive power of the ultrasound. Twenty-six states have enacted some form of legislation that requires a woman to obtain an ultrasound before terminating her pregnancy. Similar bills have been introduced in many other states.<sup>225</sup> In Kentucky, Louisiana, Texas, and Wisconsin, state law requires that the abortion provider show the woman the image on the ultrasound and describe it to her, even if she does not want to see it.<sup>226</sup> North Carolina passed a law that required physicians performing abortions to display and describe the image during the ultrasound, even if the woman actively “avert[s] her eyes” and “refus[es] to hear.”<sup>227</sup> This “real-time view” aspect of the law was challenged by physicians as compelled speech that violated their First Amendment rights (and professional ethics). The Fourth Circuit agreed that the “real-time view” part of the statute did not survive intermediate scrutiny.<sup>228</sup> It was critical to the Court’s holding that the North Carolina law not allow physicians to deviate from the required disclosures or timing, even if, in the physician’s professional judgment, she thought it was best to do so. Doctors in Kentucky are likewise challenging their state’s informed consent to abortion statute on similar First Amendment grounds.<sup>229</sup> It will be interesting to see what level of scrutiny the federal courts apply, in light of *NIFLA* and the Court’s dismissal of intermediate review for professional speech. Either way, state informed-consent laws that provide for the physician to deviate from the content of the required disclosure and timing if it is in her best medical judgment to do so, seem much more likely to be upheld.<sup>230</sup> Given that ultrasound is becoming a prerequisite to obtaining an abortion, it is necessary to see what the FDA has to say about its use in nonclinical settings, such as CPCs.

*B. Ultrasounds are FDA-Approved Devices that Should Not Be Used in Pseudo-Clinical Ways*

Ultrasound is a medical technology that is regulated by the FDA. Ultrasound provides a window into the anatomy of a fetus *in utero*, by sending sound waves through soft tissue such as the pregnant belly. The sound waves bounce off the

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225. See *State Ultrasound Requirements in Abortion Procedures*, KAISER FAMILY FOUNDATION, <https://www.kff.org/womens-health-policy/state-indicator/ultrasound-requirements/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> [https://perma.cc/76CN-5UJN].

226. *Id.*

227. 2011 N.C. SESS. LAWS 405.

228. *Stuart v. Camnitz*, 774 F.3d 238, 256 (4th Cir. 2014).

229. *EMW Women’s Surgical Ctr., P.S.C. v. Beshear*, 283 F. Supp. 3d 629, 632 (W.D. Ky. Sept. 27, 2017).

230. See *Stuart*, 774 F.3d at 254.



tissue and render images of the size and structure of these organs and tissues, including any abnormalities in fetal development.<sup>231</sup> Ultrasound has become a very important tool in obstetrics to confirm pregnancy, diagnose ectopic and molar pregnancies, and reveal fetal disfigurement, fetal movements, and uterine cysts or other abnormalities.<sup>232</sup> Modern ultrasound technology employs higher frequency sound waves that can show a moving 3-D image of the wiggling fetus.

While the technology is generally considered safe, prolonged non-clinical exposure may have negative health effects.<sup>233</sup> Ultrasound waves can heat the tissues and produce small pockets of gas in body fluids or tissues.<sup>234</sup> The long-term consequences of these effects are still unknown.<sup>235</sup> Out of concern for the negative health effects on the fetus, organizations such as the American Institute of Ultrasound in Medicine have advocated for “prudent use” of ultrasound during pregnancy, and have discouraged it from being used off-label. In addition to the biological effects of ultrasound on the pregnant woman and fetus, there are also health risks from inadequately trained staff or poorly maintained equipment.<sup>236</sup>

Even with the 3-D advancements, ultrasound images require skill to be interpreted correctly and meaningfully. This is especially true in early pregnancy, when capturing the correct angles is difficult and the rendered images may be quite ambiguous to the untrained eye. Given the skill required to capture and interpret the images, it is shocking that many CPCs lack trained or licensed radiological technicians. The lack of training of CPC staff can harm pregnant women and their fetuses.

The most obvious potential harm is that women assume, incorrectly, that their babies are healthy after having the ultrasound performed. This risk was first identified when “keepsake ultrasound” studios such as Fetal Fotos opened in malls around the country. Women assumed the photographer would tell them if they saw something abnormal in the image.<sup>237</sup> However, some photographers boldly announced that “they will ignore fetal abnormalities even if a fetus has three legs.”<sup>238</sup>

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231. 75 AM. JUR. TRIALS 55 *Ultrasound (Sonography)* § 49 (2018).

232. Sanger, *supra* note 224, at 369.

233. See *Information for Patients including Expectant Mothers*, U.S. FOOD & DRUG ADMIN. (Aug. 29, 2018), <https://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/ucm115357.htm#industry> [<https://perma.cc/GZR4-Y2VY>] (“While ultrasound is generally considered to be safe with very low risks, the risks may increase with unnecessary prolonged exposure to ultrasound energy, or when untrained users operate the device.”).

234. *Avoid Fetal “Keepsake” Images, Heartbeat Monitors*, U.S. FOOD & DRUG ADMIN. (Dec. 16, 2016), <https://www.fda.gov/forconsumers/consumerupdates/ucm095508.htm> [<https://perma.cc/FVP3-PG BE>].

235. See *Information for Patients including Expectant Mothers*, *supra* note 233.

236. Jennifer M. Uhles, *Unsound Ultrasounds? An Examination of State Legislation Regulating Non-Medical Ultrasound Use and Private Ownership*, 28 J. LEGAL MED. 263, 264 (2007).

237. Archie A. Alexander, “Just Scanning Around” with Diagnostic Medical Ultrasound: Should States Regulate the Non-Diagnostic Uses of This Technology?, 16 ANNALS HEALTH L. 1, 8 (2007).

238. *Id.*

In one instance, a woman went to a keepsake imaging studio and left believing her baby was healthy. She later discovered at her OB/GYN clinic that her baby had significant fetal anomalies that were consistent with Trisomy 18 and Smith-Lemli-Opitz Syndrome. These abnormalities were visible earlier, but went undetected or unreported by the operator at the fetal keepsake studio.<sup>239</sup> Ignoring these defects and not reporting them seems cruel, until you realize that the photographers are probably not very experienced in reading these images and are also trying to insulate themselves from claims of medical malpractice or the unauthorized practice of medicine. There are many instances of clinicians being sued for medical malpractice over improper capture or interpretation of ultrasound images.<sup>240</sup> Whatever line remains between keepsake studios and clinical practice must be defended by these businesses.

If the keepsake imaging studio were held to a medical standard of care, it could be liable for negligence for failure to report significant clinical findings. However, given that these entities are purely commercial and make no claims about diagnosing disorders, the consumers are poorly protected from the false sense of security they receive. There is significant risk of psychological injury, as well as the potential to neglect more rigorous clinical follow-up if they assume the fetus is healthy. Unfortunately, we will probably never know the extent of the harm done by these keepsake ultrasound studios, as they are unlikely to report their findings to any public health agencies.<sup>241</sup>

While the practices at keepsake ultrasound studios are troubling, the risk that the consumer will misinterpret the nature of the ultrasound is much more profound at a pseudo-clinic, such as a CPC. If you are visiting a strip mall and realize you are paying for a “fun” and “novel” ultrasound experience in an obviously non-clinical setting, your expectations differ significantly from the expectations of women entering a CPC. As discussed previously, CPCs deliberately mislead women into thinking they are seeing a nurse or doctor at a proper health clinic. Given the heightened risk of misperception, it is much less ethical for CPCs to employ ideological and unlicensed staff to interpret ultrasound images.

### *C. States and the FDA Could Prohibit the Use of Ultrasound by Unlicensed CPCs*

Louisiana has attempted to eliminate off-label, non-clinical ultrasound screening by defining them as an unauthorized practice of medicine under

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239. *Id.* at 7.

240. *LaRose v. Washington University*, 154 S.W.3d 365 (Mo. Ct. App. 2004); *see also* 75 AM. JUR. TRIALS 55 (2018).

241. Alexander, *supra* note 237, at 7-8.

Louisiana law.<sup>242</sup> California already protects somewhat against the use of ultrasound technology for non-approved uses. In 2009, the California legislature passed a bill that requires certain disclosures before ultrasound is used for non-clinical purposes. Specifically, the consumer must be told “that the FDA has determined the use of medical ultrasound equipment for reasons other than medical purposes or without a physician’s prescription is an unapproved use of medical technology.”<sup>243</sup> Unfortunately, despite their ability to do so, state and federal regulatory agencies have not enforced any actions against keepsake ultrasound studios or CPCs based on their provision of ultrasounds.<sup>244</sup>

FDA discourages the use of ultrasound in a non-clinical setting by those who are not trained in its use or interpretation. While off-label uses of devices may be allowed under the supervision of a physician and within tight statutory conditions, the use by non-clinicians such as unlicensed CPCs or keepsake studios is clearly an unapproved off-label use.<sup>245</sup> In addition to regulating how the device may be used, the FDA has also deemed the promotion of unapproved uses of a device to be a violation of FDA regulations, and the training of CPC staff for an unapproved use would be “illegal promotional activity.”<sup>246</sup> FDA could require that CPCs employ trained ultrasound technicians and comply with clinical guidelines. Ultimately, the FDA has the authority to shut keepsake-imaging studios down. However, given the limited resources available for enforcement at the FDA, senior agency officials appear to have opted to focus their attention on more high-risk devices.<sup>247</sup>

#### CONCLUSION: RECLAIMING INFORMED CONSENT IN THE ABORTION CONTEXT

By suggesting that women bring battery causes of action against unlicensed CPCs, this Article advocates for returning informed consent law to its ethical and legal roots. Informed consent doctrine surrounding abortion has been perverted by state TRAP laws, which have blurred the lines between ideology and medicine. The majority opinion in *NIFLA* exacerbates this troubling trend. When

242. Under the bill as proposed, any person who administers an ultrasound upon a pregnant woman without an order or referral shall be guilty of a Class A misdemeanor. The bill included an exception for individuals who are licensed to practice medicine, as well as licensed advanced practice nurses and licensed physician assistants. See La. State Bd. of Med. Exam’rs, *Statement of Position, Self-Referred Diagnostic Ultrasound Screening* (Oct. 25, 2000), <https://www.lsbme.la.gov/sites/default/files/documents/Statements%20of%20Position/UltrasoundScreening.pdf> [https://perma.cc/6H5A-HBSK] (last visited Nov. 19, 2018).

243. Uhles, *supra* note 236, at 270.

244. Alexander, *supra* note 237, at 9-10.

245. The allowed “off-label” uses assume that a “health care practitioner” will be prescribing the legally marketed device “to a patient” for a disease or condition “within a legitimate health care practitioner-patient relationship.” 21 U.S.C. § 396 (2018).

246. JAMES T. O’REILLY AND KATHARINE A. VAN TASSEL, 2 *FOOD & DRUG ADMIN.* § 18:94 (4th ed., 2018).

247. *Id.* § 18.1.

physicians are required to share misinformation with their patients seeking abortion, or when CPCs exploit the medical model, this does violence to the sanctity of the physician-patient relationship.<sup>248</sup> It erodes trust and sullies the professional reputation of *all* physicians. Even where abortion providers follow up the mandatory disclosures with disclaimers that “I only shared that information because I have to by law, not because I believe it,” there is still confusion. Does the physician speak for the government, or can she be trusted to protect her patients’ best interests? What does it mean if the physician is telling the patient things that she herself does not believe? Is anything objective in medicine, or is it all up for debate?

CPCs are exploiting the professional respect of physicians and the existing framework of informed consent to shoehorn ideology through medicine. Through TRAP laws and the deceptive practices of CPCs, the pro-life community is eroding the distinction between a clinic and a pseudo-clinic, and between politics and patient care. This could have sweeping negative impacts on the practice of medicine, and also on women’s health. Women who visit CPCs may delay being seen by actual doctors and might assume incorrectly that the CPC staff are held to a professional standard of care. This could impose significant health risks both on the pregnant woman and the fetus.

In the context of physician-assisted suicide, the Supreme Court has recognized that states have an interest in protecting the integrity and ethics of the medical profession.<sup>249</sup> This should also be true in the context of abortion providers. Recall that the *Casey* plurality stated that “the doctor-patient relation here is entitled to the same solicitude it receives in other contexts.”<sup>250</sup> This message has sadly been lost on many state legislators, eager to pass TRAP laws that pervert the ethical principles of patient autonomy, beneficence, non-maleficence, and justice. Physicians should be allowed to have political voices. So, too, should pro-life activists. But each should have their policy debates, and win or lose them, in the political sphere. The sacred relationship between the physician and patient should not be leveraged for ideological gains.

At present, the law is lopsided. The First Amendment protects the CPCs’ deceptive practices not in spite of but *because* they are pseudo-clinics, motivated not by commercial or professional interest but by ideology. Indeed, an auto-mechanic or plumber, and certainly a licensed health care facility, is legally prohibited from deceiving customers in the way that the CPCs do. And yet

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248. “The relationship between a patient and physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgments on patients’ behalf, and to advocate for their patients’ welfare.” See Code of Medical Ethics Opinion 1.1.1, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/patient-physician-relationships> [https://perma.cc/2XDC-8ATB] (last visited Nov. 19, 2018).

249. See *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

250. *Casey*, 505 U.S. at 884.

precisely because the clinic is not a clinic at all, its deceptive practices are afforded the greatest possible protection as ideological free speech. This is an absurd outcome, given how underhanded CPCs are about revealing their ideological underpinnings.

To correct this imbalance, it would have been wise for the Supreme Court to adopt the perspective of the objective listener of the compelled disclosures when determining how to classify CPCs' speech. This would have been a better way to balance the free speech rights of organizations against the public's need to understand who exactly is speaking to them. Political organizations such as CPCs should not be allowed to hide behind their ideology to deceive unsuspecting individuals. Unfortunately, at present this is not a practical solution. It is not reasonable to expect injured women to wait until the Supreme Court revisits or overrules its *NIFLA* precedent.

There are already tools at the disposal of our prosecutors and agency regulators which can help to provide some protection for pregnant women. Consumer protection statutes could restrict the deceptive advertising practices of CPCs. State laws prohibiting the unauthorized practice of medicine could be enforced, as New York's attorney general is attempting to do. FDA enforcement actions could chip away at the CPC's use of FDA-approved medical devices in non-approved ways. But each of these existing tools requires the political will of elected and appointed officials. And so far, there are very few of these leaders who are willing to spend the political capital to protect pregnant women from deceptive CPCs. This has left the injured pregnant women with very little recourse.

Following basic tort remedies of compensatory damages, these injured pregnant women should be compensated for their pain and suffering, any resulting lost wages or income, and any other reasonable financial damages that stem from the battery, such as increased medical expenses from delayed diagnosis of pregnancy complications, or even wrongful death if the CPC's conduct results in the unwanted death of the fetus.<sup>251</sup> Additionally, where the CPCs deliberately defrauded these women to gain access to their bodies, these women would also be good candidates for punitive damages, which would help to fund the litigation and attorney's fees.

We must fight to reclaim informed consent. It is not a meaningless tool to shoehorn ideology through. It is not an amorphous concept, which allows a pseudo-clinic to make a woman think she is being treated medically, when she is actually being persuaded to submit to a religious ideology. By returning to the roots of the informed consent doctrine, suing for the intentional tort of battery,

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251. For the same reasons discussed above related to "wrongful birth" claims, *supra* notes 196-198 and accompanying text, states are not likely to allow for damages from the resulting birth of a child, even where the CPC's deceptive practices led a woman to delay receiving an abortion until after it is prohibited by the state.

victims of the misleading practice of CPCs can obtain personal redress. In the absence of proper public enforcement, tort law emerges as our last and best resort. And while tort law is scattershot and *ex post*, it can nonetheless provide meaningful and necessary regulation of CPCs' deceptive behavior.